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 31st July 2013**
in: **The Boardroom, The York Hospital, Wigginton Road, York, YO31 8HE**

Time	Meeting	Location	Attendees
8.30am - 9.10am	Non-Executive Director Meeting with Chairman	Critical Care Seminar Room	Non-executive Directors
9.15am – 12.00pm	**Board of Directors meeting held in public**	**Boardroom**	**Board of Directors and observers**
12.10pm – 1.15pm	Board of Directors to consider confidential information held in private	Boardroom	Board of Directors
2.00pm – 2.30pm	Charitable Funds Trustee meeting - Year-end Accounts	Boardroom	Charitable Trustees
2.35pm – 4.00pm	Equality &Diversity presentation – "Unconscious Bias", lead by Sue Holden	Boardroom	Board of Directors and Corporate 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
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 31st July 2013**

At: **9.15am – 12.00pm**

In: **The Boardroom, The York Hospital**

A G E N D A					
No	***Item***	***Lead***	***Comment***	***Paper***	***Page***
Part One: General **9.15am - 9.30am**					
1.	**Welcome from the Chairman** The Chairman will welcome observers to the Board meeting.	Chairman			
2.	**Apologies for absence** No apologies for absence received.	Chairman			
3.	**Declaration of Interests** To receive any changes to the register of directors' declarations of interest, pursuant to section 6 of Standing Orders.	Chairman		A	5
4.	**Minutes of the Board of Directors meeting** To review and approve the minutes of the meeting held on 26th June 2013.	Chairman		B	11
5.	**Matters arising from the minutes** To discuss any matters arising from the minutes.	Chairman		Verbal	
6.	**Patient Experience** To hear a letter of complaint and compliment.	Peta Hayward Jennie Adams		Verbal	

No	Item	Lead	Comment	Paper	Page
Part Two: Quality and Safety 9.30am – 10.30am					
7.	**Quality and Safety Performance issues** To be advised by the Chairman of the Committee of any specific issues to be discussed. • Chief Nurse Report • Medical Director Report	Chairman of the Committee		C C1 C2	21 27 47
8.	**Director of Infection Prevention and Control Quarterly Report** To receive the quarterly report from the Director of Infection Prevention and Control.	Chief Nurse	Mike Keaney	D	67
9.	**Francis Report Update** To receive an update on the Trust's work around implementation of the recommendations.	Chief Nurse	Dianne Willcocks	E	75
10.	**Healthcare Governance Unit Quarterly Report** To receive the quarterly report from the Healthcare Governance Unit.	Chief Nurse	Philip Ashton	F	83
Part Three: Finance and Performance 10.30am – 11.00am					
11.	**Finance and Performance issues** To be advised by the Chairman of the Committee of any specific issues to be discussed. • Finance Report • Trust Efficiency Report • Operational Performance Report	Chairman of the Committee		G G1 G2 G3	123 131 143 149
12.	**NHS 111** To receive a report on the Initial Impact of the NHS 111 Telephone Triage Service.	Deputy Chief Executive		H	157

No	Item	Lead	Comment	Paper	Page
Part Four: Governance 11.00am – 12.00pm					
13.	**Report of the Chairman** To receive an update from the Chairman.	Chairman		I	163
14.	**Report of the Chief Executive** To receive an update on matters relating to general management in the Trust.	Chief Executive		J	167
15.	**Monitor quarterly return** To receive the quarter 1 return for approval to be submitted to Monitor.	Finance Director		K	175
Any Other Business					
16.	**Next meeting of the Board of Directors** The Board of Directors does not formally meet in public during the month of August, therefore the next public meeting of the Board will be Wednesday 25th September 2013 at Scarborough Hospital. Venue to be confirmed.				
17.	**Any other business** To consider any other matters of business: • York Research Facility Memorandum of Understanding (SH) • Short video of proposed catering arrangements at York site (BG)				

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:

- Consultant revalidation
- Contract for combined heat & power scheme

York Teaching Hospital NHS
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Additions: Professor Willcocks—Member—without Walls Board

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

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

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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 Boardroom, The York Hospital on 26th June 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
	Ms P Hayward	Executive Director of Human Resources
	Mrs S Holden	Executive Director of Corporate Development & Research (from item 13/089)
	Mr M Keaney	Non-executive Director
	Mr M Proctor	Deputy Chief Executive/Chief Operating Officer
	Ms L Raper	Non-executive Director
	Mr M Sweet	Non-executive Director
	Professor D Willcocks	Non-executive Director
Attendance:	Mrs K Gamble	Patient and Public Involvement Specialist for item 13/086
	Ms K Holgate	Matron for General Surgery and Urology for item 13/086
	Mr K Mainprize	Deputy Medical Director
	Mrs A Pridmore	Foundation Trust Secretary
	Mrs A Stanford	Directorate Manager for General Surgery and Urology for item 13/086

Observers: 3 observers (including 2 governors)

Mr Rose welcomed members of the public to the Board meeting. Mr Rose also welcomed Mr Mainprize, Deputy Medical Director, who was attending on behalf of Dr Turnbull.

13/082 Apologies for absence

Apologies were received from Dr A Turnbull, Medical Director and Ms McManus, Chief Nurse, and Mrs S. Holden, Executive Director for Corporate Development (joined the meeting at item 13/089)

13/083 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.

13/084 Minutes of the meeting held on 26th May 2013

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

13/085 Matters arising from the minutes

There were no matters arising from the minutes.

13/086 Patient Experience

Mr Rose welcomed Mrs Stanford, Ms Holgate and Mrs Gamble to the Board meeting and invited them to present to the Board.

Mrs Gamble provided an overview of the in-patient survey results and the purpose of the in-patient survey. She also explained how the survey was circulated in the Trust and the corporate expectation made to the Directorates.

Mrs Stanford presented the approach adopted in her directorate, as an example of how the Trust is acting upon the survey. She explained that the results had been shared with all staff and the top three actions had been identified. The Directorate had agreed that those identified would be audited, once it was established that improvements had been made a further three issues would be chosen. Mrs Stanford added that the three items chosen were not necessarily the top three "worst performers", but they were the top three that would help to empower patients and liberate staff.

The three actions chosen were: pain, delayed discharge and information given to patients before their operations.

Mrs Stanford described the actions being taken to address each of the priorities and the auditing work that his being undertaken to support them.

The Board discussed the presentation and the effect of the work.

Mrs Stanford commented that one of the areas for considerations was how the directorate was taking patient views into account. Mr Crowley commented that the complaints process centrally in the Trust had been tightened-up. He and Mr Proctor, along with Ms McManus and the patient experience team, now review each complaint every week and agreed the handling of the complaint. This ensures there is high-level support and direction given to the team. The Patient Advisory Liaison (PALs) team is also working better and able to manage the expectation of how the Trust engages with patients and families. The Board enquired how many complaints they are dealing with at each meeting. Mr Crowley advised that it is around 10-12. Professor Willcocks added that the changes to the PALs service mean that they now only have a telephone service, so there is no presence in the reception area. She suggested that it would be helpful to highlight that the Trust takes the comments received seriously and welcomes feedback from all patients and family members.

The Board thanked Mrs Stanford, Ms Holgate and Mrs Gamble for their presentations.

13/087 Quality and Safety Committee

Ms Raper highlighted the key points in the Quality and Safety Committee notes. Mrs Raper mentioned that she felt the work of the Committee was strengthening and deepening. She advised the Mr Ashton had joined the Committee.

Family and Friends – Mrs Raper mentioned that there continued to be some concern about the achievement of the target. Mr Crowley commented that for month 1 the return was very poor and, although there were improvements, for month 2 they were still low. He added that

the ward areas are achieving the target; the Emergency Department does however continue to have problems. The issues have been debated through the Executive Group and action is being taken to ensure the Trust achieves the target. He added that it is not possible to achieve the target and let the system just run; there needs to be some significant interaction from staff to encourage people in the Emergency Department to complete the cards. The Trust has previously taken a more pragmatic approach; this has changed and a more direct approach to the target through the operations and performance teams has been taken. This change is beginning to show results.

Mr Crowley added that he was grateful to Mr Proctor, the Operations team and the Performance team in taking this on.

Mr Proctor added that there are similar issues with the pressure ulcer Commissioning for Quality and Innovation (CQUIN) target, which are also being addressed.

The Board agreed that there were some challenges around getting the public to understand the benefits of the test. Mr Rose asked if lessons were being learnt about the speed of response to data. Mr Crowley agreed that there were lessons to learn. He added that the Board did receive early insight into the results and the Board was aware of the elements that were missing at the May meeting. The Board did hold a good discussion and provided the support that was needed. He added that the Executive Board had also discussed the issues in detail.

Mrs Adams asked how the Trust compares to other Trusts. Mr Crowley advised that he was aware of mixed success in terms of the Friends and Family test around the patch. As CQUIN applications become more aggressive, it becomes even more important for the Trust to do the right things. Mr Proctor reminded the Board that this year the Trust has put in place a far more robust set of accountability arrangements, with each CQUIN target being linked directly back to an Executive Director.

Mr Bertram added that the imposing of fines is new this year. In past years there has been some protection, through the System Management Executive (SME) that existed.

The Board enquired why the Family and Friends targets were not included on the Signal dashboard, along with other CQUIN measures. It was felt this was a timing issue and it would be included in future.

Development of Monthly Reporting – Ms Raper commented that discussions were being held to develop a full quality and safety dashboard, but the Committee continued to seek progress.

Electronic Prescribing – Ms Raper advised that progress had been made on the system and that it would be rolled-out in the autumn.

Theatre Safety Briefings – Ms Raper advised that the Committee shares the same view as the Governors and she welcomed the continued focus the Governors showed as part of the Quality Report. Mr Crowley added that the Executives also have a focus on this. He explained that there had always been anecdotal evidence that the briefings were being completed; as a result, a slight adjustment has been made to the recording system so it now requires a positive response that the briefing has taken place. He added that this also relates to conformity. The Board will remember that work was undertaken to develop a conformity approach to be used across the organisation. In this case, the nominated lead has to ensure the briefing has taken place properly.

Patient Safety Walkrounds – Ms Raper asked the Board to note the refreshed approach that was being taken. Mr Mainprize commented about the background to the development of the walkrounds and highlighted that the purpose was to just concentrate on patient safety. He explained that a timetable is set up for every area to be visited and each area has a multi-disciplinary team that has time to talk to staff about any issues. An action plan is developed from the visit. Mr Mainprize added that recently there has been a change to the administration support and a new coordinator has been put in place. A set of model questions have been introduced. In terms of night walkrounds these are different and have a different (broader) purpose, but patient safety walk rounds do need to take place at night too.

Mr Ashton commented that he felt the coordination of the action report that had resulted from a recent walkround he had been part of had taken a long time to produce and the final report had not included a key finding. Mr Mainprize commented that only the key actions go in to the Board report, he would check on the actions and see why a key one was missed.

C-Diff performance – Mr Mainprize was invited to comment on the performance against the C-Diff trajectory. Mr Mainprize reminded the Board that the Trust was historically a strong performer and had a low level of incidents. He advised that the Trust is still performing highly against its peers, but the trajectory is a concern. For this quarter, the Trust should have been below the trajectory of 11, but in fact there have been 16 cases. The Root Cause Analyses (RCA) show that the use of antibiotics by individual clinicians seems to be causing the difficulties. The Trust continues to keep the antibiotic prescribing formulary under review and is working with the community to have one formulary. The Trust has also invited a number of experts recognised nationally to review practice in the Trust.

Mr Mainprize gave an example of the complexities that exist. He talked about a patient who had an unknown infection and was given a broad spectrum antibiotic, but it was known that it if a patient took this drug there was a greater chance of developing C-Diff. The challenge is that the patient might have died without the antibiotic. He added that consideration be given to restricting antibiotic prescribing to Consultants.

Mr Rose asked for confirmation that the Trust did not have any authority over the local GP prescribing. Mr Mainprize confirmed that was the case, but did add that the Trust and the GPs were working towards a single formulary.

Mr Sweet asked what the implications (of being above trajectory) would be with Monitor. Mr Crowley advised that Monitor had accepted the potential breach at the year end. The three cases are still being considered. In terms of the quarter 1 position, Monitor has yet to decide and that will not take place until after the Trust has submitted quarter 1. He added that the Trust will continue to take action and believes the right policies are in place and the use of the RCA system is allowing the Trust to understand the cases.

Mr Bertram added that at the recent Contract Management Board (CMB) there was increased attention on community C-Diff. The CCGs are being expected to have more of a core role in coordinating.

Mrs Adams asked how much of this related to bed pressures. Mr Proctor advised that he was not seeing patient-to-patient transmission.

The Board noted that on a macro-scale (in society generally) the increased resistance to antibiotics could be inevitable and ultimately problematic.

Follow–ups - Ms Raper asked if Mr Crowley and Mr Proctor would comment on the current position. Mr Crowley explained that, as the Board is aware, the local CCGs (with the exception of East Riding) have decommissioned a significant portion of follow-up activity from 1 July 2013. From this date they will only pay for follow-up activity at a ratio of 1 new patient to every 1.5 follow-ups. This is effectively a reduction of 90,000 outpatient appointments for 2013/14. They have taken this course of action because, following discussions with their Governing Body, they believe this measure carries less clinical risk than other alternative measures which they might have to take to achieve the statutory requirement of financial balance.

Our organisation has been working closely with CCGs to deliver this target reduction in a way which minimises clinical risk. We have been clear from the outset that the actions are not risk-free and that any patient discharged by us becomes the responsibility of their General Practitioner.

We have maintained throughout that all patients discharged from our care are able to be re-referred back to the hospital at any stage by their GP. In essence, this arrangement provides a ‘safety-net’ for patients.

As an organization, we accept that our local CCGs have to deliver financial balance and have the right to commission services as they think fit. We are cooperating in every way we can. However, the Board should know that many of our consultants are nervous of the measures taken and how these will impact on patients.

In truth, the effectiveness of these measures either in financial or clinical terms is uncertain. We will keep the Board informed of the consequences of these actions and the on-going dialogue with CCG colleagues, as events unfold.

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

Mr Keaney asked if it was possible to track if a person is readmitted after being discharged for the same reason (i.e. when follow-ups have been curtailed). Mr Bertram explained that would be difficult in the formal systems because each time a patient is admitted it is a new event. Mr Mainprize said that the Consultants would be keeping a track of it and any information and if the Trust required that information from the Consultants he was sure it could be provided.

The Board asked how this change was being communicated. Mr Crowley explained that a communication plan is being developed with the CCG. The CCG are the front-line people to respond, but the Trust will respond and provide assurance and assistance where necessary.

Mrs Adams asked what the position was with East Riding. Mr Proctor said they had agreed in the contract to a ratio of 1 new patient to 2.1 follow up. Mr Crowley added that the approach is not designed to create a two-tier system, so the communication will have to be very carefully managed.

Mr Mainprize added that the aspiration is to remove variability in quality and safety.

Mr Rose asked Mr Crowley to ensure that if there is any press release or significant discussion would he please ensure the Board and the Governors are informed.

The Board thanked everyone for their comments.

13/088 Finance and Performance Committee

Mr Sweet presented the deliberations from the Finance and Performance Committee. He explained that he felt there was an overlap of current topics between the two monthly Board Committees, but which he felt was a good position to be in.

Acute Strategy – Mr Sweet referred to the acute strategy and summarised the discussion held at the meeting. He referred to the initiatives and the level of resources available for them. Mr Proctor advised that there were no additional resources available; the approach was to re adjust people's priorities. Mrs Adams asked Mr Proctor to confirm that the project was also being run in Scarborough. Mr Proctor confirmed that the project did work across the whole organisation but that there were slight variations in applicable content and there would be slight variations in the delivery timings.

CQUIN – Mr Sweet summarised the position of the CQUIN targets. The Board had already discussed the Family & Friends test and pressure ulcer target. Mr Sweet described the breakdown of the CQUIN between pre-qualification, national and local targets and outlined the financial implications of each one.

18 Week target –Mr Sweet confirmed that the target had been achieved.

62 day cancer target –Mr Sweet advised at this stage the information has not been validated, but he had not received any information that the target would not be achieved.

4 hour wait target – Mr Sweet asked the Board to join him in congratulating everyone in achieving the target. The Board did congratulate everyone involved.

Ambulance Turn Round Time – Mr Sweet advised that there had been significant improvements.

Finance – Mr Sweet reported that this was broadly in line with plan, although, there are still very high levels of referrals. It has also been reported that the Area Team have confirmed to the CCGs that there will be no additional financial support for CCGs.

Mr Sweet asked Mr Bertram to comment on the end of year contract negotiation position. Mr Bertram advised that the negotiations had gone well and the final agreements were being put in place. There was still one issue to resolve which it was expected would be concluded this week.

Mr Rose asked how the Trust should interpret the current trading position. Mr Bertram advised that the contact is not signed, when it is he is expecting some closure of the gap between the plan and activity. Mr Bertram added that during this period the CCG will be solely reliant on the Trust's information as the system is not in place for the information to be provided to the CCG by the national support units. He has been advised that this position will remain until September. Mr Bertram added that when the contact is eventually signed the Trust will most likely need to write to the CCG formally because of excess referral and activity levels as required by the contract to request an activity management meeting. There are two options to the CCG at that stage, they can either agree to a contract variation, or an action plan will be developed and agreed to bring the activity back to plan, so addressing the current trading position.

The Board discussed the issue of the possible gap that exists between the plan and the activity and how the Trust would be paid for it. Mr Bertram advised at this stage there was no

mechanism in place. He explained that the system requires commissioners to take responsibility for commissioning, which they must do within plan. The Board agreed that the fundamental problem required a national solution and this was being raised regularly through the MPs.

Several board members expressed their discomfort with this state of affairs, especially in view of the uncertainty over what mechanisms (or lack of them) might be applied later in the contract year to resolve the disparity between activity and contract.

Efficiency Report – Mr Sweet explained that the Trust was £2.5m behind plan and the planning gap is £2.0m. He added that the plan is significantly non-recurrent and the team is intending on reviewing the conversion from non-recurrent to recurrent, earlier this year, in September. He also explained that the team has been working with another Trust to see how the approach can be amended. Mr Sweet added that there has now been a quality and safety dashboard introduced related to the cost improvement programme (CIP). Professor Willcocks asked for confirmation that the amended approach would not have the effect of disengaging staff. Mr Crowley explained that the team are acutely aware of the importance of keeping staff engaged and are continuing to work hard to make sure that does happen. Mr Bertram explained that this work is with a Trust York has been working with for a while and includes a very disciplined approach. Mr Keaney supported the work, he believes that in years 3 and 4 the savings become very hard to achieve if there is not a step change and different processes are not developed.

The Board **noted** the comments and assurances given.

13/089 Workforce Strategy Committee

Professor Willcocks presented the summary documents of the deliberation of the Workforce Strategy Committee. She reminded the Board that this Committee is different from the Finance and Performance Committee and the Quality and Safety Committee, but is complementary to these. The Committee meets only four times a year and is a strategy committee.

Professor Willcocks advised that the Board can see a theme running through the two sets of notes, that specifically being the nursing establishment review. She advised that a significant level of investment has been agreed that will address some of the areas where there were perceived low levels of establishment.

Rostering – In terms of rostering, the work is continuing and will be reported at a later stage to the Board.

Board data – work is ongoing to try and identify a better way of providing the Board with more informative data.

The Board **noted** the report.

Action: Mrs Hayward would continue to keep the Board informed of any developments.

13/090 Report of the Chairman

Mr Rose gave a verbal report. He raised a number of points:

- He referred to the commissioner allocation method being reviewed following the comments in Parliament by the local MPs – but t hat it may take 5-10 years to fully feed through to local commissioning budgets. The focus may become more on the elderly and less on economic deprivation as the driver of allocations.
- He advised that the Non-executive Directors and Governors feel there should be a "one year review" of the acquisition. Mr Rose explained that he will work with Mr Crowley to devise how the comments will be sought across the Trust and put into a document the Board and Governors can review.
- Monitor will be visiting the Trust on 28 August – more details will be provided when they are available.
- Monitor will be expecting the Trust to undertake an external review of the Trust Board every two to three years, as outlined in the licence. He added that Mrs Pridmore has been reviewing the approach that will be taken by Monitor and will be undertaking a self-assessment to provide some assurance on the governance. The review is likely to be in calendar Q1, 2014.
- Mr Rose asked the Board to note the recent death of Rev. Keith Jukes. He was a Non-executive Director at the Trust from 1999-2006.

The Board **noted** the Chairman's report.

13/091 Report of the Chief Executive

Mr Crowley presented his report. He commented that he had arranged for Ms Anne McIntosh MP to visit the Trust at the end of July and meet with the female doctors to discuss her recent comments. Mr Crowley invited the Non-executive Directors to attend.

Mr Crowley highlighted the emerging thinking around the collaboration with North Lincolnshire (NLAG) and Hull (HEY). He advised that a further meeting was held with Mr McCarthy (National Director, Policy NHS England) who acted as a sounding-board for the recent discussions. He advised that a seven point plan is to be published in the near future of which this collaboration is consistent with point 3.

Mr Crowley added that the Board will have heard the spending round just announced by the Government this week. He advised that £2 billion of the budget for health will be moved to social care and NHS England is now considering how this can be achieved.

Mr Crowley referred to his report on the North Yorkshire Health and Wellbeing Board. Mr Crowley explained that this was a welcome development. Formally the Board had informal representation from the acute and mental health sector. The Board has confirmed the formalisation of those arrangements and Tees Esk and Wear Valleys are now members as a mental health provider and Harrogate Trust (HDFT) is the acute provider. This was supported by Mr Crowley, as he attends the City of York Health and Wellbeing Board. Mr Crowley asked the Board to support the change too.

The Board confirmed they supported the arrangements, but asked that they received regular feedback from the Board (via HDFT) as they do for the York Health and Wellbeing Board.

Mr Crowley advised that the next meeting of the York Health and Wellbeing Board is arranged for 10 July, at which he will provide an update on the Francis report.

Mr Rose asked about the Trust's representation at the sub-groups of the H&WB. Mr Crowley advised that he and Mr Proctor were the two who represented the Trust at the sub-groups and Board. Mr Crowley agreed that it would be useful to gain some clarity about who was on what group and he had asked for that information.

Mr Crowley asked the Board to note his report on the Experimental Medical Unit. He explained that this development had been the result of a lot of hard work and the change in mindset at the University was testament to that hard work. Mrs Holden added that this change will allow the Trust to undertake more research and more commercial work. The website will be launched in August, when commercial sponsorship will be sought.

The Board **noted** the report.

13/092 Any other business

There was no other business.

13/093 Next meeting of the Board of Directors

The next meeting, in public, of the Board of Directors will be held on 31st July 2013 in the Boardroom, The York Hospital.

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Quality & Safety Committee –24th July 2013, Patrick Crowley's Office

Attendance: Libby Raper
Jennie Adams
Libby McManus
Alastair Turnbull
Diane Palmer (for item 3)

Apologies: Philip Ashton, Anna Pridmore

	Agenda item	Comments	Assurance	Attention to Board
1.	**Last meeting notes dated 19 June 2013**	The minutes were agreed. Actions from the minutes will be picked up during the meeting.		
2.	**Chief Nurse Report** • C-Diff • Update on revised board report • Family and Friends • SI Internal Audit Report • Maternity Strategy • Quarterly Complaints Report	**C-Diff** Still an area of increased focus and management activity. LM detailed the revised CDI Reduction Strategy, which includes a renewed focus on antibiotic prescribing, engagement with the CCG to develop a collaborative plan. Reinforced by a strong focus from Executive Board and through an operational CDI Group. The Committee again requested that C-Diff performance data be provided monthly, ahead of time, as a matter of course. **Nursing and Midwifery - Strategy Implementation Plan** LM briefed on the plan for 2013. The Committee welcomed the increasingly detailed approach being adopted. It was suggested that, as the plan	Public Health England to provide external advice and scrutiny. A quarterly progress report to be provided to the committee and the Board.	LM to update.

		develops, a clearer set of described outcomes could be noted to support the monitoring of progress, that single named roles be identified as a lead for each action, that progress markers be developed against those actions which are more strongly values based and which therefore may be more difficult to note robust progress against. The committee discussed the issue of Patient Experience in the context of this Strategy. LM confirmed the development of a separate PPI Strategy and Implementation plan, led by Bev Geary and Wendy Brown. **End of Life Care** LM and AT updated the Committee on the revised approach across the Trust. It was again confirmed to the Committee that at no stage had this Trust adopted the LCP for a reason other than clinically based decision. Work within the Trust to adopt and roll out the LCP has stopped. **Friends and Family** The Committee was pleased to note the improved response rate. LM briefed on the national learning with regard to the use of a token system in ED, and confirmed that this Trust would be adopting such a system. **Chief Nurse Report** LM briefed on the revised Senior Nursing structure. The committee asked to be updated once its implementation was complete.	Letter re LCP and Trusts approach from AT and LM. Trackable monthly data re completions.	LM/AT to update. LM to update.

		LM briefed on the revision to NCIs and the progress being made against the Reducing Pressure Ulcers Plan. The Committee expressed concern regarding the number of incidents in the Community and sought assurance around the availability of appropriate equipment. LM provided a detailed paper outlining the structured approach to improvement. This will be updated for the committee's attention in future months.		
3.	**Development of monthly reports**	**Dashboard** DP attended to discuss the development of a Dashboard template. The Committee reviewed an initial draft and confirmed its support for a Q & S dashboard with 3 key domains - Patient Safety, Clinical Effectiveness, and Patient Experience. It strongly supports the proposed use of RAG ratings, tracked data and spark lines, benchmarks, highlighted commentary. It was agreed that a completed draft dashboard would be presented to the next meeting for review and learning. The Committee noted the issue of resource to support this work and confirmed the value it places on the adoption of such an approach, particularly in the light of the recent Keogh recommendations. It was agreed that the separate Community Hospitals dashboards would continue for the foreseeable future.		

4.	**Medical Director Report** • **SHMI** • **Consultant appointments** • **Mortality programme Update** • **VTE**	**Reducing Mortality Programme** AT briefed on the most recent SHMI. There continues to be a disparity between York and Scarborough sites. However, all sites are demonstrating an improved trajectory. Weekend mortality data was also discussed, and AT confirmed that there is not a significant difference with the mortality rate; however, the committee noted that there is a slight rise when looking at patients admitted on a Friday, and asked to be kept informed on this issue. **Follow Up** AT updated the Committee on work towards the CCG target of 1:1.5 The Committee asked about implications for patient safety v. quality and AT detailed the process in place to support individual clinical decisions as well as to monitor practice over the coming months to enable a better understanding to be developed. **VTE** In the light of the tougher target, the Committee noted concern over compliance in some directorates. AT described ongoing work to support improvements. **Theatre Safety Briefings** Whilst understanding the context of both clinical practice and administrative assurance, the committee was pleased to note the improved performance, and congratulates those involved. This continues to be a priority of focus for Trust	SHMI data inc. comparator charts. Detail of compliance by directorate. Data by authorised list and by area.	AT to brief Board. AT to brief Board. AT to brief.

		Governors. **Corporate Risk Register - EPMA** The Committee retains its focus on this area, and noted the decision to fund and adopt an in house approach. It continues to encourage a speedy roll out. **SUItcase** The Committee expressed concern over the absence of new SUIs; it was explained that they had been deferred at the most recent Exec Board. AT reminded the Committee that a 3-month summary of key findings would be produced, and confirmed that this did not impede any immediate remedial actions once identified. **Patient Safety Walkrounds** The Committee continues to welcome the detail provided, and supports the revised approach to these important Walkrounds. It asked for detail as to how NEDs would be assured of follow up actions; AT will discuss with colleagues and update at the next Committee meeting. It was specifically noted that the 4 June walkround of ED in Scarborough was now scheduled for a revisit. **Consultant Treatment Outcomes** AT updated the Committee, who strongly welcomed the data. Discussion took place around the varying number of procedures per surgeon; the committee		

		wished to understand appropriate minimum activity levels to retain safe practice.		
5.	**Other**	The Quarterly Patient Experience Report was circulated too late for the Committee to consider it. It will be reviewed at the next meeting. The Committee noted the publication of the Keogh report and observed that it highlighted some extremely important issues. Further, more granular, consideration will be given to it and the Committee will pick this up at the next meeting.		

C1

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 31 July 2013

Chief Nurses Report – Quality of Care report

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 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	Elizabeth McManus – Chief Nurse
Author	Beverley Geary – Deputy Chief Nurse
Date of paper	June 2013
Version number	Version 1

Board of Director – 31 July 2013

Chief Nurses Report – Quality of Care

1. Key priorities

Nursing and Midwifery Strategy
The draft implementation plan for the Nursing and Midwifery Strategy has now been developed and will go to the Chief Nurse Advisory Group in July for discussion and approval (appendix 5).
The four focus areas of the strategy are:

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

The implementation plan details the key areas for delivery during the first year of the strategy and maps the Chief Nursing Officer for England's 6C's in order to embed and demonstrate a culture of compassion and care.

Senior Nursing Structure
In order to focus on the patient care and professional agendas (nursing and midwifery) it has been agreed that Matrons will be line managed by the Chief Nurse Team (Assistant Directors of Nursing & Head of Midwifery).
This is with an overall intention to bring a strong professional nursing and midwifery management structure delivering key outcomes for patients and the organisation.

- A clear focus upon the nursing, quality and standards of care
- Ensure patient experience and safety is aligned with finance and activity
- Allow consistent delivery of the PPI agenda
- Ensure Matron cover in all areas of the organisation
- Allow clear professional accountability
- Reduce risk
- Support nursing leadership at all levels of the organisation

The process will include a review of the Matron role and how it can be delivered consistently across the organisation.

In order to expedite a timely and smooth transition a small group of Directorate Managers and senior operational managers will work closely with the Chief Nurse Team in the coming weeks to identify areas, process, and timeframes.

Nursing Care Indicators
A more simplified version of the Nursing Care Indicators' (NCI's) have been implemented in order to rationalise ward audits and also to provide more meaningful data at ward and Directorate level.

The Maternity indicators are currently being developed by the Midwifery teams and work has begun with Nursing Ward Sisters to review the current revised indices and to agree new and meaningful indicators of quality and a more robust assurance of care delivered.

2. Quality & Safety in care

Pressure Ulcer Reduction Plan (PURP)

The focus on reducing the incidence of pressure ulcers continues and weekly reporting from all areas of the organisation is now in place.
The PURP action plan is being updated monthly in order to demonstrate progress against the key deliverables, these include:

- An audit has been undertaken in order to establish the availability of pressure relieving equipment across the organisation. Early indications shows unavailability in some areas in the community and the potential need for investment in additional pressure relieving seating and standardisation of all chairs. There is a significant issue relating to the contract arrangements for community equipment which is being managed via Contract Management Board. Interim arrangements have been made for patients to receive timely access to equipment in community services.

- Engagement events on pressure ulcer identification, care and reduction have been attended during the month of June for key clinical staff and more planned for the coming months.
- The use of comfort rounding has been extended into Paediatrics, Maternity and ED and is also being tested in community services for the first time.
- There has been an increase in reported pressure ulcers which is to be expected at the beginning of more focussed work.
- Safety Thermometer data suggests a downward trend in incidence for acute services. Detailed work is taking place to analyse all pressure ulcer data for accuracy, trends and learning.

There is a high risk associated with delivery of the CQUIN target of 50% reduction in pressure ulcer prevalence in the community. Targeted work with Community Services teams including clarification of data definitions used by mangers and earlier interventions' are being implemented and meetings are planned to agree immediate strategies for action in order to mitigate the risk.

Midwifery Services Update
The refurbishment of labour rooms on the York site is due to complete in July 2013. This has created 3 en-suite rooms, a further birthing pool room with shower and a visitors waiting area.

The refurbishment will improve women's privacy and dignity, promote active birth and increase patient choice for pool labour and birth.
The Maternity theatres ventilation work and refurbishment is now complete with both theatres in use.

Staffing on the labour Ward (Scarborough site - which includes Maternity theatre) is highlighted as a risk and steps are being taken to mitigate this which include changes in the utilisation and deployment of the workforce, additional training to increase midwifery skills in theatre and support from main theatre. Additional planning to ensure the Maternity theatre is staffed for emergency caesarean section 24 hours a day is currently underway.

3. End of Life Care (EOLC) update

Work to improve end of life care continues and an EOLC educator has recently been appointed on a fixed term basis to focus on the AMBER care bundle and Advance Care Planning.

The AMBER care bundle is a tool that helps to identify and respond to a person's needs appropriately when recovery is uncertain (in the last 2-3 months of life). It is designed to support treatment plans alongside palliative care.

A - assessment
M- management
B- best practice
E-engagement
R - recovery uncertain

AMBER and advance care planning help to ensure that treatment plans are regularly reviewed, ensuring that patient's are at the centre of their care and the decision making process. In turn, this enables a person's individual needs and wishes to be documented and met where possible.

A baseline audit for Advance Care Planning has been undertaken, the results have helped to identify learning needs and priorities for the organisation. The EOLC team plan to be more visible on the wards to offer support and ongoing education, to the delivery of excellent care and to develop and improve the culture around end of life care.

In order to standardise, simplify and reduce the amount of documentation an EOLC pack is being developed, this will be supported by an algorithm to inform the decision making process of both nurses and Doctors.

An electronic toolkit has also been formulated and will be available for all staff to access via Horizon, work with the Organisational Learning and Development Team is ongoing to ensure a consistent approach to the delivery of training. A structured roll out of the toolkit is planned for late July 2013. In addition, an e-learning package which will encompass all EOLC tools, this will be available by August/September 2013.

A palliative care funding review is currently underway to identify a tariff for palliative care. Data collection has commenced in the community and at York hospital site. The data for the funding review will be complete by November 2013,

Following the recent review of the use of The Liverpool Care Pathway and the resulting recommendations, we are currently developing alternative guidance and supporting documentation to ensure that the highest quality of care continues to be delivered to patients at the end of life. On completion the new guidance will be shared at the end of life forum and Trust wide.

4. Corporate Risks

Infection Prevention & Control
Increased focus and management of clostridium difficile infection (CDI) continues and includes:
A revised CDI Reduction Strategy; this has been approved at HIPC Steering Group.
Timely Root Cause Analysis and close monitoring of every infection are in place and are integral to organisational governance, performance and assurance for the management of all cases of CDI.
An operational CDI group is being convened with actions including reinforcing this as priority at Board level which include:

- Dedicated time to discuss CDI and strategies for reduction at length at Executive Board
- A letter will be sent to all clinicians regarding the prescription of antimicrobials from the Chief Executive
- External advice and scrutiny from Public Health England has been sought in order to support the reduction strategy and management of risk

The CDI reduction strategy has now been shared with Clinical Commissioning Group and a meeting with their Executive Nurse is arranged for the 17th July to discuss this and begin to develop a collaborative IP plan across the health economy interface.

Friends and Family Test – June 2013
The Friends and Family Test (FFT) has now reached the end of the first quarter of implementation our inpatient wards have significantly improved on response rates over this period and are achieving in excess of 15% across our sites.
The overall result for June was 19.8% (appendix 4)

There still remains an organisation risk in terms of continual achievement of the required response and subsequent increase in response rate from Q4. Actions to mitigate the risk are that the Trust has reviewed its methodology within the Emergency Department and is in the process of moving to a token/disc system across both sites in Quarter 2. This system has been used successfully in other Emergency Departments across the Country.

An FFT Maternity Services Project Group has been set up which will oversee the early implementation of FFT across maternity services from August, ahead of the October national implementation date.

The Trust Net Promoter score for the first quarter was 68.

Child Protection training
The Child Protection Service is responsible to provide a child protection training programme with content and the number of sessions that will ensure Trust staff will develop a level of competency, knowledge and skills to comply with Trust Child Protection Policy, CQC, Local Children Safeguarding Boards, and CCG's requirements.

As a result of acquisition, the complexity of the provision of the Child Protection Services, and increased requirements for training we have seen an impact upon delivery, uptake and numbers of staff who are trained in Child Protection. Whilst work is ongoing to address these factors steady progress is being made.

Level 1 is covered by the York Child Protection Team for all new starters at Induction for York and Scarborough. No concerns for Level 1.

Level 2
For many years the level 2 training was at 33 % however we have seen improvement in recent years

01:04:2010 – 30:04:2013 Level 2 = 42% Level 3 = 80%
31:03:2013 – 30:06:2013 Level 2 = 44% Level 3 = 83%

Issues
1. Feedback suggests that training dates were released too late in the year to allow effective rostering of staff, therefore we have seen low uptake on sessions, this has impacted on planning for the CP team.

Level 1 covered well within induction package no concern.
Level 2 training: 1316 places offered 952 filled = 72%.
Level 3 training: 890 places offered 445 filled = 51%.

2. E-learning is an alternative to face to face training and this method of delivery has resulted in reaching a larger proportion of Staff with a resultant increase in delivery.

3. Until recently Scarborough Staff received Level 2 and 3 training via HDFT CP Team and the training was undertaken and recorded in a different way to York, this made interpretation difficult and results ambiguous.
The York CP Team now deliver all the CP induction training for new Staff since April this year, the expectation is that we will se a resulting improvement in the delivery statistics.

Plan/Already implemented Action	**Time table**
1. Improve percentages over the next year and Training sessions are later than April. Managed to provide extra session. Payoff- Impact on CP Team and reduced Staff to manage cases and other required work load – risk to service.	1. Agree required percentages at the next Child Protection Board. The outcome to move session will not be measured until the end of the year.
2. Training session tailored to areas within the Trust	2. ongoing
3. Development of an e-learning level 2 package for Staff to access	3. Planned for April 2014 training programme.
4. Scarborough, Whitby and Ryedale area figures to be merged with York's. The training programme is being merged to mirror the York programme and will move the Level 2.	4. Liaison with CLAD re figures and work of CP Team to merge the figures so the programme can be merged to comply with Trust requirements and Trust ability to monitor.

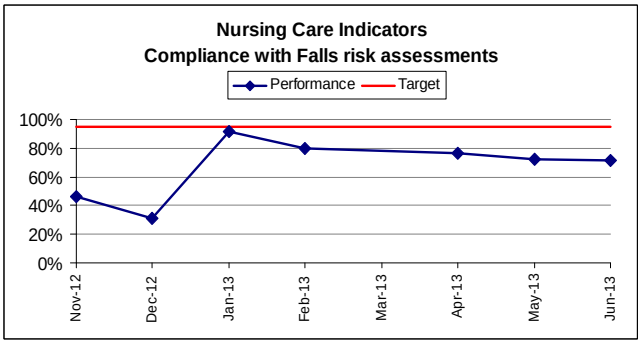
Author	**Beverley Geary, Deputy Chief Nurse**
Owner	**Elizabeth McManus, Chief Nurse**
Date	**July 2013**

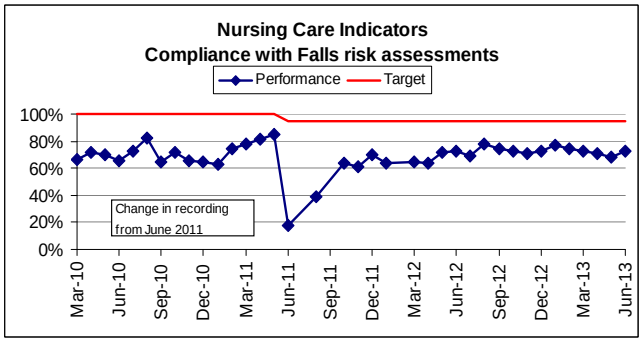
Nursing Care Indicators results for 2013

Scarborough & SWR Community Hospitals	York & York and Selby Community Hospitals

Falls

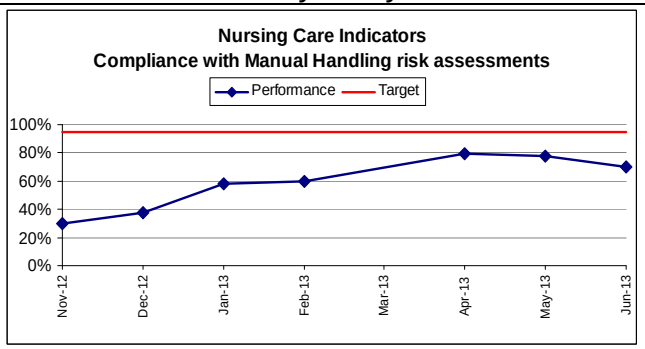
This includes a fully completed bedrail assessment within 24 hours of admission with reassessment every 7 days. A fully completed falls assessment within 2 hours of admission with reassessed every 7 days and that a Falls care plan is present if applicable

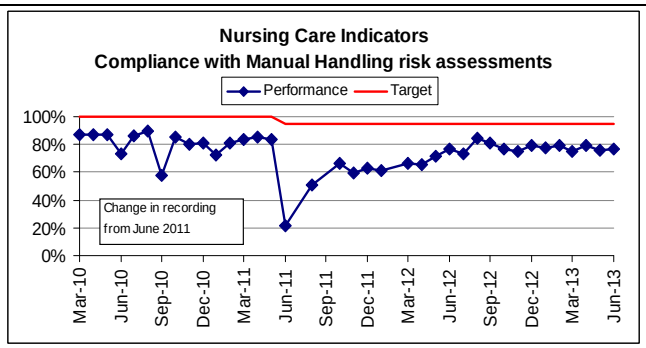




Manual Handling

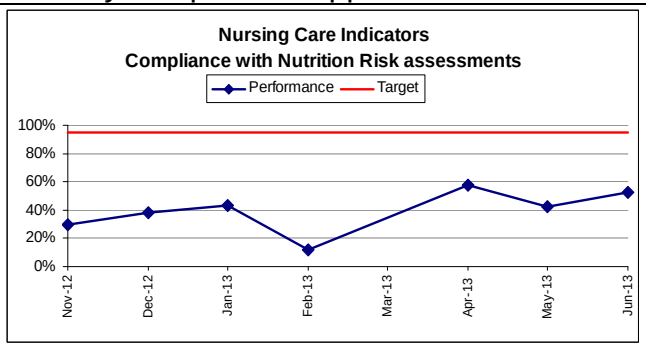
This includes a fully completed Manual Handling assessment within 24 hours of admission with a reassessment every 7 days

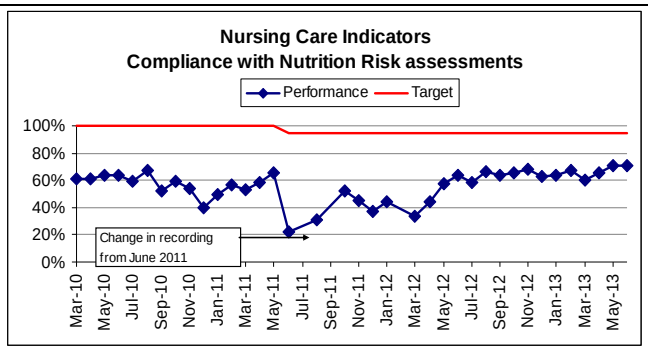




Nutrition

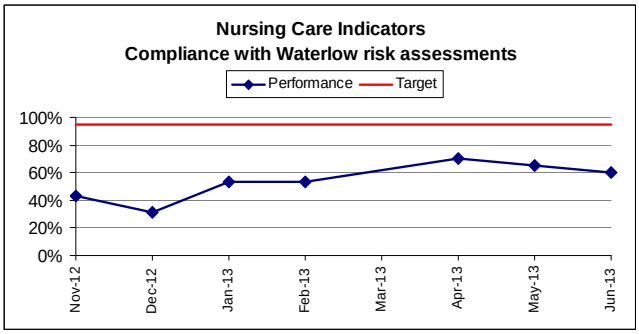
This includes the fully completed Nutrition assessment within 24 hours of admission, reassessment every 7 days. If an appropriate Nutrition care plan and a food chart are present and fully completed if applicable

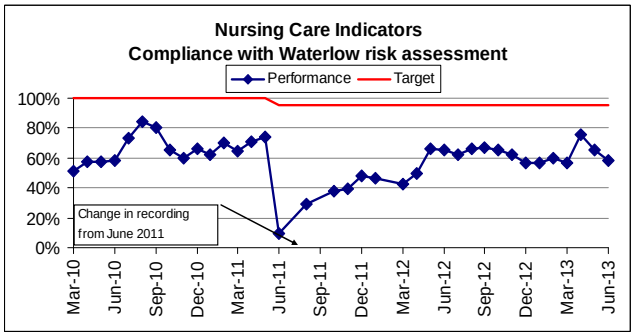




Waterlow

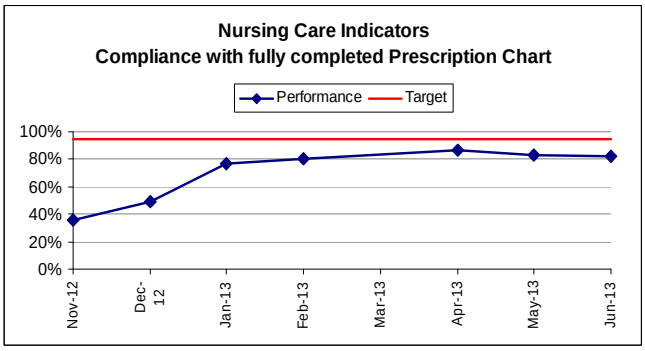
This includes a fully completed waterlow assessment within 2 hours of admission, reassessment every 7 days and that a wound care plan is present if applicable

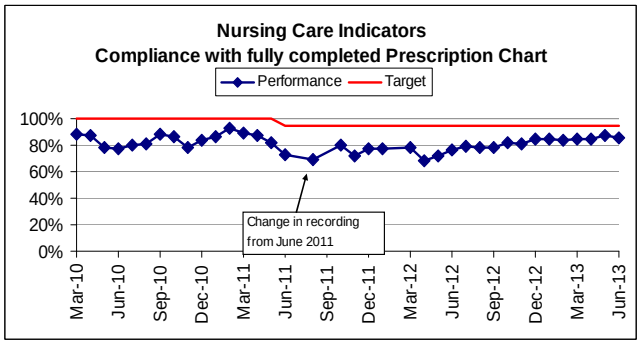




Prescription Chart

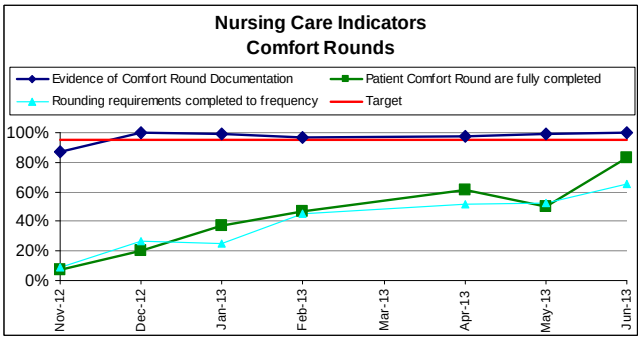
This includes, that an omission code is documented for each occurrence when a prescribed drug was not given. There should be no ticks, question marks or blank spaces present and the allergy box should be completed and signed by a doctor

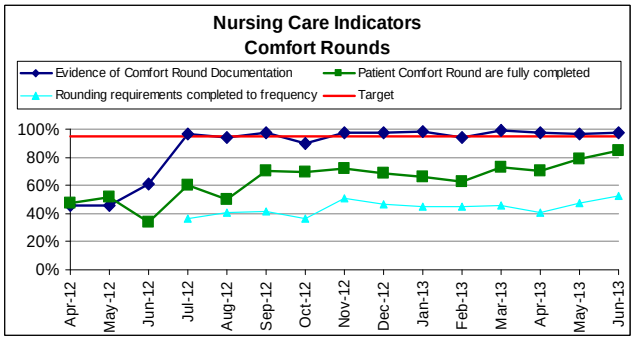




Comfort Rounding

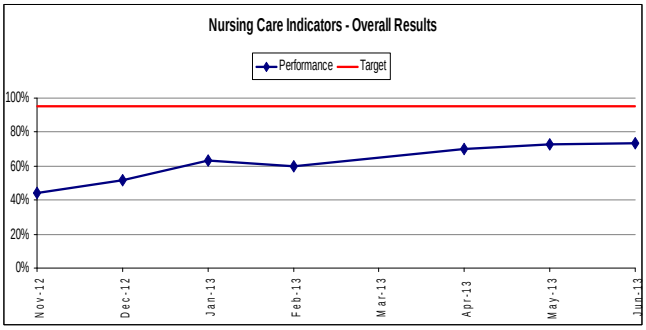
This chart has 3 parts the first if a Comfe tool is present, the second is if the comfe tool has been fully completed, including patient demographics, ward and frequency, the last being if the rounding has been completed to the documented frequency

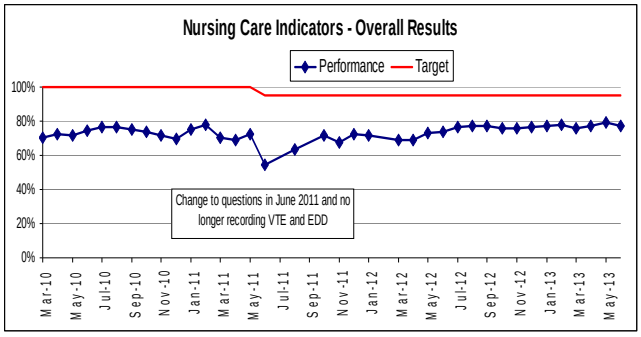




Overall Results

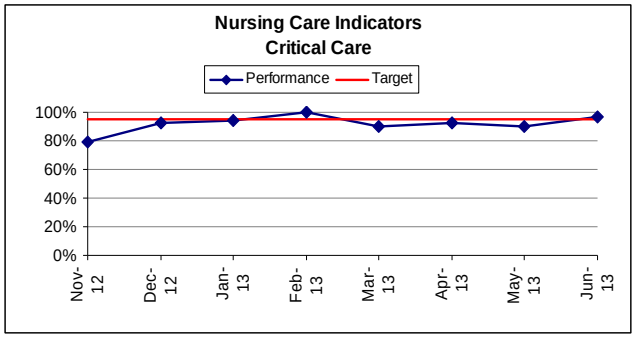
This is the overall results that includes all the above charts for both York and Scarborough



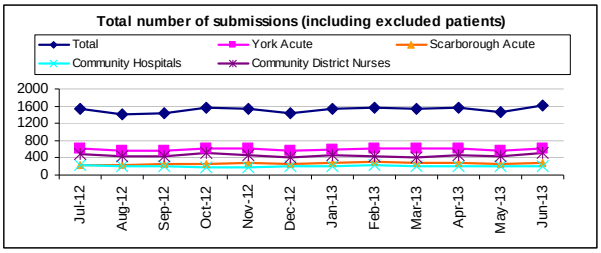


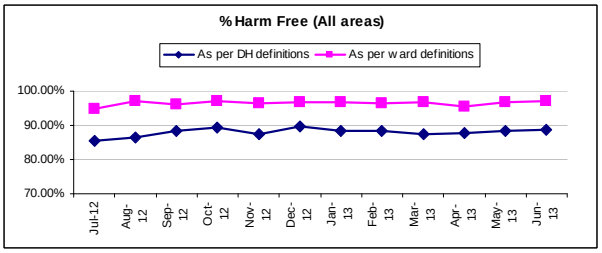
Critical Care NCIs – York only

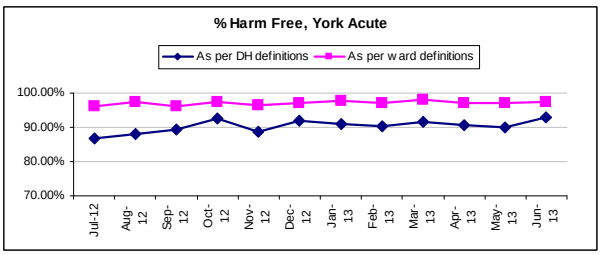
These are is ICU/HDU specific questions, they are currently only performed in york as the questions are being finalised with Scarborough ICU sister

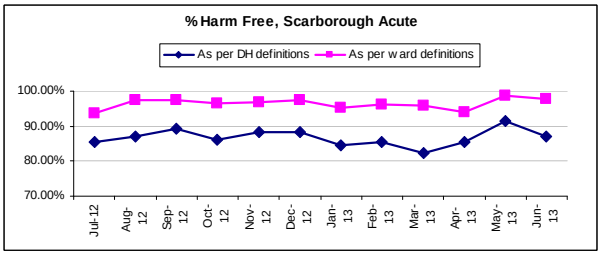


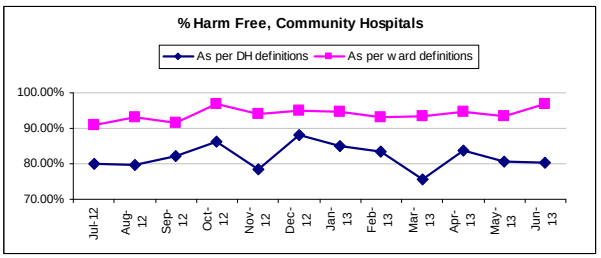
Safety Thermometer Data

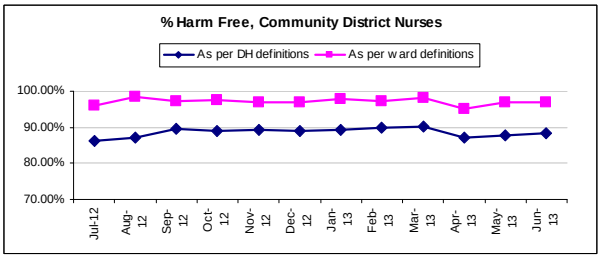


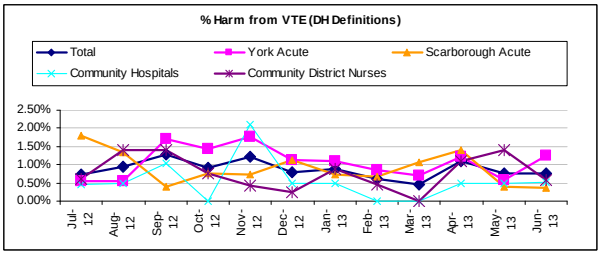


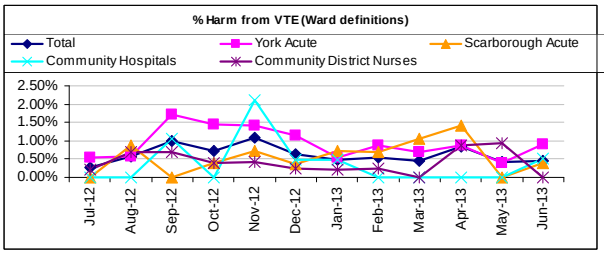


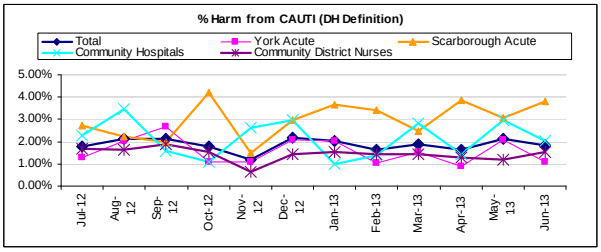


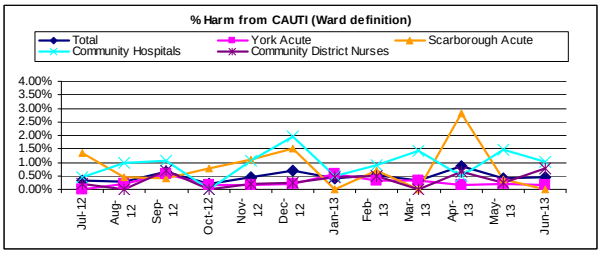


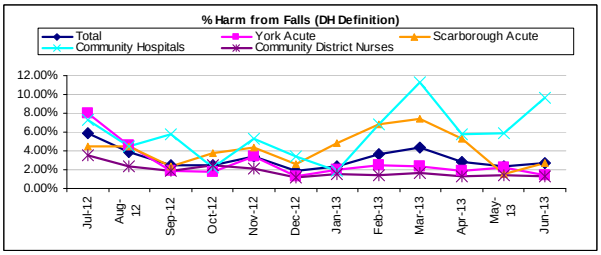


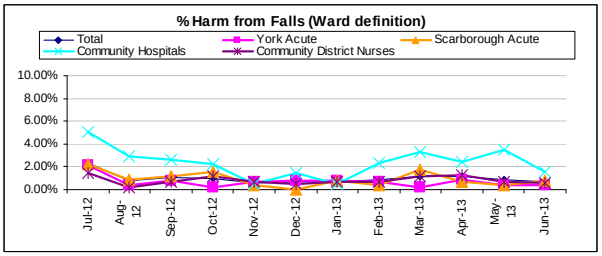


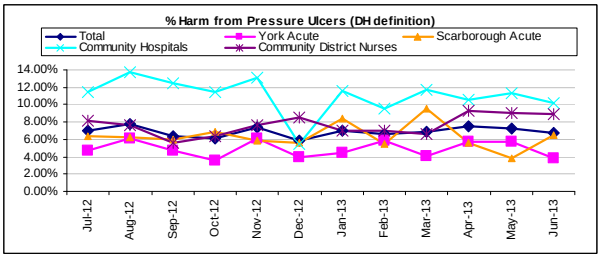


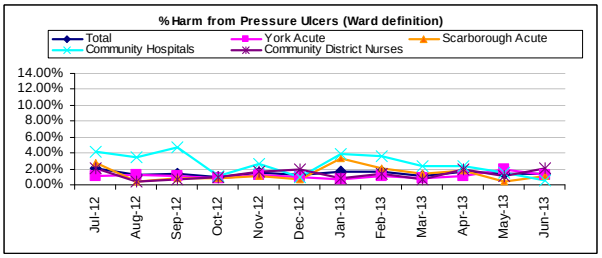








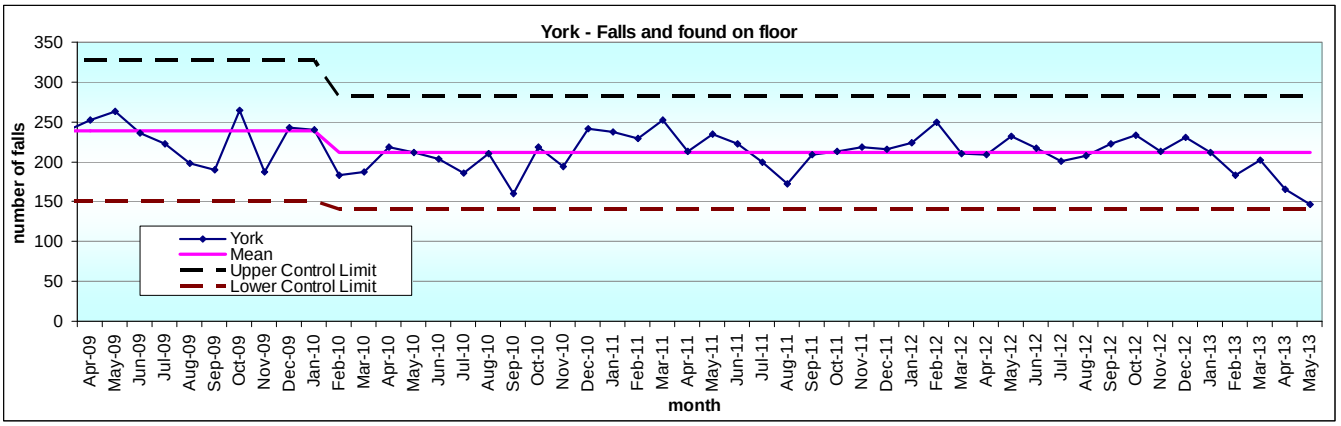




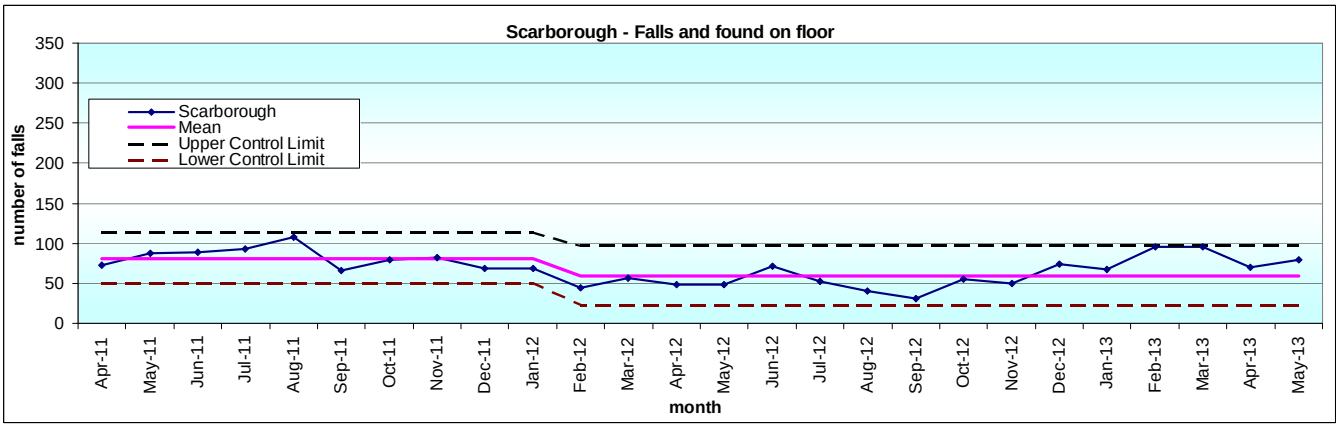
Falls and pressure ulcer adverse incident data

Falls

York Hospital falls data:

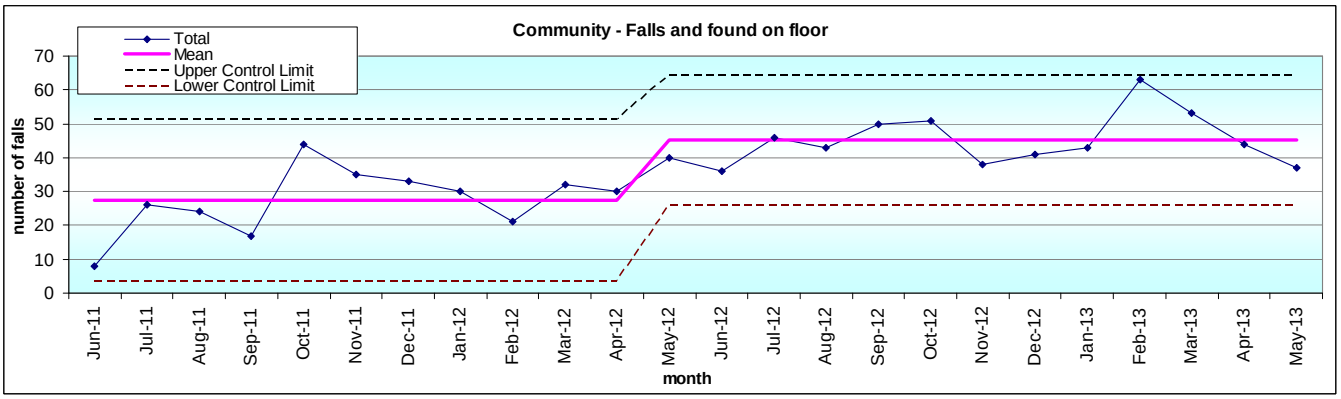


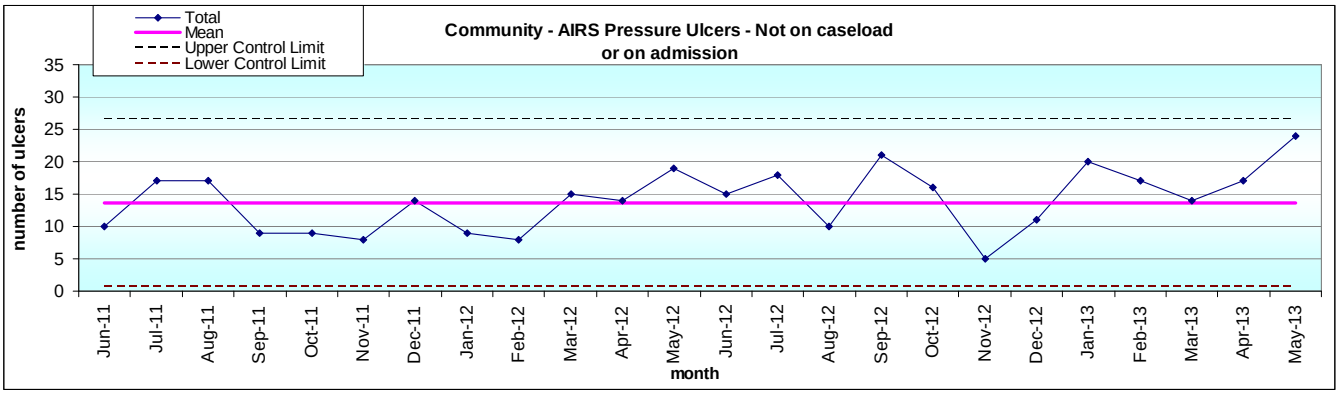
Scarborough Hospital falls data:

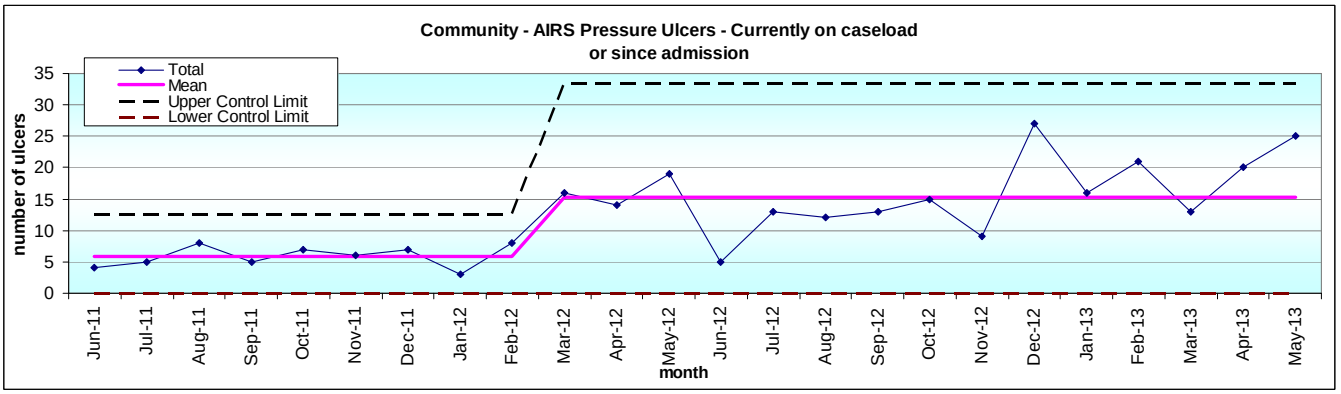


Community falls data:

Data includes all community (Archways, Selby, St. Monicas, Whitby and Malton and virtual wards)

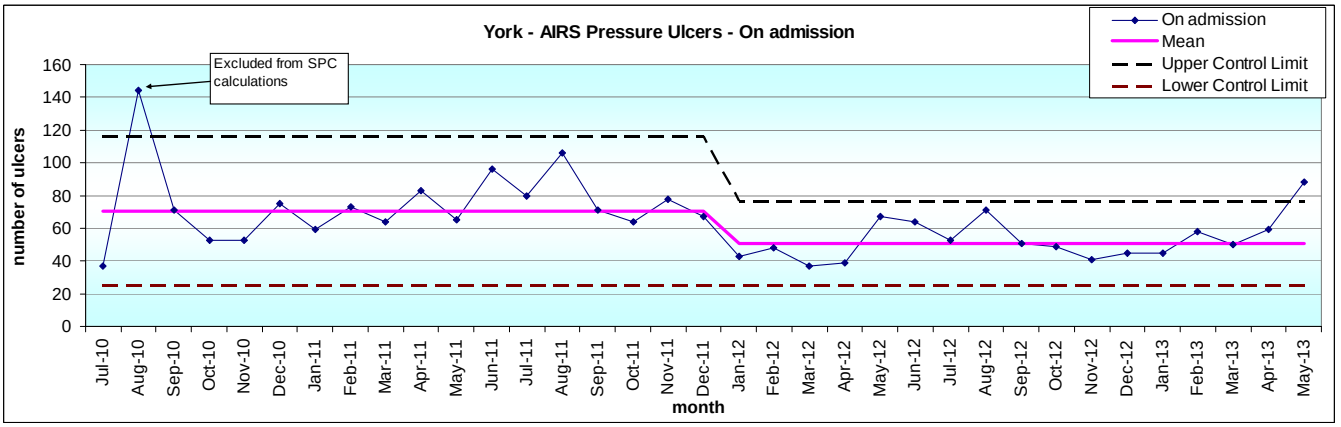


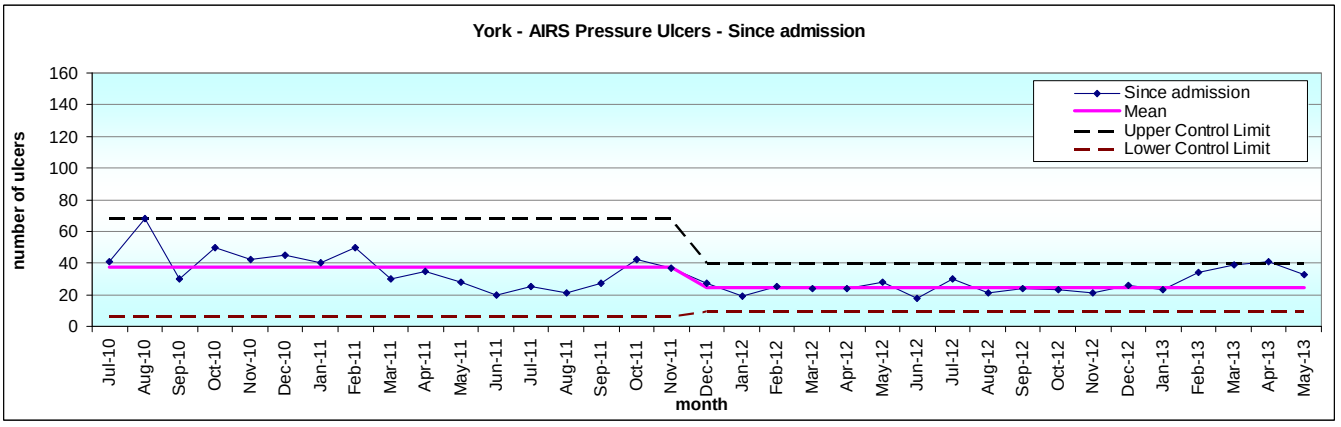




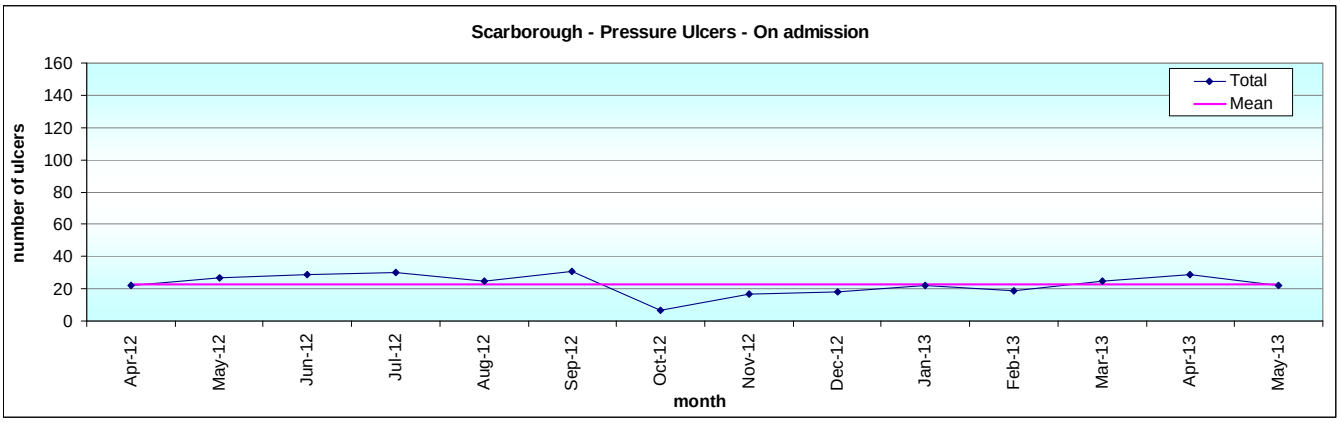
Pressure ulcers:

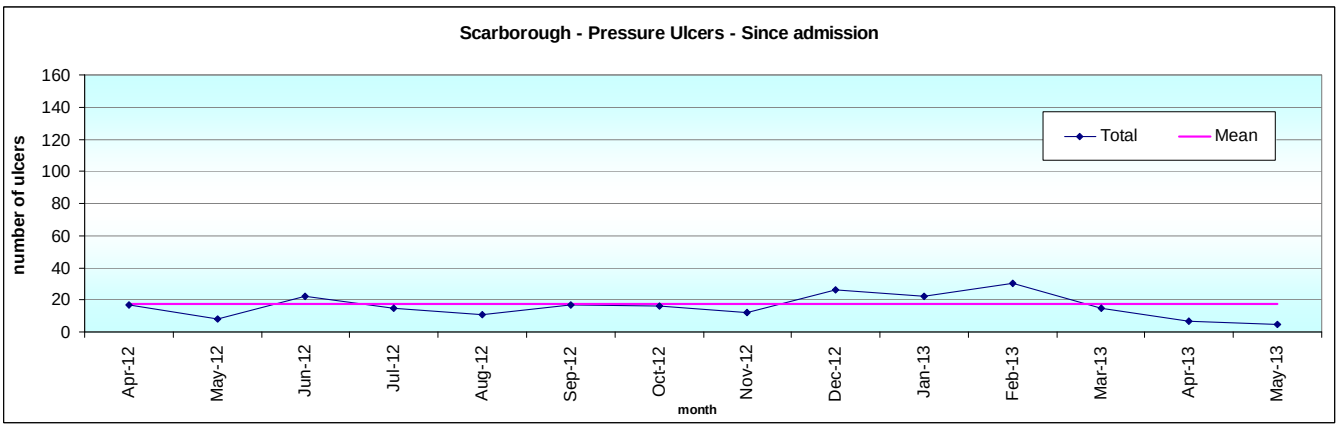
York Hospital pressure ulcers data:





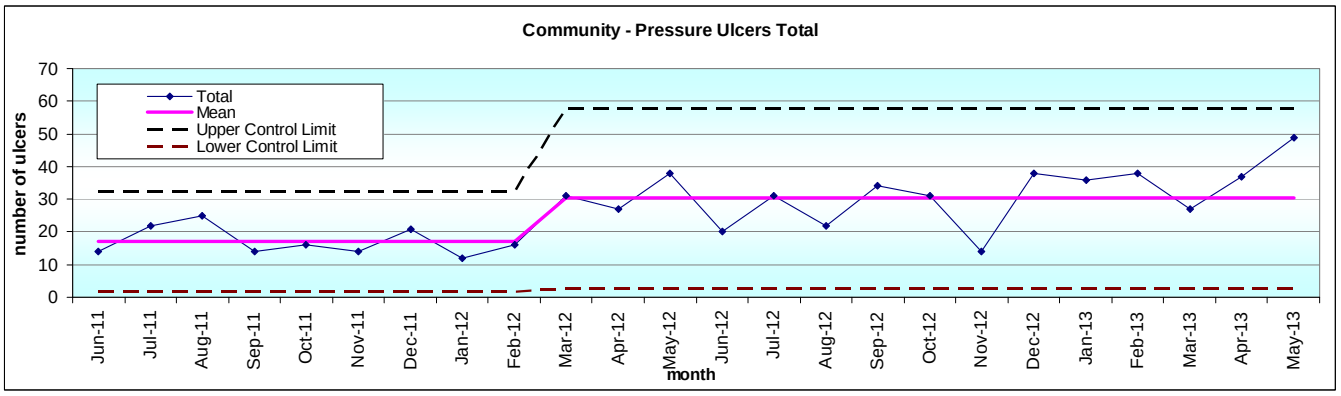
Scarborough Hospital pressure ulcers data:



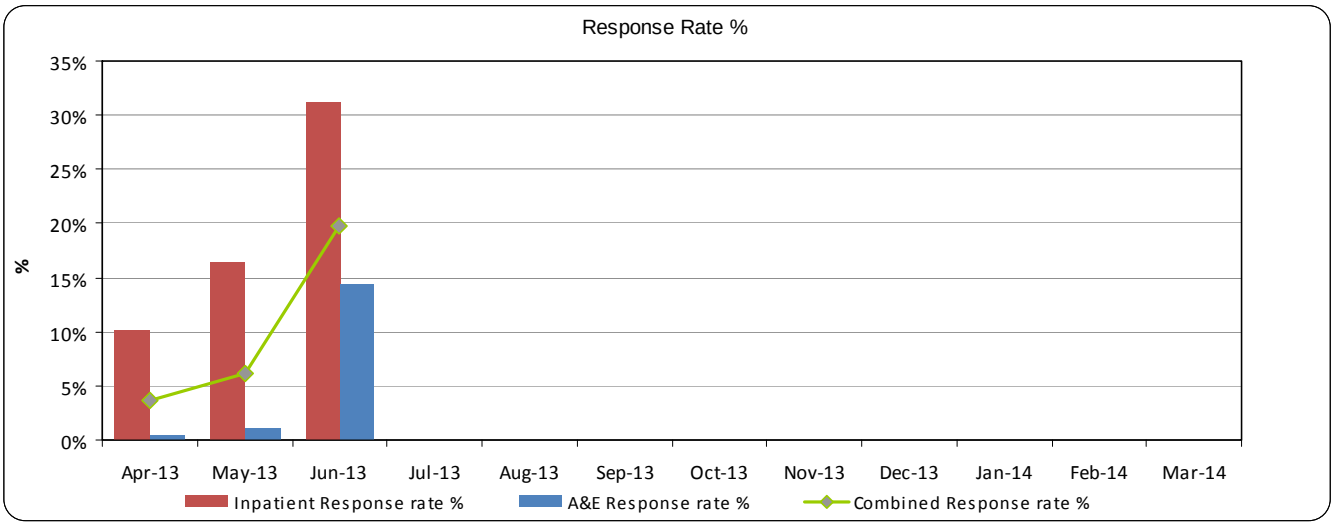


Community pressure ulcers data:

Data includes all community (Archways, Selby, St. Monicas, Whitby and Malton and virtual wards)



APPENDIX 4


Response Rate %
35%
30%
25%
20%
15%
10%
5%
0%
%
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
Inpatient Response rate %
A&E Response rate %
Combined Response rate %

Appendix 5

Nursing and Midwifery Strategy Implementation Plan: Year 2013

The Nursing and Midwifery strategy sets out priorities to achieve high quality nursing care over the next 3 years and was approved at Board in May 2013.The implementation plan outlines current work streams and priorities and demonstrates progress to date.
The strategy has been aligned to the Chief Nursing Officers 6 C's in order to ensure compassion in care and to embed these values and behaviours in all Nursing and Midwifery practice.
C1 -Care
C2 -Compassion
C3 -Competence
C4 -Communication
C5 -Courage
C6 -Commitment

Priority 1	**Improve Patient Experience**

Number	**6C's**	**Action**	**Target Date**	**Update / Evidence**	**Lead**
1 a)	C1 C4	Develop PPI strategy.	December 2013	Meeting arranged for July 2013	Lead Nurse Patient Experience/ Deputy Chief Nurse
1b)	C2 C4	Introduce patient stories to key meetings.	September 2013	Weekly review of complaints by CN & CEO begun. Plan to introduce to Corporate Directors' Patient stories embedded in BOD meetings. Introduced to Matrons & CNAG	Chief Nurse Team
1c)	C4 C5	Clarify the role of ward sister in the management of and learning from complaints in their areas	September 2013	Ward Sisters meetings planned for July(	Matrons, PPI team
1d)	C1 C4	Work with PPI team to identify priority areas for improvement and areas of best	December 2013	Integral to PPI strategy	Chief Nurse Team / PPI team

		practice.			
1e)	C5 C6	Work with voluntary services team to develop the role of the volunteer.	November 2013		PPI / Voluntary Services team
1f)	C2 C4	Review of trust visiting policy in order to meet the needs of patients and relatives.	December 2013	Matrons currently working together to review and revise policy and present recommendations to Matrons/CNT meeting	Matrons
1g)	C6	Introduce Friends and Family Test	April 2013	Project plans agreed March 2013, FFT introduced in April 2013 to inpatient wards and Emergency Department	Lead Nurse for Patient Experience
1h)	C4 C5	Use Friends and Family evidence to provide real time feedback to staff and take actions where appropriate.	April 2013 and ongoing	Matrons are reviewing feedback themes to staff when boxes are emptied	Matrons
1i)	C2 C4	Implement in Maternity, Paediatrics and Out Patient Department ahead of national role out in order to embed.	August 2013	Implementation plans developed	Patient Experience Team

Priority 2	**Delivering High Quality Safe Patient Care**

Number	**6C's**	**Action**	**Target Date**	**Update / Evidence**	**Lead**
2a)	C5 C6	Strengthen nursing leadership by empowering ward sisters and charge nurses to ensure all care is of a high standard and meets values of the organisation		Ensure all ward sisters attend IMW programme and skills days.	ODIL Chief Nurse Team
2b)	C1 C6	Conduct bi-annual dependency and acuity audits and advise on actions.	April 2013 and ongoing	Results reported to workforce committee, approval from Board of changes to numbers and skill mix. Further audits planned in October & March	HR/ Chief Nurse Team
2c)	C1 C2 C6	Work with patient safety and compliance teams to ensure delivery of patient safety strategy. Evidence	April 2013 and ongoing	Pressure Ulcer Reduction Plan Deterioration Patient initiative Work to decrease Missed Medications	Patient Safety Team Chief Nurse Team
2d)	C5 C6	Introduce a programme to review all documentation with the aim to ensure the	December 2013	Working group formed and met in June, work has begun to prioritise	Chief Nurse Team

		patient is at the centre and to reduce bureaucracy. Increase dependence on CPD as primary patient record.			
2e)	C1 C3	Evaluate and review current status of productive ward principles across the organisation and identify key priorities and actions.	September 2013	Annual update received, meeting with Matrons and Productive Ward facilitator to be arranged	Chief Nurse Team Matrons
2f)	C1 C2	Introduce Advanced Clinical Practitioner's to facilitate early decision making and timely access to treatment.	August 2013	First cohort of trainees have commenced the 2 year programme 3 Trained in post by the end of July 2013	BG/NMc
2g)	C1	Make a significant contribution to the CDI reduction strategy	Ongoing	Senior Nurse walkabouts planned to be introduced September 2013 Discussion re: Matron role in IPC & how to raise the profile	IP&C, Chief Nurse Team Matrons

Priority 3	**Measuring the impact of care**

Number	**6C's**	**Action**	**Target Date**	**Update / Evidence**	**Lead**
3a)	C5 C6	Review all nursing metric to ensure nurses and midwives have meaningful data to influence the delivery of care.	April 2014	Matrix rationalised May 2013 Meeting of Ward Sisters and Chief Nurse team to review metrics and identify priorities, follow up meeting planned for August 2013	Chief Nurse Team /HR
3b)	C3 C5	Pilot and evaluate the use of an EWTT to identify key risk and / or best practice.	April 2014	Triggers agreed, meetings with IT to establish an electronic system ongoing. Discussion with NEDs May 2013 with planned showcase of tool in September 2013 with a view to piloting.	Chief Nurse Team
3c)	C1 C3	**Utilise IT systems to give real time feedback** Explore feasibility of IT solutions to documentation	April 2014	Meetings to discuss & develop already planned	Chief Nurse Team /IT
3d)	C1 C6	Roll out electronic observations	April 2013	Electronic observations completion January 2013	IT

3e)	C1 C6	Implementation of NEWs	July 2013	NEW's rolled 8.7.13 Scarborough 21.7.13	CL
3f)	C3 C6	Introduce Senior Nurse walkabouts to all clinical areas to observe care delivery and support staff.	September 2013	Terms of reference drawn up, to be agreed at CNAG	Chief Nurse Advisory Group

Priority 4	**Staff experience**

Number	**6C's**	**Action**	**Target Date**	**Update / Evidence**	**Lead**
4a)	C2 C4	Utilise staff survey feedback to understand key themes and identify priorities.	December 2013		Chief Nurse Team with HR Workforce team
4b)	C4 C6	Ensure all Nurses and Midwives receive a valid appraisal which includes an agreed development plan	April 2013-14	Ongoing work in all Directorates' to achieve annual appraisal	Matrons, Ward Sisters
4c)	C3	Explore and consider the training requirements of nurses and midwives and identify alternative methods of delivery.	April 2014	Review of Statutory & Mandatory training requirements for Nursing & Midwifery staff	Chief Nurse Team/ ODIL
4d)	C4 C6	Evaluate Band 5 & HCA induction programme.	December 2014		Chief Nurse Team with HR Workforce team
4e)	C3 C5	Introduce revised pre-ceptorship programme / policy and supportive framework.	December 2014		Chief Nurse Team with HR Workforce team
4f)	C5 C6	Consider centrally supported recruitment process to reduce duplication, ensure recruitment in a timely fashion.	April 2014		Chief Nurse Team with HR Workforce team
4g)	C4 C6	Works with HR to utilise e-rostering to make the most efficient use of resources.	April 2013		Chief Nurse Team with HR Workforce team
4h)	C4 C6	Conduct an evaluation of the local induction arrangements for Nurses and Midwives	April 2013		

Assurance Processes

- Chief Nurse Advisory Group for approval, monitoring, identifying risks and progress
- Exceptions discussed at Matrons 1:1's and NMT 1/52 pm same as ops
- Quarterly update to Board via Chief Nurse report

Beverley Geary
Deputy Chief Nurse
July 2013

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C2

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 31 July 2013

Medical Directors Patient Safety Report

Summary

This report provides a detailed 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 Executive Board.
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 for Patient Safety
Date of paper	24th July 2013
Version number	1

Board of Directors – 31 July 2013

Medical Directors Patient Safety Report

1. Introduction

Top three issues this month:

1. VTE risk assessment compliance
2. Publication of surgical outcomes
3. Publication of SHMI for January to December 2012.

2. Patient Safety

2.1 Key patient safety priorities:

- Reducing mortality by
  - *ensuring a 7 day service*
  - *reviewing systems for measurement*
  - *reducing harm and deterioration*
  - *excellence in end of life care.*

- Others - *reducing medication errors*

  - *compliance with WHO surgery checklist*

  - *compliance with VTE assessment, prophylaxis and treatment regimens*

  - *Patient Safety Walk-rounds.*

Implementation of National Early Warning Score (NEWS) in York

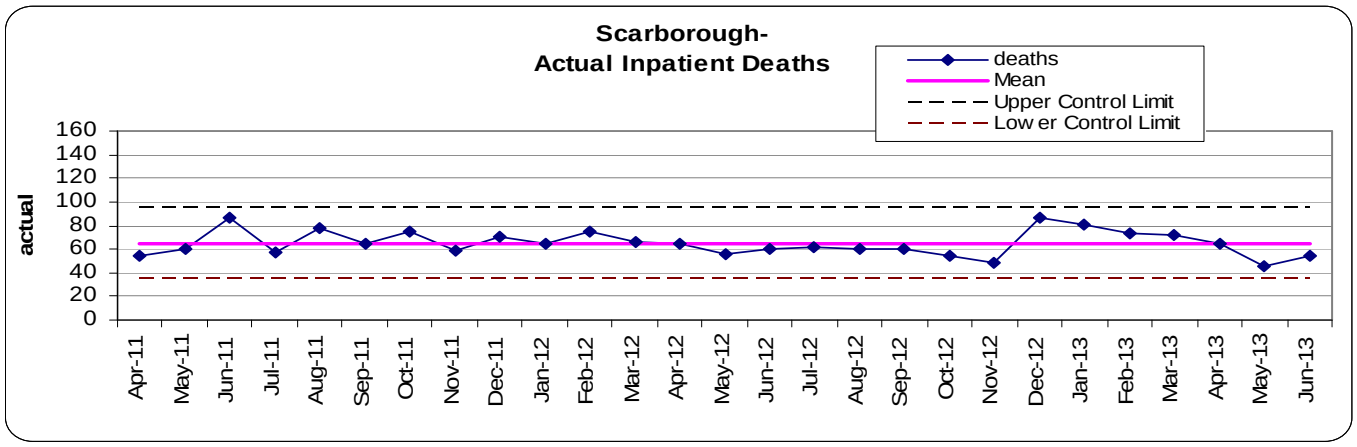
NEWS has so far been embraced by York hospital. The critical care outreach team continue to support the wards being highly visible and proactive in reaching out to patients.

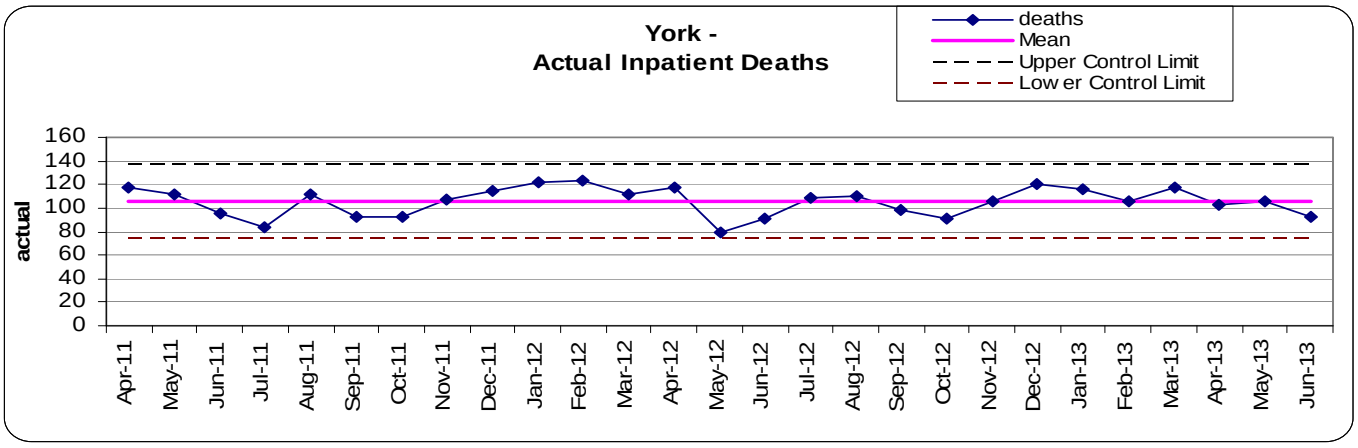
There has been concern about the volume of patients who have triggered on the NEWS score (approx 15 per day high risk, approx 50 per day medium risk) but the nursing and medical staff have responded in a positive way deescalating patients and implementing appropriate management plans where appropriate.

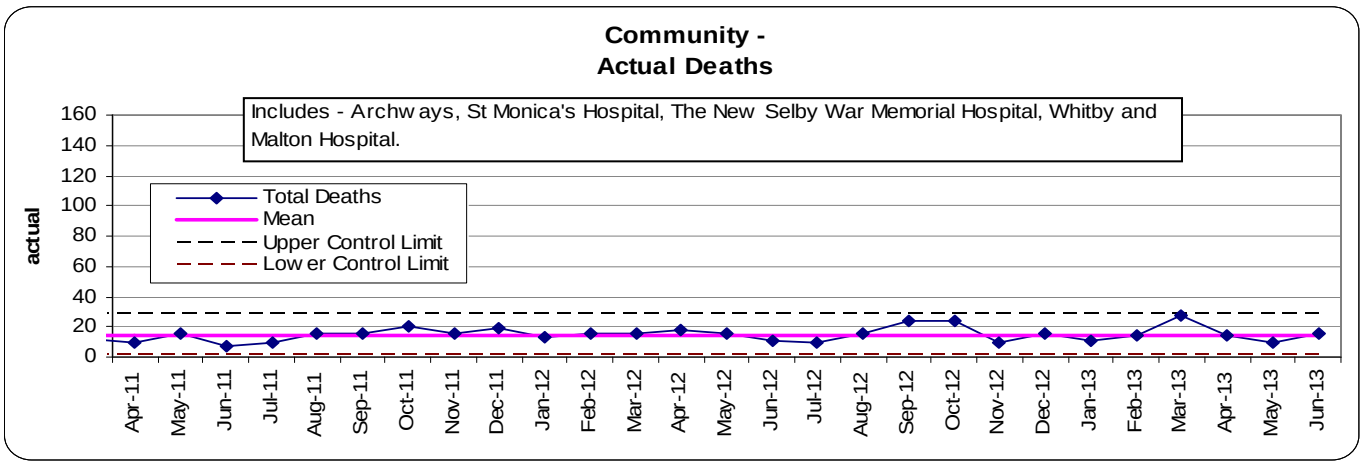
There has been one occasion where a deteriorating patient was escalated to a consultant due to junior medical staff not attending in a timely manner, which demonstrates the success of a clear escalation procedure for deteriorating patients.

In patient deaths

The number of inpatient deaths are summarised in the graphs below. Scarborough and the Community hospitals have seen a very small increase in the number of deaths compared to the previous month, whilst there has been a small reduction at York Hospital during June.





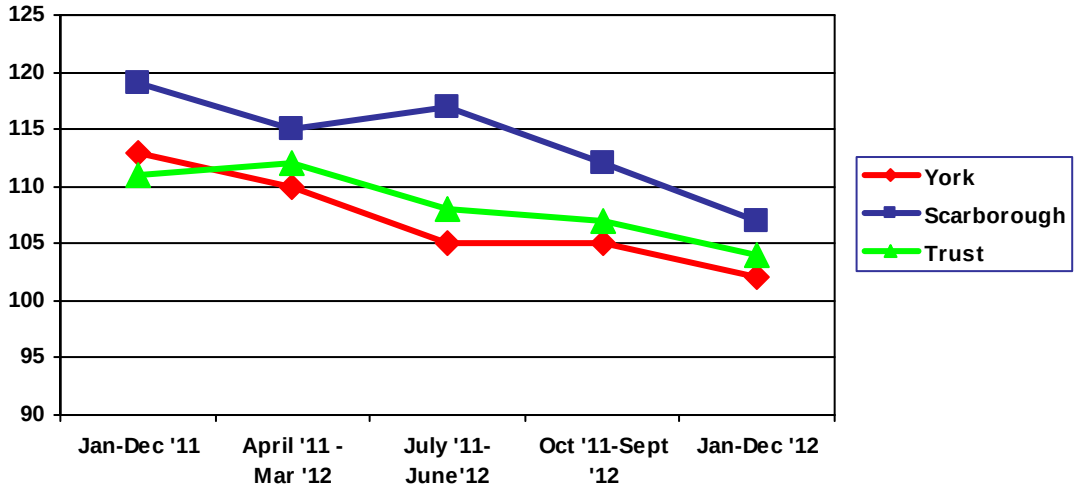


Summary Hospital-level Mortality Indicator

The Summary Hospital-level Mortality Indicator (SHMI) reports mortality at trust level across the NHS in England. The table below indicates the most recent SHMI figures, as reported by the Information Centre. The combined Trust figure of 104 for the period of 1st January to 31st December 2012 as reported on 24th July 2013 is within the 'as expected' range and demonstrates a gradual and sustained reduction in SHMI for the last three reporting periods.

	SHMI January – December 2011	SHMI April 2011- March 2012	SHMI July 2011– June 2012	SHMI October 2011- September 2012	SHMI January – December 2012
York	113	110	105	105	102
Scarborough	119	115	117	112	107
Trust combined figure	111	112	108	107	104

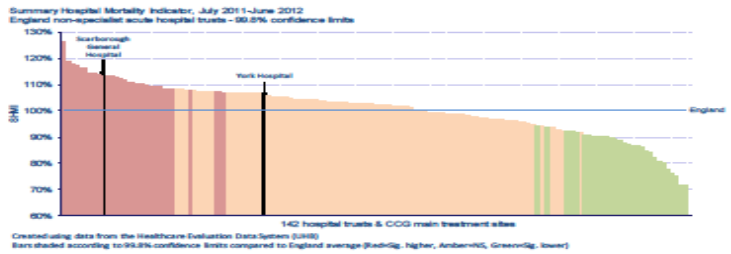
The graph below provides a comparison of the SHMI indicators for the Scarborough and York sites.



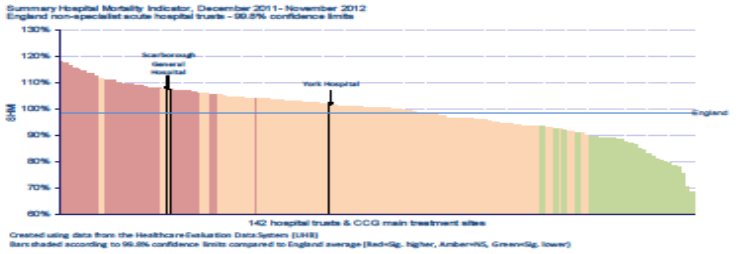
The graphs below indicate the SHMI for York and Scarborough Hospitals and a comparison with all other NHS trusts in England. The first graph represents the period July 2011- June 2012, whilst the second graph represents the period of December 2011-November 2012. The second graph demonstrates an improved position for both hospitals, although Scarborough Hospital SHMI remains at a significantly higher than expected value and remains a concern for the Trust.

Public Health England

Headline analysis:
Overall SHMI by provider trust



- Comparison of York Trust treatment sites vs all other English trusts
- Scarborough General Hospital has a SHMI of 114 which is significantly higher than England at the 99.8% level, and is ranked 10th highest
- York Hospital has a SHMI of 106 and is ranked 46th highest



- Improved relative position for both hospital sites
- Scarborough General Hospital has a SHMI of 107 which is non-significantly higher than England, and is ranked 25th highest
- York Hospital has a SHMI of 102 and is ranked 62nd highest

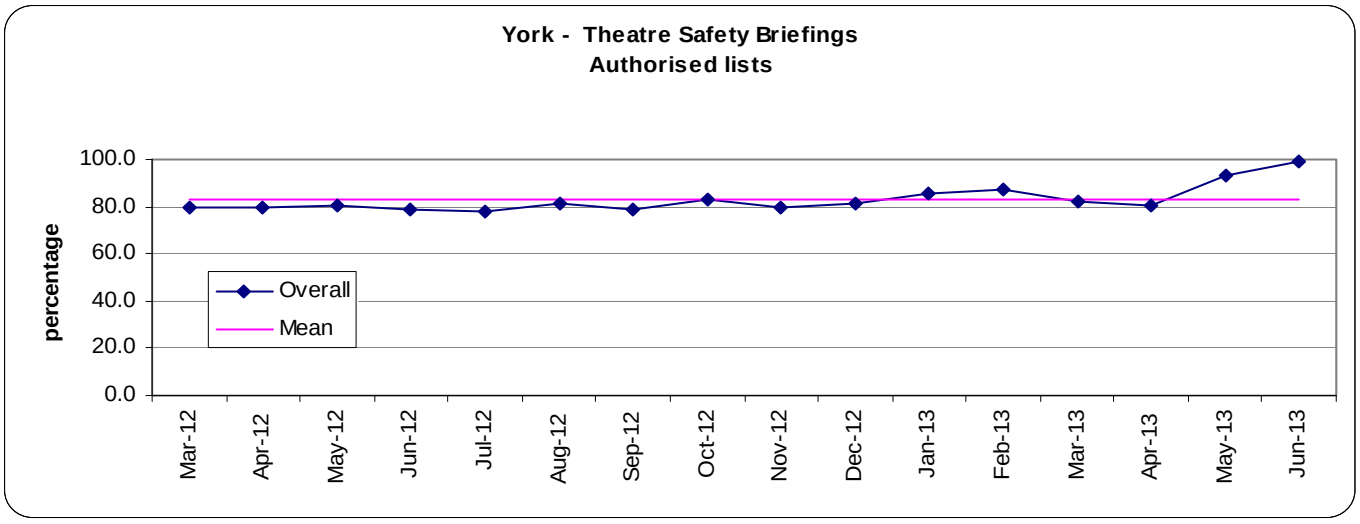
Produced by
PHE Knowledge & Intelligence Team – *Northern and Yorkshire:* Local Health Intelligence Solutions Programme 12

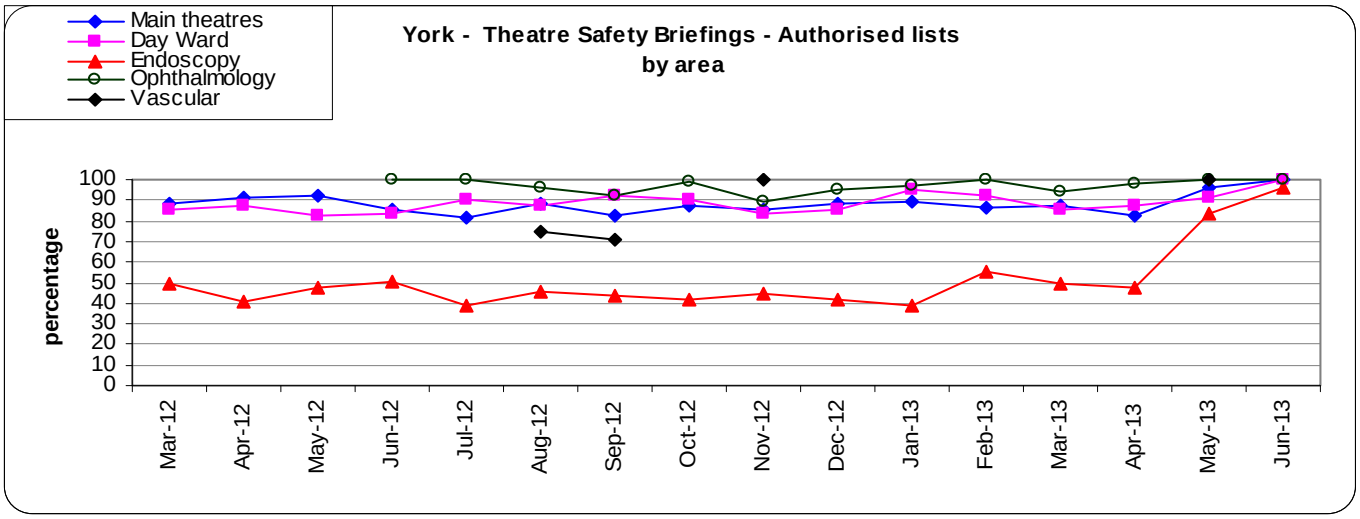
Reducing mortality programme

Good progress continues with several work-streams of the reducing mortality programme. An update on aspects of the project plans is summarized in Appendix 1.

Theatre safety briefings

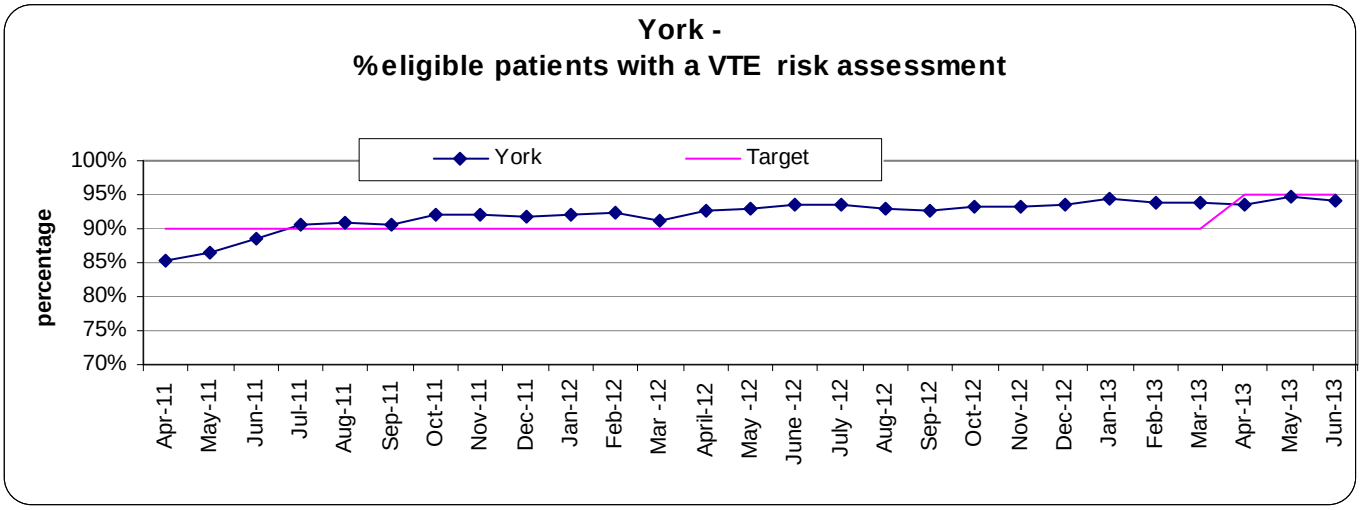
Compliance with theatre safety briefings are illustrated below for York Hospital, confirming that many areas are now achieving 100%, thus overall compliance for the York site is now at 99.27%.



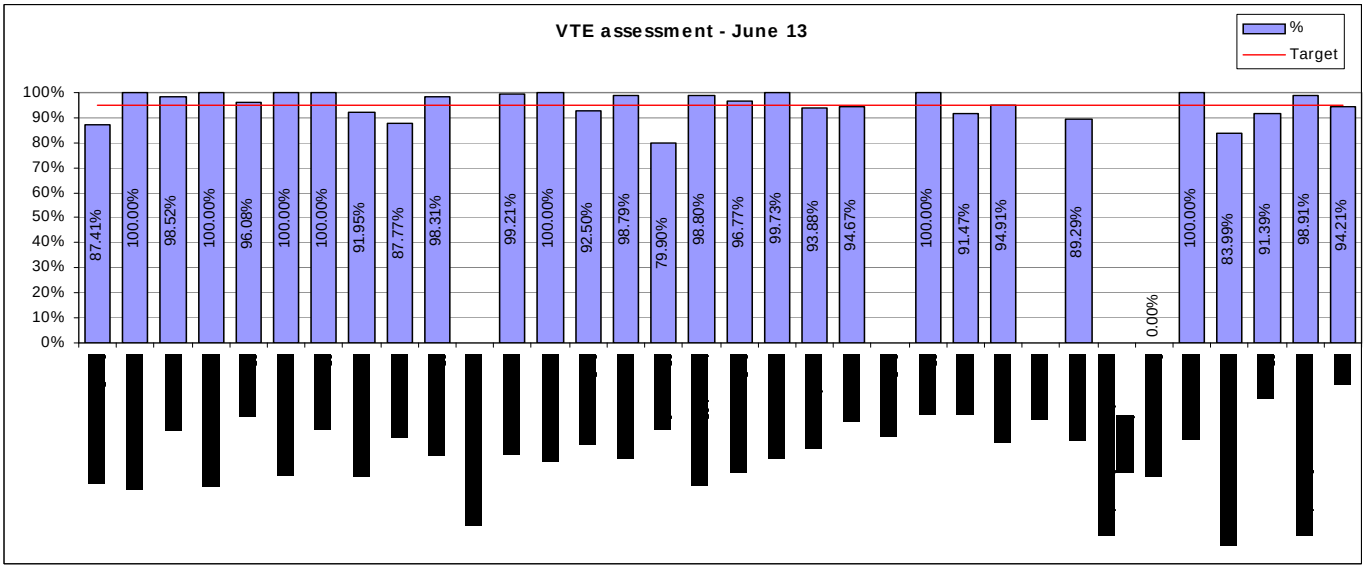


Prevention of VTE

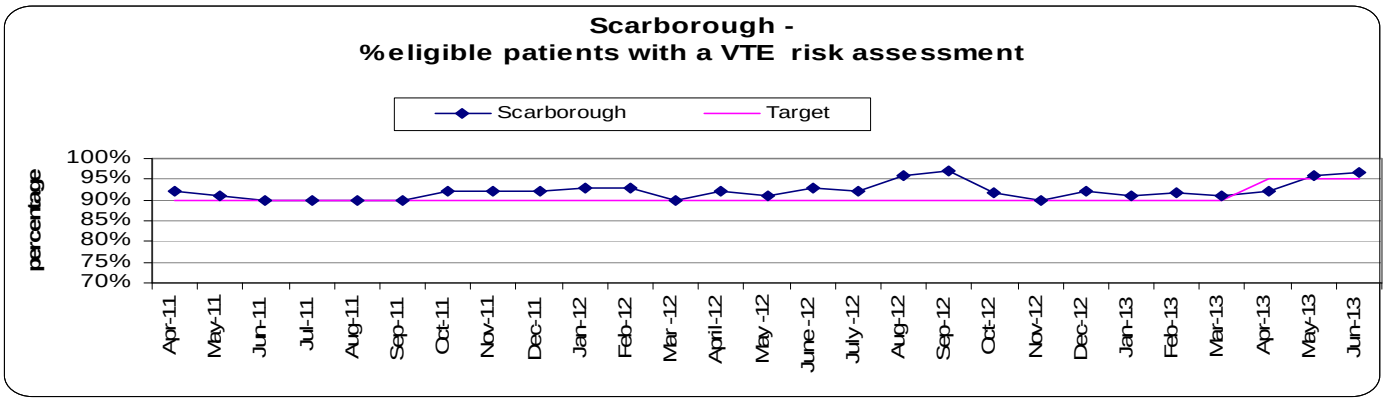
The graph below illustrates a slight decline in recording completion of VTE risk assessments at York Hospital from 94.58% in May to 94.21% in June. Clinical Directors are reminded that VTE risk assessment is a patient safety priority and that the current compliance requirement is for 95% of assessments to be completed as a minimum.



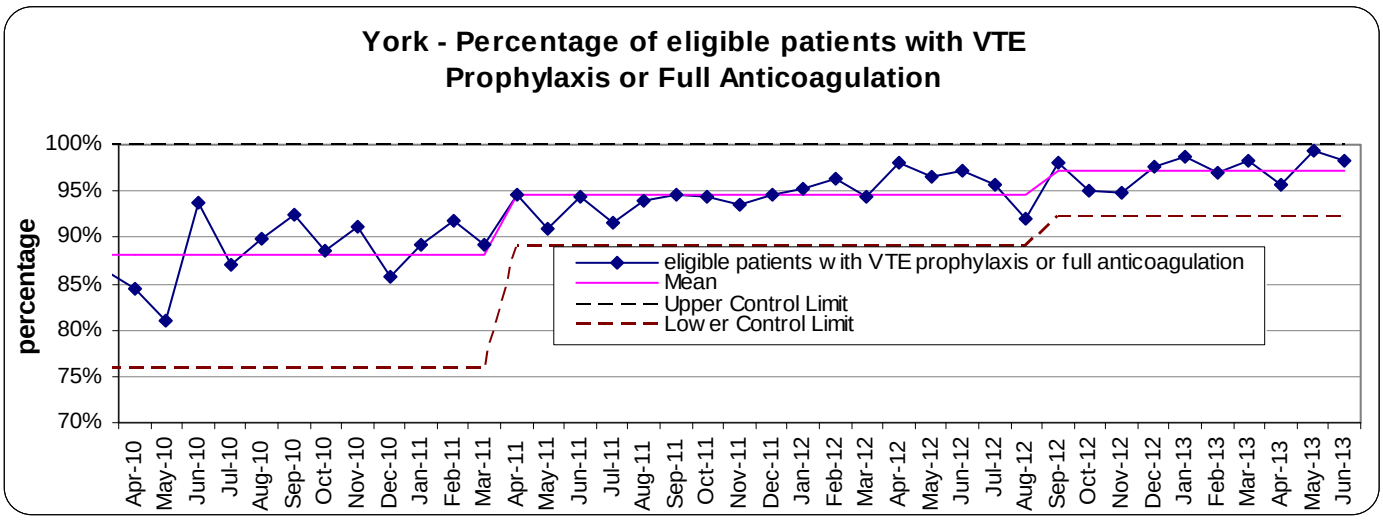
Compliance by directorate is illustrated on the graph below. Clinical Directors have been asked to review compliance locally and to ensure that where a necessary increase is achieved.



VTE risk assessments undertaken at Scarborough Hospital have increased from 95.77% in May to 96.60% in June, as illustrated below.



The percentage of patients in York Hospital who have had a VTE risk assessment and receive prophylaxis or anticoagulation is illustrated below. Data for Scarborough Hospital is not available at the time of reporting.



2.3 Patient Safety Walk-rounds

The table below provides a brief summary from the Patient Safety Walk-rounds held during June. Directorate management teams are reminded that Clinical Directors, Directorate Managers and Matrons are all expected to participate when the walk-round is scheduled for their clinical area of responsibility.

Date	Location	Participants	Actions & Recommendations
4th June	Cherry & A&E (Scarborough)	Diane Palmer Jo Southwell Mike Keeney Sister Bridget Gledhill Dr Christos Dimopolous Mr Andy Volans Miss Joan Clancey Sister Kate Harrison	**Cherry Ward** • The establishment of the Acute Physician rota and re-organisation of the work should bring about enhanced decision making and quality of service, however this system will only be functional from a Monday morning until Friday morning. Arrangements for weekend cover and on-call arrangements need to be monitored to ensure that the quality of service is maintained. • Recruitment panel respond to vacancy requests within two weeks for high risk areas. • Tape stuck to the floor, could potentially be seen as a patient fall hazard. • Learning from serious and critical incidents should be

			shared with the ward clinical staff. **Emergency Department** • Medical staff provision needs to be reviewed. • One junior doctor on-call for general surgery, urology and orthopaedics often seems to struggle with workload • No departmental staff development programme. Nursing staff do not have ALS skills and middle grade doctors struggle with management and decision making skills Ed should be re-visited in the next 3-6 months.
11th June	Ward 11 & Ward 14 (York)	Andrew Bertram Amanda Stanford Katie Holgate	**Ward 11** • 3 toilets have been refurbished, two outstanding. • The ward is used as a thoroughfare between theatres and the day unit. Infection control risk (2 instances occurred during the leadership walk round). • New kitchen issue – the positioning of the fridge results in clash of doors should anyone enter the kitchen at the same time as the fridge is open, there's also snagging issues. **Ward 14** • Significant lack of electric sockets at the patient bedside. Risk of overload due to multiple use of extension leads and risk of inability to connect appliances to electrical supply. Review kitchen layout design and snagging.
18th June	Head & Neck Ward 15	Sue Rushbrook Katrina Swires Gemma Cuss	***Report pending***

3. Adverse incidents

The total numbers of adverse incidents reported during May and June are listed below, along with the number of medication related incidents.

	Community sites	Scarborough*	York	Total number for the Trust
June 2013	149	305	696	1150
May 2013	151	356	723	1230

*includes Bridlington Hospital

	Medication issues
June 2013	126
May 2013	145

Of the medication incidents reported in June:

As of the 3rd July 2013, there are 801 incidents awaiting managers' action / sign off.

Listed below are the top ten incidents reported by category for May 2013. The number of reported incidents related to patient falls has decreased since April but the number of pressure ulcers reported has increased from 149 in April to 186 in May.

Incidents by Category – Top 10 for May 2013

Slip/ trips/ falls	264
Pressure Ulcer	186
Medication related issues	91
Communication problems	45
Other	38

Documentation	36
Mother - complications	35
Failure to adhere to dept proc/ protocol	35
Laboratory Medicine Issues	23
Equipment/ medical device	22

4. Community hospitals

The Patient Safety Dashboards from the Community Hospital Clinical Governance meetings held in June are attached at Appendix 2.

5. Clinical effectiveness

5.1 Alerts

The Trust has one overdue NPSA alert. This is a national problem in that the devices recommended for use in this alert are still being trialled.

NPSA/2009/PSA004B	Safer Spinal (Intrathecal), Epidural And Regional Devices Part B	deadline 2/4/13 - alert remains open

5.2 Consultant Treatment Outcomes

From 28th July data on clinical outcomes for individual consultants is published on the NHS Choices website. The data indicates individual consultants performance against the national average. Currently the data covers seven clinical specialties with an additional three scheduled to be published in the Autumn of 2013. This initiative is a central part of NHS England's ambition to ensure every patient gets high quality care, and to build improved services for the future.

Prof Sir Bruce Keogh, National Medical Director of NHS England, said: "This is a major breakthrough in NHS transparency. We know from our experience with heart surgery that putting this information into the public domain can help drive up standards. That means more patients surviving operations and there is no greater prize than that."

One of the publications, Adult Cardiac Surgery is not applicable to this trust. A summary of the applicable publications is at Appendix 3.

5.3 Patients new to follow up

There is continuing work on identifying groups suitable for safe discharge. The Medical Director has reiterated the need to avoid discharge where safety is clearly compromised. Discussions continue with the CCGs. There is a planned audit of effectiveness in October 2013.

6. Consultant Appointments

None during June.

7. Corporate Risk Register

The table below provides brief details of the risks identified on the Corporate Risk Register which are being monitored and reviewed by the Medical Director.

Risk	Key action	Risk rating	Start date
Increase in clinical activity and complexity of cases	Regular review of performance and clinical outcome indicators in association with analysis of incidents, complaints and claims	Red	Feb '13
Medication related incidents and errors	Implementation of electronic prescribing and medicines management – plans for EPMA are being drafted	Red	Oct '03
Lack of patient identification and compliance with NPSA Alert	Identification Policy to be reviewed and revised	Red	June '09
Failure to act on abnormal investigation results	Implementation of Notify at Scarborough Hospital	Red	Sept '07
Lack of liaison psychiatry	Discussions taken place with local mental health service providers – Sarah Lovell leading work on options/costs	Red	Jan '06
Failure to comply with NPSA/2009/PSA004B Safer Spinal (Intrathecal), Epidural And Regional Devices Part B	Awaiting availability of new products and testing	Red	Apr '13

8. Recommendations

The Board of Director's are requested to note and support the content of the report and specifically to be aware of:

- the requirement for VTE assessment to achieve 95% compliance as a minimum
- the publication of surgical outcomes
- the publication of SHMI for the period 1st January to 31st December 2012.

Author	**Diane Palmer, Deputy Director for Patient Safety**
Owner	**Dr Alastair Turnbull, Medical Director**
Date	**24th July 2013**

Appendix 1.

Patient Safety Priorities – Reducing Mortality Programme
Progress Report

Ensuring a 7 day service

1) Excellence in ward rounds

We are planning a test of the daily board round process on Oak Ward, Scarborough Hospital. The aim of the board is to review every day the needs of each patient on the ward. Identifying:

- Which patients are medically fit for discharge
- Which patients require an urgent medical review (senior or junior + priority)
- Which patients are waiting, what they are waiting for and if this wait can be expedited.

The output of the board round is to

- Prioritise the patients for medical review (new patients, sick patients and patients ready for discharge)
- Agree the days plan for each patient and the lead for each task
- Agree an EDD for all patients.
- Identify complex patients who need a full MDT discussion to progress their care
- Agree actions to take to progress discharge.

The presence of a senior doctor or consultant for each board round is vital.

2) Streaming the 'out of hours' service

A survey of out of hours commitments is being undertaken for Scarborough based consultants looking at inpatient/outpatient care, on call commitment, OOH clinics and thoughts on planning for the future . Additional information and data is scheduled to be presented at the July Grand Round..

Reviewing systems for measurement

1) Excellence in coding

Focussed work on coding symptoms and co-morbidities continues.

2) Mortality reviews of all deaths

The mortality review steering group has now enhanced the generic and community hospitals mortality review proforma. Proformas for ED, Trauma and Orthopaedics, and General Surgery are being revised to be in line with the generic proforma.

Following mortality review completed proformas are now being collated by the Patient Safety Team and analysis and report of learning will shortly be available on a monthly basis. Systems and Networks are aligning the proforma with data on CPD so that some aspects of the form will be automatically populated – although this will not be fully functional until later this year.

A system for case specific detailed review has been developed and is being tested.

A system to copy the death certificate onto CPD is being developed.

Reducing harm and deterioration

1) Improved recognition and management of the deteriorating patient

Quarterly cardiac arrest audit report for the period, September 2012-December 2012 has been completed.
The learning points were:

1. There was evidence of improved practice in taking patient observations, all patients had their observations performed as prescribed.
2. Not all appropriate patients were referred to CCOT.
3. Not all patients underwent a daily senior review.
4. There was evidence of variation in DNACPR decision making and ceiling of care / management planning.
5. There was evidence of poor escalation in some patients who showed signs of deterioration.

It is anticipated that the implementation of the new Escalation Policy to support implementation of the National Early Warning Score (NEWS) will have a positive impact on some of the concerns identified in the cardiac arrest audit. Change over to NEWS will be complete by the end of July 2013.

2) Improved management of in-patients with diabetes

Standard to be achieved – insulin prescribing errors of no more than 6% by December 2014

- April 2013 insulin prescribing errors were 9.7% (7 out of 72 errors)
- May 2013 insulin prescribing errors were 7% (7 out of 100 errors)

These figures are from York Hospital, all community hospitals and community services. Results for Scarborough Hospital and Bridlington Hospital will be available from next month.

Standard to be achieved – Hypoglycaemic episodes of no more than 2.5% by December 2014

Current figure stands at 3.63% for York Hospital (i.e. of all blood glucose tests undertaken 3.63% were <4 mmols). The figure is not yet available for Scarborough Hospital or any of the community hospitals.

3) Reduce falls

Standard to be achieved – 'Root Cause Analysis complete within agreed time frame for all falls with serious harm'

January 2013 – June 2013 there were a total of 8 falls with serious harm. Of those 8, 4 RCAs remain outstanding (50%). Details as below:

Incident date	Injury Sustained	Location of Incident
21/01/2013	# Hip	AMU
21/01/2013	# NOF	Ward 32
28/02/2013	# NOF	Whitby Hospital
08/03/2013	Dislocated hip and # acetabulum	Ward 32

Standard to be achieved – 'Falls champions identified on all wards by March 2014'.

For the York and Scarborough site (excluding paediatrics and maternity), there are 37 areas requiring Falls Champions. Nine are currently identified (24.3%).

Eight community hospitals require Falls Champions. Two are currently identified (25%).

Standard to be achieved - 'All falls champions to have undertaken the Fall Safe E-learning package by June 2014'.

As of 27th June 2013, 43 staff members have enrolled for the E-Learning package. The majority are staff that have enrolled out of their own interest without nominating themselves as a Falls Champion.

Of the identified Falls Champions (13 in total), eight have completed and passed the module (61.5%). These cover six ward areas from the acute hospitals and one community hospital.

York Teaching Hospital NHS
NHS Foundation Trust

Archways Community Hospital
Patient Safety Dashboard – May 2013

	February	March	April
Number of incidents reported on - datix web - paper forms	12	14	11**
Number of medication related incidents	0	0	0**
Number of severe incidents – SI's - CI's	0	0	0
Number of new and/or settled clinical litigation cases	0	0	n/a
Number of formal complaints	0	0	n/a
Admissions	19	35	30
Discharges	20	33	29
% compliance with infection control practices: hand hygiene glove use bare below the elbow	 100 100 100	 100 100 100	 100 80 100
CDIFF >72hrs Archways (YTD) Community (YTD)	 0 3	 0 4	 n/a n/a
VTE harm* *(% of patients)*	0(0%)	0(0%)	0(0%)
Patient falls harm* *(% of patients)*	1(4.5%)	0(0%)	0(0%)
Slip/ trips/ falls – *Datix: total for month*	11	11	5**
Pressure ulcers harm* *(% of patients)*	1 (4.5%)	0(0%)	0(0%)
Pressure ulcers – *Datix: total for month* Total Since admission On admission	1 1(grade 3) 0	0 0 0	1 0 1
UTI's harm*	0(0%)	0(0%)	0(0%)
Empty Admin Boxes *(Safety thermometer)* Omission Code 4 *(Safety thermometer)* Omitted Critical Medicines *(Safety thermometer)*	4 (19%) 1 (4.5%) 2 (9.1%)	3 (17.6%) 3 (17.6) 3 (17.6)	6 (27.3%) 2(9.1%) 2(9.5%)
Number of in-hospital deaths	0	2	1
Number of in-hospital deaths without palliative care pathway	n/a	n/a	n/a
Length of hospital stay – mean *(previous yr)*	32.7 (27.2)	19.9 (21.5)	28.3 (26)
Total number of risks on risk register	n/a	11	8

* Patient Safety Thermometer (Ward level harm – not CQUIN measure)
** Datix figures may increase as coding for month will not yet be complete

York Teaching Hospital NHS
NHS Foundation Trust

The New Selby War Memorial Hospital
Patient Safety Dashboard – May 2013

	February	March	April
Number of incidents reported on - datix web	31	30	15**
Number of medication related incidents	1	1	1
Number of severe incidents – SIs - CIs	0 0	0 0	0 0
Number of new and/or settled clinical litigation cases	n/a	n/a	n/a
Number of formal complaints	n/a	n/a	n/a
Admissions	49	47	38
Discharges	49	49	38
% compliance with infection control practices: hand hygiene glove use bare below the elbow	 100 100 100	 100 100 100	 100 100 100
CDIFF >72hrs Selby War Memorial *(YTD)* Community *(YTD)*	 2 3	 2 4	 n/a n/a
VTE harm* *(% of patients)*	0 (0%)	0 (0%)	0 (0%)
Patient falls harm* *(% of patients)*	1 (4.5%)	1 (4.8%)	0 (0%)
Slip/ trips/ falls – *Datix: total for month*	25	17	8**
Pressure ulcers harm* *(% of patients)*	0 (0%)	0 (0%)	1(4.5%)
Pressure ulcers – *Datix: total for month* Total Since admission On admission	1 1 0	1 1 0	0** 0** 0**
UTI's harm*	0 (0%)	0 (0%)	1(4.5%)
Empty Admin Boxes *(Safety thermometer)* Omission Code 4 *(Safety thermometer)* Omitted Critical Medicines *(Safety thermometer)*	3(13.6%) 1(4.8%) 3 (14.3%)	1(4.8%) 2(9.5%) 1(4.8%)	3(13.6%) 0 (0%) 1(6.7%)
Number of in-hospital deaths	0 (0%)	4 (8%)	1(2.6%)
Number of in-hospital deaths without palliative care pathway	n/a	n/a	n/a
Length of hospital stay – mean *(previous yr)*	21.7(33.3)	21.8 (26.2)	32.1(27.3)
Total number of risks on risk register	n/a	n/a	n/a

*Patient Safety Thermometer (Ward level harm – not CQUIN measure)
** Datix figures may increase as coding for month will not yet be complete

York Teaching Hospital NHS
NHS Foundation Trust

St Monica's Community Hospital
Patient Safety Dashboard – May 2013

	February	March	April
Number of incidents reported on - datix web - paper forms	2	5	2**
Number of medication related incidents	0	0	0
Number of severe incidents – SIs - CIs	0	0	0
Number of new and/or settled clinical litigation cases	0	0	n/a
Number of formal complaints	0	0	n/a
Admissions	14	12	20
Discharges	14	13	21
% compliance with infection control practices: hand hygiene glove use bare below the elbow	100 100 88	100 100 100	100 100 88
CDIFF >72hrs St Monica's (YTD) Community (YTD)	0 3	0 4	n/a n/a
VTE harm* *(% of patients)*	0(0%)	0(0%)	0(0%)
Patient falls harm* *(% of patients)*	0(0%)	1 (8.3%)	0(0%)
Slip/ trips/ falls – *Datix: total for month*	1	1	0**
Pressure ulcers harm* *(% of patients)*	1(10%)	0(0%)	0(0%)
Pressure ulcers – *Datix: total for month* Total Since admission On admission	1 0 1	2 0 2	0 0 0
UTI's harm*	0(0%)	0(0%)	0(0%)
Empty Admin Boxes *(Safety thermometer)* Omission Code 4 *(Safety thermometer)* Omitted Critical Medicines *(Safety thermometer)*	2 (20%) 2 (20%) 0(0%)	0(0%) 0(0%) 1 (12.5%)	2(18.2%) 0(0%) 0(0%)
Number of in-hospital deaths *(% pts disch as died against all discharges)*	2 (14.3%)	7 (53.8%)	4(19%)
Number of in-hospital deaths without palliative care pathway	n/a	n/a	n/a
Length of hospital stay – mean *(previous yr)*	13.1(11.7)	27(18.9)	24.4 (40)
Total number of risks on risk register	n/a	10	10

*Patient Safety Thermometer (Ward level harm – not CQUIN measure)
** Datix figures may increase as coding for month will not yet be complete

York Teaching Hospital NHS
NHS Foundation Trust

Whitby Community Hospital
Patient Safety Dashboard – May 2013

	February	March	April
Number of incidents reported on - datix web	16	19**	24**
Number of medication related incidents	1	1**	0**
Number of severe incidents – SIs - CIs	0	0	0
Number of new and/or settled clinical litigation cases	0	0	0
Number of formal complaints	1	0	0
Admissions	37	56	44
Discharges	39	53	48
% compliance with infection control practices: hand hygiene glove use bare below the elbow	 100 100 95	 100 100 100	 100 100 100
CDIFF >72hrs Whitby (YTD) Community (YTD)	 1 3	 1 4	 n/a n/a
VTE harm* *(% of patients)*	0(0%)	0(0%)	0(0%)
Patient falls harm* *(% of patients)*	0(0%)	0(0%)	0(0%)
Slip/ trips/ falls – *Datix: total for month*	5	5**	13**
Pressure ulcers harm* *(% of patients)*	0(0%)	2 (5.7%)	1(2.9%)
Pressure ulcers – *Datix: total for month* Total Since admission On admission	5 2 3	1** 1** 0**	1** 1** 0**
UTI's harm*	0 (0%)	0 (0%)	0 (0%)
Empty Admin Boxes *(Safety thermometer)* Omission Code 4 *(Safety thermometer)* Omitted Critical Medicines *(Safety thermometer)*	1(2.9%) 2(5.9) 0 (0%)	0 (0%) 1(2.9%) 0 (0%)	4 (11.4%) 8(22.9%) 0 (0%)
Number of in-hospital deaths	6	8	6
Number of in-hospital deaths without palliative care pathway	1	3	n/a
Length of hospital stay – average *(previous yr)*	21.6 (24)	25.6 (21)	22.3 (15.)
Total number of risks on risk register	34	n/a	n/a

*Patient Safety Thermometer (Ward level harm – not CQUIN measure)
** Datix figures may increase as coding for month will not yet be complete

Consultant Treatment Outcomes

For each specialty and report the data is presented slightly differently. A brief summary of the salient outcomes from each report for surgeons in York is presented below.

Outcomes after vascular surgery

All York surgeons had outcomes in the 'as expected range' for their level of clinical activity.

Carotid Endarterectomy

	CEAs	% stroke and/or death
Mr M. Baroni	96	3.1%
Mr S. Cavanagh	78	4.0%
Mr A. McCleary	136	4.1%
Mr A. Thompson	35	2.9%

Elective Abdominal Aortic Aneurysm Repair

	AAA	Open	EVAR	Mortality
Mr M. Baroni	55	24	31	3.6%
Mr S. Brooks	14	14	0	7.1%
Mr S. Cavanagh	76	23	53	2.6%
Mr A. McCleary	72	48	24	1.4%
Mr A. Thompson	17	10	7	0.0%

Outcomes after thyroid and endocrine surgery

No data published for York Hospital – participation in the audit was voluntary.

Outcomes after bariatric surgery

The surgeons who undertake procedures recognised as bariatric surgery are listed below.

Mr W. Wong	mortality rate 0.000%	19 procedures
Mr G. Miller	mortality rate 0.000%	53 procedures
Mr . M. Giles	mortality rate 0.000%	21 procedures

Outcomes after percutaneous coronary intervention

The clinicians who undertake the interventional cardiology procedures are listed below.

	Major adverse cardiac & cerebrovascular event rate/ 100 procedures	
Dr J. Crook	0.00%	115 procedures – 84 in York
Dr N. Durham	-0.88%	113 procedures – 84 in York
Dr M. Pye	1.23%	163 procedures – 135 in York

Outcomes after orthopaedic surgery

Data on outcomes from surgeons working in Scarborough and York Hospitals who perform hip and knee surgery have been published, with all surgeons from the Trust having mortality rates in the expected range. The data refers to all arenas of their practice.

Outcomes after urology surgery

Data on outcomes from surgeons working in Scarborough and York Hospitals who perform nephrostomy procedures have been published. All procedural mortality and complication rates lay within expected limits.

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 31 July 2013

Director of Infection Prevention and Control (DIPC) Report, Quarter 1

Action requested/recommendation

The Board of Directors is asked to note this report and any specific actions for Clinical Directors, Directorate and Clinical Managers. The report summarises Healthcare Associated Infection incidence across the Trust

Summary

Throughout Q1 the Trust has experienced a period of increased incidence of *C.difficile* infection for which a detailed reduction strategy has been agreed and shared with CCG colleagues. Public Health England have been invited to evaluate with us our control plans. Executive Board have been briefed about the enhanced control measures and a Consultant Gastroenterologist appointed as lead Clinician for *C.difficile* infection.

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

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

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

Progress of report CQC Registration Patient Safety Objectives.

Risk	No risk.
Resource implications	The cost and operational impact of HCAIs together with improvement and financial penalties that may be incurred from external regulation (CQC, Monitor) and Commissioners.
Owner	Elizabeth Mc Manus, Chief Nurse, Director of Infection Prevention and Control (DIPC)
Author	Vicki Parkin, Deputy DIPC
Date of paper	April 2013
Version number	1

Board of Directors – 31 July 2013

Director of Infection Prevention and Control (DIPC) Report, Quarter 4

1. Introduction and background

This report together with the IP performance dashboard App 3 summarises performance and compliance against the Hygiene Code 2009, key performance indicators and the IP Annual Plan 2012/13. It aims to assure the Board that IP systems and processes aimed at achieving sustainable reductions in the incidence of avoidable Healthcare Associated Infections (HCAIs) are both in place and effective.

2. Executive Summary

Continued engagement and ownership by Directorate and Divisional management teams is demonstrated in data reported on the IP dashboard, App 3

At the end of Q4 the York site exceeded trajectory for Clostridium Difficile Infection (CDI) with an incidence of 39/27. Decision has yet to be made regarding financial penalty by the PCT. Scarborough incidence at the end of Q4 was 15/24 giving a total combined incidence of 54/51. Monitor observe a trajectory of 51. Progress with the CDI reduction strategy for York site, developed when this challenging target was set is summarised in App 2. It is important to note that compliance with infection prevention practices are critically monitored, reflect best practice and are aimed at keeping patients safe. Root Cause Analysis of all cases continues to identify antimicrobial prescribing as a key concern for which an emergency Stewardship meeting was held at the end of March. Key priorities and actions aimed at developing the drug chart to improve prescribing practice and adherence to formulary were agreed.

There were no cases of MRSA bloodstream infection in Q4 leaving the total at 1 for the year across the Organisation.

Seasonal Norovirus has continued to occur with significant impact on ward closures and elective activity. The IPT work closely with Operational leads to identify ways of maintaining both safe patient placement and flow.

There have been some water safety issues on both sites that have been managed through the site water safety committees. A detailed report will be provided in Q1 when definitive testing results are known following water treatment and filtration interventions. Changes in practice were advised to ensure provision of safe practice and equipment.

2.1 Discussion

The Annual Plan (App 1) summarises progress with all Trust IP objectives for quarter 4

HCAI Incidence Summary

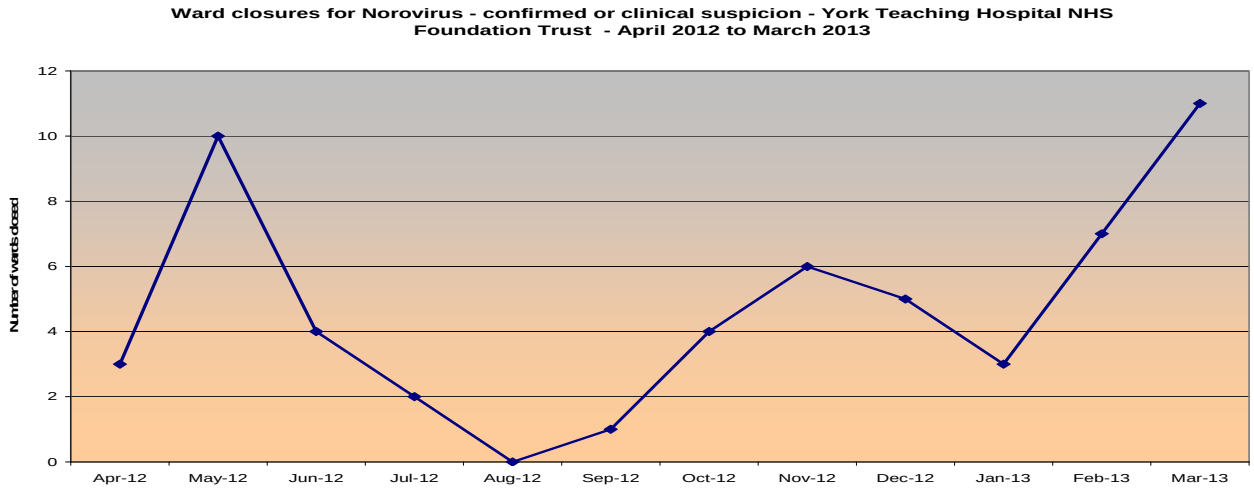
Quarterly report data – Trust attributed cases only

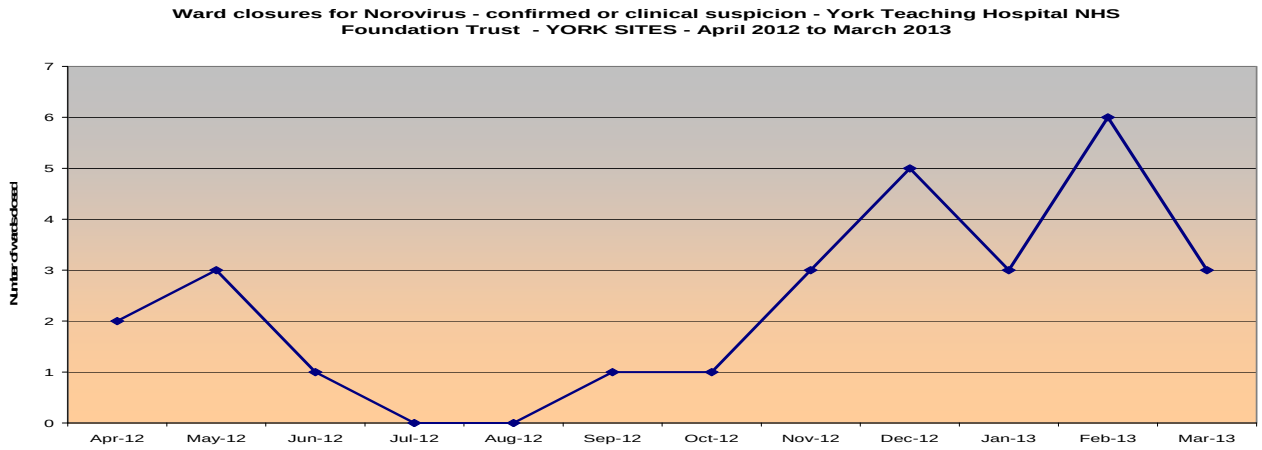
Combined	Q1	Q2	Q3	Q4	Year total
MRSA bacteraemia	0	1	0	0	1
MSSA bacteraemia	10	7	10	6	33
E.coli bacteraemia	24	29	21	34	108
CDI (toxin positive)	12	14	12	16	54

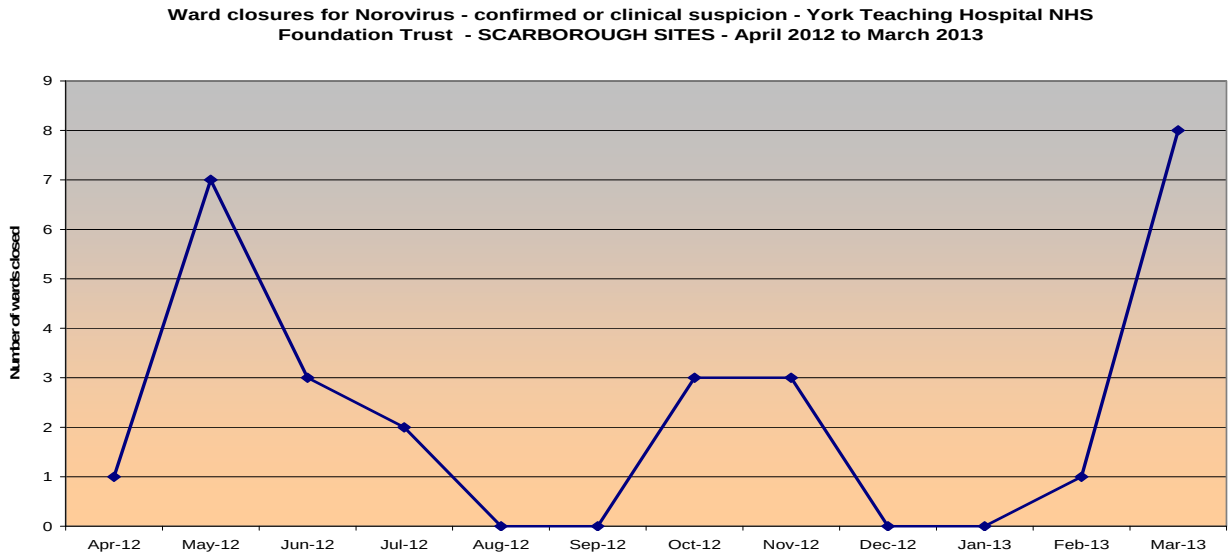
York	Q1	Q2	Q3	Q4	Year total
MRSA bacteraemia	0	0	0	0	3
MSSA bacteraemia	8	5	6	2	21
E.coli bacteraemia	18	18	13	19	68
CDI (toxin positive)	8 (+1 Selby)	10 (+1 Whitby)	9 (+1 Malton)	12 (+1 Malton, +1 Selby)	39

Scarborough	Q1	Q2	Q3	Q4	Year total
MRSA bacteraemia	0	1	0	0	1
MSSA bacteraemia	2	2	4	4	12
E.coli bacteraemia	6	11	8	15	40
CDI (toxin positive)	4	4	3	4	15

Ward closures following Norovirus outbreaks







3. Conclusion

IP performance and compliance with the Hygiene Code 2009 and other indicators continue to Improve. There has been significant progress with implementation key objectives on the Scarborough site

It is important for Directorates and Divisions to own and continually engage with IP priorities if the Trust is to achieve sustainable reduction in HCAI and ensure patient safety

4. Recommendation

The Board of Directors is asked to note this report and any specific actions for Directors and Clinical Leads.

5. References and further reading

Health and Social Care Act 2008 – Code of Practice for health and adult social care on the prevention and control of infections and related guidance, Dec 2009.

Author	**Vicki Parkin, Deputy DIPC.**
Owner	**Elizabeth Mc Manus, Chief Nurse,**

	Director of Infection Prevention and Control (DIPC)
Date	**April 2013**

DIPC QUARTERLY INFECTION PREVENTION REPORT FOR TRUST BOARD. Q1 2013										
Parameter		**Annual threshold/ target**	**April**	**May**	**June**	**Q2**	**Q3**	**Q4**	**YTD**	**TREND**
MRSA Bacteraemia attributable to Trust	York sites		0	0	0				0	
	Scarborough sites		0	0	0				0	
	Trust	0	0	0	0				0	
MSSA Bacteraemia attributable to Trust	York sites		1	3	4				8	
	Scarborough sites		1	0	1				2	
	Trust	30	2	3	5				10	
E Coli Bacteraemia attributable to Trust	York sites		6	3	5				14	
	Scarborough sites		2	0	1				3	
	Trust	Not set	7	5	6				18	
Clostridium difficile Associated Diarrhoea attributable to Trust	York sites	26	6	3	7				16	
	Scarborough sites	17	1	2	2				5	
	Trust	43	7	5	9				21	
CDI per 10000 bed days attributable to Trust	York sites		2.87	1.48	3.63				7.98	
	Scarborough sites		1	2.06	2.12				5.18	
	Trust		2.26	1.67	3.14				7.07	
Elective MRSA admission screening	York sites	100%	89%	90%	90%				90%	
	Scarborough sites	100%	89%	90%	88%				89%	
	Trust	100%	89%	90%	89%				89%	
Emergency MRSA admission screening	York sites	100%	75%	80%	79%				78%	
	Scarborough sites	100%	93%	94%	92%				93%	
	Trust	100%	84%	87%	86%				86%	
Antimicrobial pathway compliance	York sites		Not available							
	Scarborough sites		Not available							
	Trust		Not available							
Ventilator acquired pneumonia	York sites		0	0	0				0	
	Scarborough sites		0	1	0				1	
	Trust		0	1	0				1	
CVC associated infections in ICU	York sites		0	0	1				1	
	Scarborough sites		0	0	0				0	
	Trust		0	0	1				1	
Trust attributed CAUTI (Safety Thermometer data)	York sites		2	4	3				9	
	Scarborough sites		8	1	0				9	
	Trust		10	5	3				18	
VIP score for peripheral cannula	York sites		Not available							
	Scarborough sites		Not available							
	Trust		Not available							
Hand hygiene compliance	York sites	100%	100%	100%	100%				100%	
	Scarborough sites	100%	97%	98%	100%				98%	
	Trust	100%	98%	99%	100%				99%	

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 31 July 2013

Organisational Response to the Francis Report

Action requested/recommendation

The Board of Directors is asked to note the contents of the report and support the key actions identified.

Summary

This paper seeks to provide an update the work currently being undertaken within the Trust post the publication of the Francis Report into Mid Staffordshire Hospitals Foundation Trust and the subsequent publication of the Government's response to the recommendations that were made. The recommendations made also bear in mind the impact of the Chief Inspector of Hospitals in the light of the Keogh Review; they consequently reflect a rounded view of the actions that need to be taken.

There is a requirement on the Trust to formally publish the organisation response to the Francis Report by December 2013.

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

Implications for equality and diversity

There are implications for Equality and Diversity within all of the actions recommended within this paper. As an inclusive organisation issues of equality and diversity are integrally bound into our processes and procedures.

Reference to CQC outcomes

The content of this report covers all CQC outcomes.

Progress of report	This paper will go directly to the Board of Directors
Risk	There are inherent risks associated with failure to act on the recommendations that have been made.

Resource implications	Each recommendation within the paper has its own underpinning work plan where resource implications have been considered.
Owner	**Elizabeth McManus, Chief Nurse**
Author	**Fiona Jamieson. Assistant Director of Healthcare Governance**
Date of paper	July 2013
Version number	V1

Board of Directors - 31 July 2013

Response to the Francis Report

1. Introduction and background

This paper seeks to provide an update the work currently being undertaken within the Trust post the publication of the Francis Report into Mid Staffordshire Hospitals Foundation Trust and the subsequent publication of the Government's response to the recommendations that were made. The recommendations made also bear in mind the impact of the Chief Inspector of Hospitals in the light of the Keogh Review; they consequently reflect a rounded view of the actions that need to be taken.

There is a requirement on the Trust to formally publish the organisation response to the Francis Report by December 2013.

2. Progress Made

Under the leadership of the Chief Nurse, the Trust has established a Task and Finish Group to co-ordinate the organisational response to the publication 'Patients First and Foremost', the Government's reflections on the recommendations made in the Francis Report.

The focus of the group is to co-ordinate a view on the organisation's current position & progress, identifying any gaps that become evident and ensuring that any required actions are identified and addressed.

The 5 key domains will mirror those in the publication 'Patients First and Foremost' and are outlined below.

- Preventing problems
- Detecting problems quickly
- Taking action promptly
- Ensuring robust accountability
- Ensuring that staff is trained and motivated.

2.2 Prior Consultation

Prior to the establishment of the Task and Finish Group, the Chief Nurse sought views and responses to the Government's initial response to the Francis Report from Matrons, Clinical Directors, Directorate Managers, Corporate Directors and the Corporate Nursing Team. Meetings and briefings have also taken place with the Governors, and with the Board of Directors.

The Chief Nurse and Deputy Chief Executive have also offered several open forum sessions to staff across the organisation to encourage open discussion.

The HR team have been holding focus groups for staff to ascertain how staff want to have their voice heard and what the best ways are for them of doing this. Whilst not solely focussed on the Francis report this is a supportive piece of work and will inform our

approaches to staff engagement.

Staff side representatives have also been asked to consider how they might wish to comment.

The responses received to date have informed the work of the Task and Finish Group.

2.3 Task and Finish Group

The Task and Finish Group is led by the Assistant Director of Healthcare Governance and has the following representation:

- Beverley Geary: Deputy Chief Nurse
- Jacqueline Gilbey: Deputy Director of Human Resources
- Gail Dunning: Deputy Director Applied Learning & Research
- Diane Palmer: Deputy Director of Patient Safety
- Anna Pridmore: Foundation Trust Secretary
- Jo Southwell: Operations

Each member of the group will undertake a review of the key domains outlined above from the perspective of the service area or function that they represent. We will now also seek the input of Estates and Facilities.

This will include

- A statement on the current position
- Identification of any gaps and an associated risk rating. This will assist developing the organisational priorities
- Establishing action plans where required to mitigate risk

This first part of this critical piece of work has now been completed and has been summarised into key themes, with three priority actions in each category.

3.0 The Key Themes

3.1 **Culture** ***Links to***
Preventing Problems/detecting problems quickly/taking action promptly/ensuring robust accountability

What have we done?

Organisational values have been a key development theme for the last five years. A significant review of organisational values was undertaken pre integration, preparing for the clarity and direction required for staff around these changes. We have also introduces a Personal Accountability Framework which aims to ensure that all staff are aware of their lines of accountability. We have developed 'Being Open and "Whistle Blowing" policies that foster our culture of openness and transparency these are already under review.

What do we need to do?

The Task and Finish Group recommends that our priority actions are

1. Through leadership at all its management levels the organisation needs to continue to

build on its espoused culture of accountability and responsibility, of openness and transparency. Embedding the use and understanding of the Personal Accountability Framework, ensuring all staff understand what the PAF means for them.
2. Finalise the review of the 'Whistle blowing" and 'Being Open Policies' to ensure that staff understand how and who they can raise a concern to, and that we fulfil our responsibilities in being an open and transparent organisation
3. Ensure that all staff understand the organisations values and how they relate to them personally and the job that they do by continuing to embed organisational values in all that we do

3.2 Patient Safety
Links to Preventing Problems/detecting problems quickly/taking action promptly/ensuring robust accountability/Ensuring staff are trained

What have we done?

The organisation has a commitment to Patient Safety which is reflected in its prominence in the Agenda of Board of Director meetings. Post integration the organisation has focused on bringing best practice to all aspects of patient's safety, including the production of a revised Patient Safety Strategy. We have a dedicated programme of mortality review, implemented the electronic capture of observations, introduced the Safety Thermometer , reviewed our approach to pressure ulcer reduction, improved VTE performance and revised our CDI Strategy.

What we need to do

The Task and Finish Group recommends that our priority actions are

1. Undertake a systematic review of risk management processes within the organisation
2. Review of Clinical Guidelines (in the light of organisational integration)
3. Ensure that clinical management practices are clear and explicit by agreeing a set of clinical management standards to be published internally and externally

3.3 Risk Management
Links to Preventing Problems/detecting problems quickly/taking action promptly/ensuring staff are trained and motivated

What have we done?

The organisation has risk management processes in place that it has worked on embedding within the enlarged organisation over the past year. Significantly we have introduced electronic Datix Web reporting across all sites enabling the swift identification and addressing of risk/patient safety issues.

We have also introduced a process to address concerns generated from Internal Audit around the validation of patient safety data prior to upload to the NRLS. A Review of the role of the Corporate Risk Management Group is already underway, and a high level review of the process of investigating a serious incident has already been completed. In addition, the organisation has a programme of Compliance Review that has been extended to cover the wider organisation, thus identifying risks and enabling action to be taken to resolve or mitigate them.

What we need to do

The Task and Finish Group recommends that our priority actions are

1. Undertake a general review of all risk management processes within the organisation
2. Continue with our programme of compliance review
3. Ensure that key policies are reviewed and implemented.

3.4 Information
Detecting Problems, taking action promptly/ ensuring robust accountability

What have we done?

The Francis Report placed a focus on the wealth of information that is available within an organisation about the services that it provides. The Board does receive most 'key trigger' information but not contained within one report (i.e. Chief Nurse, Medical Director, HR reports) and it may be prudent to bring some of that information together into one over arching dashboard. The organisation has an internal reporting system (SIGNAL) that enables managers to view the key performance data for their directorates, and action has been taken to establish new internal and external internet sites that reflect the enlarged organisation. In addition the process of rolling out CPD in Scarborough Hospital is currently under way. We do not however maximise the potential use of the information we have, or seldom do we make it public via publication on our website.

What we need to do

The Task and Finish Group recommends that our priority actions are

1. Continuation of the development of the Patient Safety Dashboard
2. That we demonstrate our commitment to openness and transparency by publishing information about our performance /outcomes externally on our website,
3. The organisation considers how it might share information internally about areas of potential risk (for example where appraisal may flag a significant concern, or where a grievance may point to issues of leadership).

3.5 Learning and Listening
Links to: Taking action promptly/ensuring robust accountability/ensuring and educated and motivated workforce

What have we done?

As an organisation we need to ensure that we learn, and can demonstrate that we learn from our mistakes, and that we listen to the feedback that is given about our services by patients, staff and the public. We have taken strides to learn , by listening to feedback from our Governors, patients, staff and the public. Each Serious Incident Report is considered at Executive Board as a vehicle for sharing learning. The organisation is represented at various external health associated boards (i.e. Health and Scrutiny Committee, Wellbeing Board) where it listens to and acts on the feedback it receives. Whilst we do engage patients and the public , via various internal and external groups we recognise we could do this in a more proactive way.

What we need to do

The Task and Finish Group recommends that our priority actions are

1. Develop our Public Patient Involvement Strategy to reflect how we are going to

engage with patients and the public in a more proactive way
2. That its develops a suitable mechanism that facilitates the dissemination of learning from claims, incidents, inquests, Friends and Family Test, Pals , complaints etc into the organisation
3. In the spirit of openness and transparency the organisation needs to consider how it will demonstrate its learning to the wider public

Education and Training
Links to Taking action promptly/ensuring robust accountability/Ensuring Staff are trained and motivated

What have we done?

The organisation has a commitment to ensuring that it has a capable and competent workforce that delivers quality care in the right place in the right time and this is reflected in our organisational values. In delivering this commitment the organisation has a multi faceted approach to education and training with access to both internal and external training. Much work has been undertaken over the past year in Education and Training with a key example being the Introduction of the It's My Ward Programme for Ward Sisters and Charge Nurses and the HCA programme. It has structured programmes of leadership management and in addition, is in the process of introducing a new on line E Learning management system that will enable individual members of staff and their managers to ensure that training identified as being required has been undertaken.

What do we need to do

The Task and Finish Group recommends that our priority actions are

1. Continuing to review and evaluate the quality and effectiveness of all training it delivers/commissions
2. Improves attendance at statutory/mandatory training
3. Ensures that any new requirements for training are identified and met

The Directorate of Applied Learning and Research have a significant annual plan of education and training development in place which is critical to ensuring that it has a capable and competent workforce.

3.7 Workforce
Links to Taking action promptly/ensuring robust accountability/Ensuring Staff are trained and motivated

What are we doing?

The organisation currently employs about 8,500 staff and as such it is its most expensive and important asset. The organisation takes action to ensure that it appoints the right people to the right posts, and example being its recruitment scheme for HCA's that has received national acclaim. It invests in both the learning and continued development of its staff through both internal and external training provision (as noted in section 3.6) and it has a well defined Human Resources structure that is supported by policies and procedures that are in the process of being further embedded within the enlarged organisation. It has a robust programme of team brief, staff engagement and staff benefits.

What do we need to do

The Task and Finish Group recommends that our priority actions are

1. Builds on the acclaimed work of values based recruitment and considers extension of this approach
2. Reviews its Appraisal Framework, to focus on a link to Trust Values, Quality of Appraisal and a recognition of care, compassion and leadership
3. As part of the work on further developing the Personal Accountability Framework, an associated 'Consequences Framework' (i.e. a consequences scheme for failing to follow a process, this would apply to clinical/nursing and non clinical staff) should also be developed and implemented

Human Resources have a detailed work plan under pinning the issues identified above.

4. Conclusion

The Francis Report and Keogh Review have generated the need for organisations to give consideration to the recommendations made. The Task and Finish Group have undertaken the initial review of the areas that in the light of the recommendations require further development . The three priority recommendations made in each sub section of section 3, are underpinned by significant detail collated by the Task and Finish Group, and whilst many actions are already in process there are some that the Group will need to consider how they might best be delivered (for example the external reporting of outcome data).

The Group has also identified the need to involve participation of colleagues from Estates, and in these light further recommendations may be made. The Group will continue its work and report to the October meeting of the Board of Directors on progress made. Detailed action plans re the delivery of the priority actions are either already in place, or in the process of being developed.

5. Recommendation

The Board of Directors are asked to note the actions already planned and the process of continued review

The Board of Directors are asked to agree the priority actions identified in Section 3 of this Report.

6. References and further reading

The Francis Report
Patients First and Foremost
The Keogh Review

Author	**Fiona Jamieson, Assistant Director of Healthcare Governance**
Owner	**Elizabeth McManus, Chief Nurse**
Date	**July 2013**

F

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 31 July 2013

Report from the Healthcare Governance Directorate

Action requested/recommendation

The Board is asked to note the report.

Summary

This paper seeks to provide an update on the work currently being undertaken within the Healthcare Governance Directorate. This will include a focus on Trust compliance with CQC regulations and outcomes. It identifies the progress made on the issues previously identified as requiring work, flags some emerging issues and reports on the issues identified by the CQC at local review meetings.

The report also provides a focus on Risk and Legal issues currently being addressed within the Trust

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

Implications for equality and diversity

There are actions that need to be undertaken to ensure we are compliant with legislation. These are in hand.

Reference to CQC outcomes

Each relevant risk area is identified within the report with action plans in place, or in the process of being put in place.

Progress of report	This paper will go forward to the Board of Directors
Risk	This paper identifies some risks within the organisation

Resource implications	Resources implication detailed in the report
Owner	Elizabeth McManus: Chief Nurse
Author	Fiona Jamieson: Assistant Director of Healthcare Governance
Date of paper	June 2013
Version number	1

Board of Directors – 31 July 2013

Report from the Healthcare Governance Directorate

1. Introduction and background

This paper seeks to provide an update on the work currently being undertaken within the Healthcare Governance Directorate. This will include a focus on Trust compliance with CQC regulations and outcomes. It identifies the progress made on the issues previously identified as requiring work, flags some emerging issues and reports on the issues identified by the CQC at local review meetings.

The report also provides a focus on Risk and Legal issues currently being addressed within the Trust

2. Progress Made

The following section outlines the progress made since the report last received in March 2013

2.1 Overview

The CQC Mental Health Commissioner visited the trust on the 22 April 2013 with a specific focus on the management of patients detained under the Mental Health Act. During the course of the visit, the inspector met with representatives within the organisation (ie ED, Safeguarding, Mental Health Liaison Team), and external partners, (the Police and Ambulance Service).

The Trust described how the lack of a designated place of safety within North Yorkshire often placed ED under pressure, as patients sectioned under Section 136 were often brought to ED inappropriately. Staff also described how a significant number of ED breaches were the result of having to wait for a Mental Health Assessment by colleagues at the Leeds York Partnership.

The CSU has convened a meeting on the 11 June 2013 with all key stakeholders to discuss the place of safety issue . It is understood that this will become Bootham Park Hospital from 2014.

The Inspector also visited ward 37 and saw the work of the Mental Health Liaison Team.

Meetings have also taken place with the Leeds York Partnership and TUVE around the provision of psychiatric liaison.

We await the CQC report.

The team is continuing to work on the organisational key trigger dashboard and is looking at examples used within other Trusts. This work will be completed by the end of June 2013, and will initially be shared with Corporate Directors.

The Team have just concluded their work on the organisations Quality Report. This is an extensive piece of work where we also need to provide validation to our external auditors of the claims that we make within the report.

2.2 Regulation 18: Outcome 2: Consent to Care and Treatment

Governance Facilitators are currently in the process of reviewing compliance with DNAR/CPR orders at ward level. Whilst compliance is better than it has been, we continue to find some issues with

- The review of DNAR's travelling with a patient completed by a GP or nursing home
- Demographics not always being completed
- Review date being left blank

The review so far has indicated that conversations with patients/and relatives are being documented.

The team will be widening the focus of the review of this standard to cover the full scope of the consent standard.

We will continue to report of this issue.

2.3 Regulation 11: Outcome 7 Safeguarding Service Users from Abuse

The Safeguarding Team will join the Governance Facilitators in reviewing safeguarding standards across the organisation as part of the programme of regular inspection.

2.4 Regulation 15: Outcome 10 Safety and Suitability of Premises

There are well documented issues pertaining to the Scarborough and Community sites that will take some time to resolve. At Whitby Hospital there are particular issues with the location of the Minor Injuries Unit and obstetric outpatients

The team continue to identify issues relating to the condition of the estate on inspections which are by and large addressed through regular liaison with colleagues in Estates and Facilities.

The team wishes to acknowledge the work of Brian Golding's Teams in enabling improvements to be made.

2.5 Regulation 16: Outcome 11 Safety, Availability and Suitability of Equipment

The space previously identified for the equipment library is no longer available and the project is currently back with capital planning who are trying to identify alternative accommodation. This is now linked to the catering project where space has been identified near the main kitchens in York Hospital. Refurbishment of this area commences in April once all new ward kitchens have been fitted. Work will commence on the equipment library when the space is confirmed.

The Healthcare Governance Directorate will continue to update the Corporate Risk Management Group on these issues.

2.6 Regulation 14 Outcome 5: Meeting Nutritional Needs

We continue to identify issues with the consistent recording of foods and fluids. This may range from fluids not being totalled, to food intake at some mealtimes not being recorded. This issue remains high on the national agenda and an operational nutrition group has been established in order to ensure any identified issues are addressed.

The roll out of the installation of the new ward kitchens in York has now been completed.

2.7 Regulation 13 Outcome 9: Management of Medicines

Incidents pertaining to the management of medicines are within the top 5 reported adverse incidents within the Trust. This can cover a multitude of different issues from mis-doses, a failure to administer drugs, to drugs being left unattended.

Our programme of inspections have identified that whilst there are some improvements in the management of medicines, particularly in the undertaking of required checks there continue to be some issues .

The Medicines Management Specialist Nurses continue to participate in Compliance Unit inspections and undertake a full review of medicines management processes. The key issue currently being identified is lack of attendance on the medicines module of the statutory and mandatory training programme. This is important given that medicines management is a key issue within the Trust , with a significant number of adverse incidents being raised

2.8 Regulation 20 Outcome 21 - Records

The Trust is often not able to defend some of the clinical negligence claims made against because actions are not always supported by robust document all the elements of patient care that were delivered.

Our compliance reviews continue to identify issues with record keeping standards. This correlates with the information coming from local clinical audit, and the annual record keeping audit both of which indicate that records do not always comply with the mandated standards, ie in black, legible, time, dated, signed etc.

We continue to identify areas where there is a need for a care plan, (ie the patient is at risk of fall, pressure sore etc) and there was either no subsequent care plan, or the care plan was not being completed.

The current review of nursing documentation will help streamline some of the processes and this has also been aided by the introduction of electronic observations.

2.9 Regulation 12: Outcome 8 Cleanliness and Infection Control

Overall standards of cleanliness have begun to show sustained improvement across all sites. However there is still some further work to be undertaken on the Scarborough and Bridlington sites and this will be influenced by the Strategic Cleaning Review and the Environment Steering Group.

3. Equality and Diversity

Work continues on the Equality and Diversity Action Plan with consideration currently being given as to how as an organisation we evidence compliance in this area. The Policy for the Management and Development of Policies is currently under review and contains extensive guidance on how to undertake the equality assessment.

However, it is important to note that equality assessments also need to be undertaken as part of the business planning process, and feature in future business cases

4. Internal Audit

Over the year the Healthcare Governance Team have had several reviews undertaken by Internal Audit. These are documented below

Where reviews have resulted in limited assurance, actions have been put in place to ensure that processes are reviewed and amended as appropriate. A group has been established to review the SI process, and the Risk Team are looking at the processes involved in Datix sign off and upload.

A significant piece of work has been undertaken to clear the backlog of Datix web forms That had not been reviewed at both directorate and risk team level.

The Quality and Safety Group has considered those patient safety incidents noted as Severe harm prior to upload to the NRLS.

5. Information Governance

The IG Toolkit score for 2012/13 was 81% with a green RAG rating in all areas. The team continues to work on IG issues across the wider organisation and has recently run an Information Stand in the main entrance of York Hospital which brought many enquiries from both staff and the public.

The Information Governance Group met four times during 2012/13. It reviewed its terms of reference in terms of the acquisition of the former Scarborough and North East Yorkshire Hospital and representation was sought from the community to ensure that all areas of care within the organisation were represented. The Group was also pleased to welcome Dr Ian Jackson as Senior Information Officer, bringing a different perspective to the Group.

One of the issues that the group continues to consider is that of how , if and when clinical information should be communicated by email. This has now been clarified in Dame Fiona Caldicott's review of data sharing and guidance will be considered at future meetings of the group.

6. Quality Governance Profile

As part of the Integration Plan required by Monitor, there is a requirement to ensure key governance issues have been addressed in a timely manner. At the end of January action had been taken to:

- Complete an organisation wide TNA for Healthcare Governance
- Complete a Team TNA for Healthcare Governance
- Contributing a session on compliance and regulation on the Its My Ward Programme
- Completed the Healthcare Governance Restructure
- Drafted the Risk Management Strategy
- Drafted the Healthcare Governance Strategy
- Community governance forums have been established and are meeting with GP engagement
- Work is continuing to integrate and embed both risk management and clinical effectiveness processes in the enlarged organisation
- An integrated Board report is now being provided

We are currently in the process of pulling together the Annual Report of activity undertaken by the Healthcare Governance Directorate in the preceding year. However this is covered in the

main by contents of this report on a quarterly basis.

We are currently reviewing the SI process post the recent limited assurance report. Further feedback will be given to CRMG on this issue once this has taken place.

7. New Issues

In the light of the publication of the Francis Report in February 2013 and the Governments initial response to it, the CQC will be making three significant appointments. For the organisation the most important of these will be the Chief Inspector of Hospitals (currently out to advertisement) and the Chief Inspector of Social Care.

They are also reviewing their inspection regime, and from 2014/15 this will look significantly different from what it is now. Reviews will focus on what the regulators intelligence identifies our organisations risks to be, for example, if we had a number of never events in one specialty this would be likely to trigger an alert. Future inspections will not consist of the teams of generic inspectors that we have become accustomed too, but will be teams of specialists in the area under review. Inspections are also likely to be of a 20 day duration which would include 10-15 days on site.

In the meantime, there will be two specialist reviews undertaken this year.

- Dementia Care
- Transition of children with chronic conditions into adult services at the age of 18

The trust is likely to be selected for one of the reviews.

The Assistant Director of Healthcare Governance has been asked to co-ordinate the organisations response to the Francis Report. A 'Task and Finish' Group has been established to take this work forward.

8. Quality Risk Profile

As requested at the previous meeting of the CRMG, a high level summary of the Quality Risk Profile has been provided below. A full copy of the QRP is available from the Assistant Director of Healthcare Governance should anyone wish to review it.

The CQC have released their latest Quality and Risk profile (QRP) which provides an estimate of risk of potential non-compliance with the essential standards of quality and safety. The QRP also shows information about risks that are not related to the regulations but relate to the environment or context in which we provide healthcare. The number of measures being monitored continues to grow although a concern still remains that data being used for some indicators is significantly out of date. The CQC have confirmed they understand this is an issue.

The QRP published in April shows the combined risks for the enlarged organisation. There are no major risks for the Trust. A comparison of the current risk estimate against the previously reported risk estimate is shown below.

Outcome Description	Previously Reported Risk (Jan 13 QRP)	Current Risk (Apr 13 QRP)	Change in Risk
Outcome 1 (R17) Respecting and involving people who use	Low Yellow	Low Yellow	No change
Outcome 2 (R18) Consent to	Low Yellow	Low Yellow	No change

Outcome 4 (R9) Care and welfare of people who use	High Green	Low Green	Decrease in risk
Outcome 5 (R14) Meeting nutritional needs	High Green	High Green	No change
Outcome 6 (R24) Cooperating with other providers	Low Yellow	Low Yellow	No change
Outcome 7 (R11) Safeguarding people who use services from	Low Yellow	Low Yellow	No change
Outcome 8 (R12) Cleanliness and infection control	High Green	Low Yellow	Increase in risk
Outcome 9 (R13) Management of medicines	High Yellow	High Yellow	No change
Outcome 10 (R15) Safety and suitability of premises	High Green	Low Yellow	Increase in risk
Outcome 11 (R16) Safety, availability and suitability of	Low Green	High Green	Increase in risk
Outcome 12 (R21) Requirements relating to	Low Yellow	Low Yellow	No change
Outcome 13 (R22) Staffing	Low Yellow	Low Yellow	No change
Outcome 14 (R23) Supporting staff	Low Amber	High Yellow	Decrease in risk
Outcome 16 (R10) Assessing and monitoring the quality of	High Green	Low Yellow	Increase in risk
Outcome 17 (R19) Complaints	Low Yellow	Low Yellow	No change
Outcome 21 (R20) Records	Low Green	Low Green	No change

The CQC continue to identify some areas where the Trust's performance is worse than expected and these have impacted on the risk ratings for some outcomes.

The risk rating for Outcome 1 (Respecting and involving people who use services) is affected by much worse than expected performance in a number of areas on the previous inpatient survey. The QRP has not yet been updated with the findings of the most recent survey and the revised position will be reported when the QRP has been updated.

Although the risk rating for Outcome 4 (care and welfare of people who use services) has improved since the last reported QRP, mortality indicators for some diagnosis groups and HRGs continue to show much worse than expected performance. Mortality continues to be closely monitored as part of the Reducing Mortality programme and at the weekly Quality and Safety briefing. Day case surgery rates on 2 day case indicators, laparoscopic cholecystectomy and the BADS day surgery basket, is much worse than expected. The Surgical Board is reviewing day case rates and work is ongoing to default the intended management of a number of procedures to day case. Performance on length of stay for emergency admissions over the age of 75 is also much worse than expected. Work continues in Elderly Medicine to reduce length of stay.

In Outcome 6 (cooperating with other providers), performance on the proportion of ambulance journeys where the vehicle remained at the hospital for more than 60 minutes is much worse than expected and is linked to recent bed pressures. It is important to note that this reflects a National position.

9. Compliance Reviews

This year the Compliance Team will include specialists from Adult and Children's Safeguarding as part of their review. This will broaden the scope of the reviews that we undertake and give a feel for compliance with safeguarding issues within the organisation.

The team will now involve participation from colleagues in

- Estates
- Infection Prevention and Control
- Corporate Nursing
- Dietetics
- Safeguarding
- Medicines Management

Work has been on going at the Community Sites (Selby) and on Elderly Medicine in York where there a review of compliance with DNAR/CPR is also underway.

Over the coming quarter there will a return to review the Scarborough Wards once again to review progress on the actions identified on previous visits.

The aim over the coming year is to cover all wards, community units, and other service areas at least once. Return visits will be made where necessary.

The team will also be working on directorate/service level dashboards that will help DMs and Matrons spot those key triggers that might identify a potential issue. A meeting has been established with the Associate Director of Operations, some DMs and Matrons to agree what would be most helpful to them in terms of the support that can be provided.

The aim of the team is not to place additional work or pressure on wards/services, but to try and identify issues, help remedy them, and to streamline processes.

10. Clinical Audit and Effectiveness

The Clinical Audit and Effectiveness Team continue to roll out processes across the wider organisation . This work is overseen by the Clinical Standards Committee.

Recently two highlight reports were submitted to the Patient Safety Group for consideration

24/07/12
Currently no NCEPOD status for Scarborough

The team have had to implement a new evidence based process for the review of all NICE guidance at Scarborough, all confirmation of compliance was previously verbal so no evidence to support compliance was available

21/11/12

We have established that Scarborough Hospital are are currently undertaking some procedures listed by NICE as 'Do not Do' which may cause a risk to the trust and have a cost impact. The team are currently in the process of reviewing this full list.

National Clinical Audits

Patient identifiable information is required to match patient data for National Clinical Audits. It is a requirement that Trusts obtain patient consent to enable the audit to link data:

- Sentinel Stroke National Audit Programme (SSNAP) requires data six month (post admission) follow‐up assessment. This has an impact on workload.

- National Diabetes in Pregnancy - Outcome of pregnancy required

The Clinical Effectiveness Annual Report is attached at Appendix A for information.

11. Incidents Reported

- The number of reported incidents on DatixWeb across all of our sites continues to run at approximately 300 per week. Given the fact that the system is embedded in the organisation our emphasis now is to work with staff and develop the reporting functionality of the system specifically for their own areas. This allows them to use the system more proactively, to integrate it into their own practices and hence to improve the efficiency of their working patterns. As a part of the Trust's overall Pressure Ulcer Reduction Plan initiative, new Datix subcategories are being implemented to assist the accurate reporting of Pressure Ulcers and where they originated, for example. In conjunction with the Improvement Team, members of Risk & Legal Services will constitute a "Data Task and Finish" group to monitor the new arrangement and amend / finalise as appropriate.

- A substantial piece of work has been carried out with Internal Audit to review our process for uploading relevant incidents from Datix to the National Reporting Learning Service as required. The task was complicated by the fact that Scarborough's previous Datix arrangement (in place prior to the integration of our electronic system) meant that they uploaded in a different manner to us, but this has been allowed for in our workings. Overall several improvements were identified for implementation to ensure robust and accurate exported data for publication.

- The information stored within Datix that relates to the staff involved in reported incidents has been used to produce supplementary information in the staff revalidation process such that a measure of individual reporting rates and involvement can be assessed from the incident data captured.

- We have also begun to produce reports for the Risk Review meetings (see later section). As well as the Agenda for each meeting and the incidents that attending individuals bring to discuss, these reports are pre-circulated and can be used as a pro-active tool to allow greater participation during the meeting.

12. Serious Incidents

The table, below, gives the status of SIs between 2007 and 25th April 2013 (but including the former SNEY only since acquisition).

Number SIs under active investigation	10
Number SIs scheduled for consideration to next SI Group 20/6/13	8
Number SIs closed by the Trust	123
Number SIs considered open by CSU	38 in total. 2012 x 20 2013 x 18
Number SIs currently under investigation where extension has been agreed.	2
Number SIs Trust has requested for closure by CSU	4
SI's de-escalated	1

13. Critical Incidents

Incidents continue to be reviewed through the Critical Incident process. Since the last CRMG meeting a further 13 incidents have been declared and passed to Directorates to investigate. Reports are approved by the SI Group with learning being taken back into the organisation.

14. Never Events

During this period there have been no Never Events declared.

15. Directorate Risk Registers

Risk Register meetings have been arranged for all Directorates between May and December 2013 and a mechanism put in place for the six monthly reviews to be booked at these meetings to avoid slippage. Issues for escalation to the Corporate Risk Management Group for consideration for the Corporate Risk Register are identified at these meetings and also brought to our attention between meetings, as necessary

16. Risk Review Group

Risk Review meetings are held weekly, on Wednesdays in Scarborough and Thursdays in York with a shared set of Minutes is provided from the two meetings, sharing information and learning across the organisation. Terms of Reference have been approved aligning the two groups. It should be noted that the Scarborough staff have been very engaged with this meeting and have provided very positive feedback.

17. CAS Alerts

The CAS reporting system which is managed via Datix Web continues to be robust Improvements are made to the system on an ongoing basis to ensure that every alert is reviewed in all appropriate areas and all items of equipment which may be used in the Trust are known to have been identified and checked. Close cooperation between Risk and Legal Services, Purchasing, EME, Medical Devices, Manual Handling, Clinical Trials at an early stage has been developed and continues to be reviewed and improved. All areas review alerts which are cascaded in a timely manner.
One NPSA alerts is now overdue. Brian Williams, Trust lead for the alert, advises that suitable alternatives are not ready to put in use yet. This is an issue of national non compliance and the Trust has contacted the CSU to ensure no financial penalty will be applied. This issue is on the Corporate Risk Register

NPSA alerts

Reference	Title	Deadline
NPSA/2009/PSA004B	Safer Spinal (Intrathecal), Epidural And Regional Devices	02/04/2013

MDA alerts:

Reference	Title	Deadline

MDA/2013/019	Detergent and disinfectant wipes used on reusable medical devices with plastic surfaces. This alert has been closed nationally as it is being dealt with through the Decontamination Group with input from Infection Prevention. Following the Decontamination Group meeting on 24/5/13 an action plan with timescales will be provided as evidence of compliance	26/9/13

DH alerts: None open

18. Claims

There are currently 418 open claims against the Trust (209 for Scarborough; 209 for York). Of these 274 (182 Y and 92 S) are clinical negligence claims and 44 (27 Y and 17 S) are non-clinical. The number of claims received is increasing year on year. In 2013 so far we have received 87 (44 Y and 43 S) new claims compared to 72 (32 Y and 40 S) in the same period in 2012 and 35 (15 Y and 20 S) in the same period in 2011.

This reflects a national trend and we expect to receive an increased number of claims throughout 2013 following changes to the claimant funding process in April 2013.

When claims are settled directorates are asked to produce an action plan reflecting any lessons to be learned and this will be submitted to Exec Board.

19. Inquests

The Legal Services team provides support and advice to Trust employees who are required to provide evidence to a Coroners inquest. Within this process we assist the Coroner where required and also ensure that the communications team and relevant directors are involved with regard to any potential publicity.

There are currently 32 outstanding inquests for patient deaths in York, the oldest dating back to 2008. Post the publication of the Francis Report there is likely to be some pressure in the system to ensure that claims are dealt with by the Coroner on a much more timely basis. The Executive Directors therefore need to be aware of the potential impact of the clearance of the backlog at York.

For Scarborough there are 19 outstanding inquests dating back to 2012. The Scarborough Coroner generally deals much more quickly with inquests. Where necessary solicitors are instructed to provide representation for the Trust

20. Patient Information

There are 753 current Trust leaflets in the database including all sites. There have been 11 added in York (either new or existing departmental leaflets brought into the central system) one from Scarborough, one from Bridlington and one from community leaflets since the last report. In total.

14 new leaflets have been added, five requests for review have been sent, and 20 leaflets have been reviewed. We have received 17 submissions of new leaflets that have not yet been added to the system. Four leaflets have been withdrawn from use.

Leaflets are beginning to be adapted for use across sites.

Four new Procedure Specific Consent forms have been added and two have been withdrawn at York. Scarborough use only generic consent forms.

21. Conclusion

This report identifies the work undertaken within the Healthcare Governance Team since last reported in March 2013.

22. Recommendation

The Corporate Risk Management Group are asked to note the report.

23. References and further reading

CQC Quality Risk Profile
Francis Report
Patients First and Foremost

Author	**Fiona Jamieson, Assistant Director of Healthcare Governance**
Owner	**Elizabeth McManus, Chief Nurse**
Date	**June 2013**

Appendix A

York Teaching Hospital NHS Foundation Trust

Clinical Effectiveness Annual Report 2012/2013

The Clinical Effectiveness Team monitors and facilitates the Clinical Audit process for the Trust and establishes current position of National Clinical Guidance.

Two members of the team have recently retired and the team will be recruiting a new Clinical Effectiveness Officer.

The members of the team at this time are:

1 WTE Clinical Audit & Effectiveness Manager
2 WTE Clinical Effectiveness Officers
1 WTE Effectiveness Support

Clinical Audit
York Teaching Hospital NHS Foundation Trust is committed to the delivery of best practice and to ensure continuous quality improvement through clinical audit.

The Clinical audit systems and processes that are operational in York are being embedded at Scarborough. This will support the participation in national and local audit, and will improve future compliance.

The Trusts Clinical Standards Group (CSG) continually reviews the quality of:

- National Clinical Audit
- Local Clinical Audit
- Local Service Evaluations
- National Confidential Enquiries

Including the monitoring of action plans; this enables a systematic process to address risks and to provide assurance to the Trust, Commissioners and Monitoring Bodies. (Please see Appendix 1 for project details)

In the 2012/13 financial year five CSG meetings took place.

Attended	May	July	Sept	Nov	Mar
Medical Director	1	1	1	0	0
Deputy Medical Director	1	0	1	0	0
Associate Medical Director	0	0	0	1	1
Assistant Director of Healthcare Governance	1	1	1	1	1
Finance Manager	0	1	0	0	1
Deputy Chief Nurse	0	0	1	1	0

Clinical Audit & Effectiveness Manager	1	1	1	1	1
Clinical Effectiveness Team	3	4	5	2	3
Total number of attendees	**7**	**8**	**10**	**6**	**7**

Two highlight reports were submitted to the Patient Safety Group.

24/07/12
Currently no NCEPOD status for Scarborough

Started from scratch with all NICE guidance at Scarborough, all confirmation of compliance was previously verbal so no evidence to support compliance was available

21/11/12
We are currently undertaking some Do Not Do's which may cause a risk to the trust and have a cost impact.

Clinical projects reviewed by the CSG:

York
- 5 Quality account national clinical audits
- 13 Other national clinical audits
- 134 Local clinical audits

Scarborough
- 13 Local clinical audits

Quality Accounts

A Quality Account is a report about the quality of NHS services provided by an NHS healthcare provider. The reports are published annually by each provider and are available to the public.

Quality Accounts aim to enhance accountability to the public and engage the leaders of an organisation in the quality improvement agenda.

The regulations state that Quality Accounts must be published by 30 June each year following the end of the reporting period.

Information submitted to Quality Account 2012/13:

Financial Year 2012/13 – York Hospital
- Thirty nine (39) national clinical audits and 5 national confidential enquiries covered NHS services that the Trust provides

- The Trust participated in 90% (35) of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in

- The national clinical audits and national confidential enquiries that the Trust was eligible to participate in are listed in appendix one

- The reports of 5 quality account national clinical audits and 13 other national clinical audits were reviewed by the Trust and it intends to take the actions listed in appendix two to improve the quality of healthcare provided

- The reports of 134 local clinical audits were reviewed by the Trust and it intends to take the actions listed in appendix three to improve the quality of healthcare provided

Financial Year 2012/13 – Scarborough Hospital

- Thirty eight (38) national clinical audits and 5 national confidential enquiries covered NHS services that the Trust provides

- The Trust participated in 74% (28) of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in

- The national clinical audits and national confidential enquiries that the Trust was eligible to participate in are listed in appendix one

- The reports of 0 national clinical audits were reviewed by the Trust and it intends to take the actions listed in appendix two to improve the quality of healthcare provided

- The reports of 13 local clinical audits were reviewed by the Trust and it intends to take the actions listed in appendix three to improve the quality of healthcare provided

Audit Title	York	Scarborough	Trust	Comments
1. Peri-and Neo-natal				
NNAP National Neonatal Care	100%	100%	100%	
2. Children				
BTS: Paediatric Pneumonia	Did not participate, participation to commence 2013-14			
BTS: Paediatric Asthma				
National Childhood Epilepsy Audit	84%	52%	68%	
National Paediatric Diabetes Audit				Awaiting data
3. Acute care				
BTS: Emergency Use Of Oxygen	105%	Did not participate	53%	
BTS: Adult Community Acquired Pneumonia		Did not participate		Data input ends May 2013 report available July 2013
BTS: Non Invasive Ventilation in Adults	20%	Did not participate	20%	
National Cardiac Arrest Audit	Did not participate, participation to commence 2013-14			
ICNARC Adult Critical Care	286%	82%	184%	
NHSBT Potential Donor Audit				Data available July 2013
CEM Paediatric Fever	100%	100%	100%	
CEM Fractured Neck of Femur	100%	100%	100%	
CEM Renal Colic	100%	100%	100%	
4. Long term conditions				
National Diabetes Audit- Adult	Did not participate, participation to commence October 2013 2013-14			
National Pain Audit - Chronic Pain	100%	100%	100%	
National Parkinson's Audit	Did not participate	120%	120%	
BTS Adult Asthma	155%	50%	103%	
BTS Bronchiectasis Audit	635%	Did not participate	635%	
National Inflammatory Bowel Disease Audit				Inpatient data available June 2013 - Biologics data available August 2013
5. Elective procedures				
National Joint Registry				Data available Dec 2013
PROMS - Hip	80%			Data up to Sept 2012. Available by Trust only
PROMS - Knee	97%			
PROMS - Varicose Veins	43%			
PROMS - Hernia	85%			
NICOR Coronary Angioplasty		Not relevant		Data available Sept 2013
VSGBI National Vascular Registry	108%			Available by Trust only
6. Cardiovascular disease				
Myocardial Infarction National Audit Programme ACS	60%	Did not participate	60%	Denominator based on an average of last years figures
National Heart Failure Audit				Data available May 2013
SSNAP Stroke National Audit Programme	100%	Did not participate, participation to commence 2013-14	100%	
NICOR Cardiac Rhythm Management	104%	91%	98%	

Data shows percentage of audit cases submitted against required number of cases				
	York	**Scarborough**	**Trust**	**Comments**
7. Renal disease				
Renal Registry				Data input to be completed 30th June 2013. Scarborough figures submitted as part of extract from Hull
8. Cancer				
LUCADA National Lung Cancer Audit				Data for 2011/2012 available June 2013. Data for 2012/2013 available June 2014.
NBOCAP National Bowel Cancer Audit Programme				
DAHNO National Head & Neck Cancer Audit				
National Oesophago-Gastric Cancer Audit				
9. Trauma				
National Hip Fracture Database	100%	100%	100%	Coding not completed until 10/05/2013
TARN Trauma Audit and Research	67%			Data by Trust only
10. Blood transfusion				
National Comparative Audit of Blood Transfusion Programme a) Medical Use of Blood b) Audit of blood Sampling and Labelling	100% 100%	Did not participate 100%	100% 100%	
National Confidential Enquiries	**York**	**Scarborough**	**Trust**	**Comments**
NCEPOD Alcoholic Liver Disease	100%	100%	100%	
NCEPOD Subarachnoid Haemorrhage	100%	100%	100%	
NRAD Asthma Deaths	100%	100%	100%	
RCPCH Child Health Reviews	100%	100%	100%	
MBRRACE Maternal Infant and Perinatal				Data available July 2013

Quality Account National Clinical Audits

Audit Title York		**Actions to be taken**
742	NBOCAP National Bowel Cancer Audit Programme	• Continue to submit data to audit
941	National Hip Fracture Database	• Ongoing NHFD data input • Discuss results at fractured neck of femur operational meetings
1204	National Paediatric Diabetes Audit	• Continue data collection • Business case for new diabetes dietician post • Business case for diabetes psychologist
1505	BTS: Emergency Use Of Oxygen	• Introduce target saturations on drug prescription chart • Education of medical/ nursing staff • Introduction of oxygen administration chart • Introduction of electronic observations
1506	BTS Bronchiectasis Audit	• Discuss results with respiratory team and review current practice • Consideration of bronchiectasis clinic

Other National Clinical Audits

Audit	Title York	Actions to be taken
1126	Saving Lives High Impact Intervention 1 Central Venous Catheter care bundle	• Review content of the care bundle in line with any Department of Health changes
1128	Saving Lives High Impact Intervention 3 Renal dialysis catheter care bundle	• Review content of the care bundle in line with any Department of Health changes
1142	National Cardiac Rehabilitation Audit (NACR)	• Aspiration to develop heart failure cardiac rehab. Business case for heart failure rehab • Continue to evaluate numbers of patients seen and those missed from coded data • Identify areas where patients are recurrently not being referred for cardiac rehabilitation
1322	National Audit of the Management of Familial Hypercholesterolaemia	• Establishment of a Familial Hypercholesterolaemia database
1398	National Kidney Care Audit (Vascular Access)	• To look at failed radial fistulae to see whether the scan showed good vessels • Continue monthly run chart • Annual audit of access in incident and prevalent patients
1522	National Hip fracture database: Audit of Best practice criteria	• Review of National Hip Fracture Database data
1588	National care of the dying audit	• Extra member of staff for Liverpool Care Pathway (LCP) • Focused training sessions on ward • Increased presence of LCP facilitators on wards (one day not covered) • Steering Group for LCP
1776	National Comparative Audit for Bedside practice 2011	• Discuss with Risk management/senior nursing team options for transfusion policy wording to reflect need to have observations recorded on patients undergoing transfusion as per British Committee Standards in Haematology guidelines but also to ensure compliance with NHS Litigation Authority standards • Emphasise during Mandatory training sessions and competency assessments that stop times must be recorded on the Transfusion protocol • Emphasise during Mandatory training sessions and competency assessment need for clear recording of observations to all staff
1842	National Audit of Theatre Equipment	• No action required
1856	National Audit of Falls in Care settings - PILOT	• Full report, results and recommendations to be discussed with Falls Prevention Group
1862	College of Emergency Medicine - Pain Management (children)	• All timings will be affected by introduction of Unscheduled Care Centre (UCC) in March 2012, manned mainly by Emergency Nurse Practitioners. • Children in moderate pain expected to be seen and definitively managed quicker here, than in main Emergency Department (ED). And when UCC wait is long, children being triaged through ED route to ensure analgesia. • Will need re-auditing next year to evaluate effects of new service
1863	College of Emergency Medicine Severe Sepsis and	• Continue within constraints of service currently and measure future performance against current. Difficult to gauge

	Septic Shock	performance based on only 30 patients – this is more of a baseline and guide against national performance
1982	Acute Medicine's pilot Benchmarking Audit	• To continue to submit York Hospital data on an annual or other periodic basis as requested by the Society for Acute Medicine in the expectation that more a more detailed national comparator dataset will develop

No of Local Clinical Audits York	Actions to be taken
30	Improve documentation
20	Change process
65	Re-audit
31	Additional training
13	Improve communication
14	Other e.g. additional equipment

No of Local Clinical Audits Scarborough	Actions to be taken
2	Improve documentation
4	Change process
9	Re-audit
1	Additional training
2	Other e.g. additional equipment

National Clinical Guidance

The Clinical Standards Group acts as a monitoring and advice body for all matters involving the implementation of nationally agreed best practice and reviews and monitors all current nationally agreed best practice to gather evidence and to take further action in cases which: –

- Pose a risk to patients/ public/ the Trust
- Requires extra training or resources

The CSG provides regular assurance to the Trust regarding the status of current guidance and where risk remains ensure action plans exist, to ensure it has appropriately been considered and evidenced.

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Clinical Audit and Other Effectiveness Projects
(For detail please see Appendix 1)

Projects in progress 31/03/2013

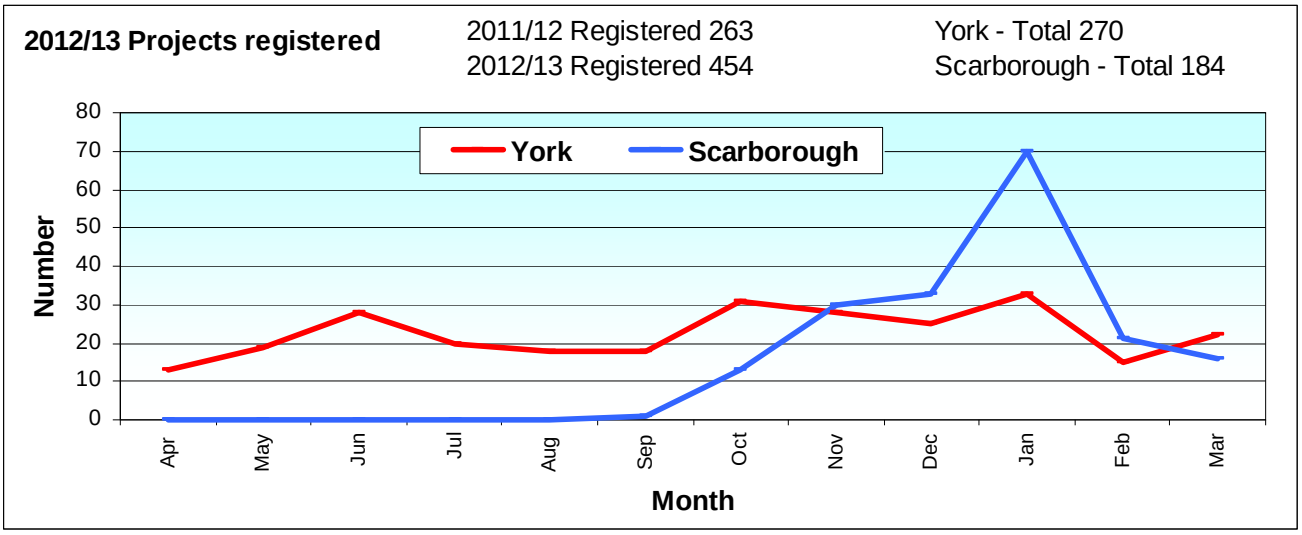
Site	Continuous Measurement	With Completion Date	Total
York	**85**	**66**	**151**
Scarborough	**31**	**32**	**63**
TOTAL	**116**	**98**	**214**

Expected end date between 01/04/12 and 31/03/13

Site	Not Completed	Awaiting BriefCASE	BriefCASE Received	Total
York	**22**	**159**	**108**	**289**
Scarborough	**6**	**75**	**25**	**106**
TOTAL	**28**	**234**	**133**	**395**

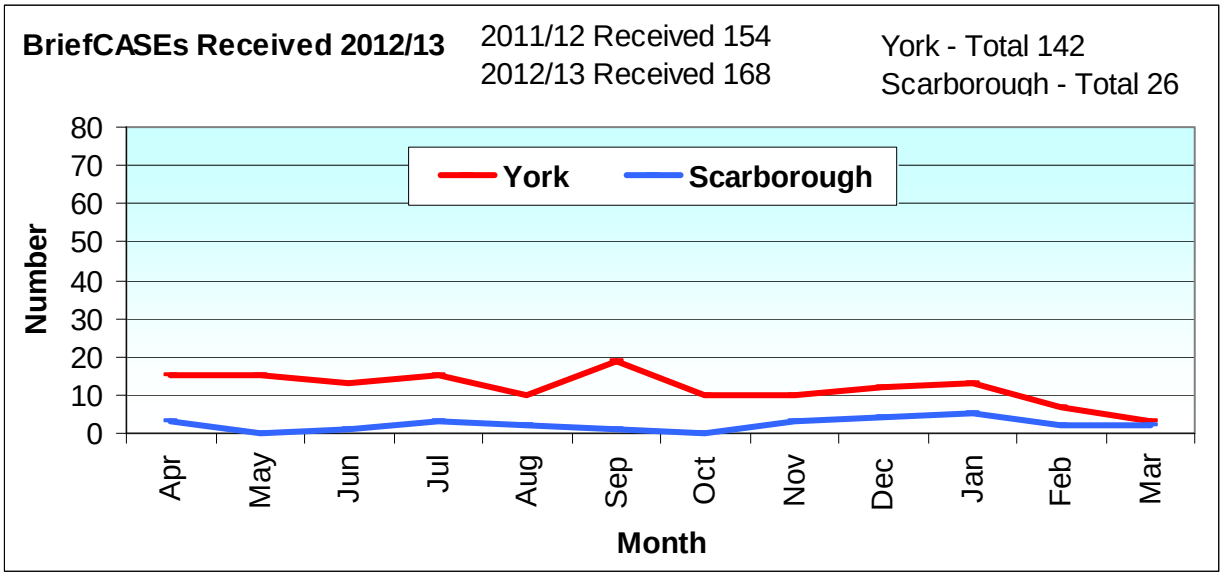
- Not Completed will include no action plan received

Projects registered financial year 2012/13



All Clinical audits undertaken in Scarborough are now registered on the York database and follow the York process. This is highlighted in the graph above.

BriefCASEs received financial year 2012/13

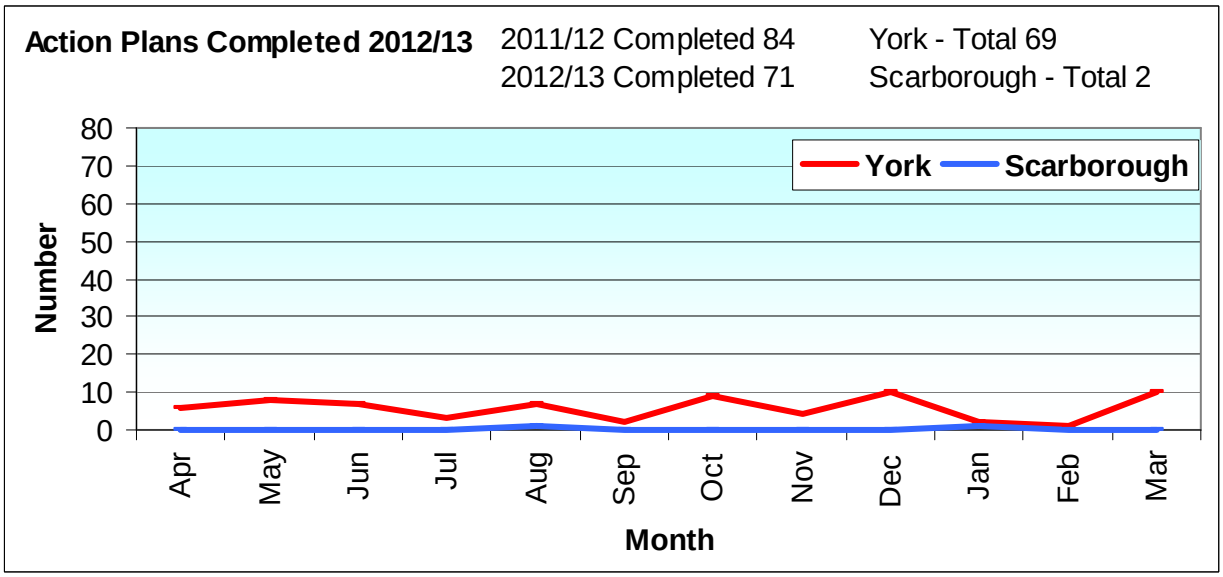


Action plans received financial year 2012/13

Site	Action Plan not required	Action Plan Required	Action Plan Received	Percentage required and received
York	**12**	**130**	**130**	**100%**
Scarborough	**4**	**22**	**21**	**95%**
Total	**16**	**152**	**151**	**99%**

The Clinical Effectiveness Team is now receiving BriefCASEs from Scarborough including action plans when required.

Action plans completed financial year 2012/13



NICE Clinical Guidance
(For detail please see Appendix 2)

Clinical Guidelines (CG)									
Site	**Compliant with evidence**	**Compliant**	**Partial**			**Not compliant**		**Pending**	**Total**
			With action plan	**No action plan required**	**No action plan**	**No action plan**	**With action plan**		
York	21	36	36	7	3	0	0	12	**115**
Scarborough	16	11	2	0	11	0	0	59	**99**

16 CG are not relevant to Scarborough but relevant to York

Do Not Do							
Site	**Compliant**	**Non Compliant**			**N/A**	**Pending**	**Total**
		With Action Plan	**No Action Plan Required**	**No Action Plan**			
York	471	0	7	8	17	194	**697**
Scarborough	165	0	0	9	35	488	**697**

Non- Drug TA's									
Site	**Compliant with evidence**	**Compliant**	**Partial**			**Not compliant**		**Pending**	**Total**
			With action plan	**No action plan required**	**No action plan**	**No action plan**	**With action plan**		
York	3	13	0	2	0	0	0	0	**18**
Scarborough	2	6	0	0	0	0	0	8	**16**

2 Non – drug TA's are not relevant to Scarborough but relevant to York

Quality Standards (QS)									
Site	**Compliant with evidence**	**Compliant**	**Partial**			**Not compliant**		**Pending**	**Total**
			With action plan	**No action plan required**	**No action plan**	**No action plan**	**With action plan**		
York	3	3	5	2	2	0	0	11	**26**
Scarborough	2	4	1	0	2	0	0	17	**26**

Cancer									
Site	**Compliant with evidence**	**Compliant**	**Partial**			**Not compliant**		**Pending**	**Total**
			With action plan	**No action plan required**	**No action plan**	**No action plan**	**With action plan**		
York	3	1	2	3	0	0	0	0	**9**
Scarborough	1	0	0	7	0	0	0	1	**9**

Medical Technologies			
Site	**Performed**	**Pending**	**Total**
York	4	3	**7**
Scarborough	0	7	**7**

Diagnostic Guidance			
Site	**Performed**	**Pending**	**Total**
York	1	1	**2**
Scarborough	0	3	**3**

Interventional Procedures (IPG)				
Site	**Not Performed**	**Performed**	**Pending**	**Total**
York	339	50	9	**398**
Scarborough	359	5	34	**398**

NCEPOD (National Confidential Enquiries into Patient Outcome and Death)

Code	Title	Compliance Status	
		York	**Scarborough**
NCEPOD001	Acute Kidney Injury (Adding Insult to Injury)	Partial	Pending
NCEPOD002	Emergency Admissions (A Journey in the Right Direction)	Pending	Pending
NCEPOD003	Death in Acute Hospitals (Caring to the End)	Partial	Pending
NCEPOD004	Severely Injured Patient (Trauma: Who Cares?)	Partial	Pending
NCEPOD007	Systemic Anti-Cancer Therapy (For Better, For Worse)	Partial	Pending
NCEPOD008	Parenteral Nutrition (A Mixed Bag)	Partial	Pending
NCEPOD009	Emergency & Elective Surgery in the Elderly (An Age Old Problem)	Partial	Pending
NCEPOD0011	Paediatric Surgery (Are We There Yet?)	Compliant	Pending
NCEPOD0012	Peri-Operative Care (Knowing The Risk)	Partial	Pending
NCEPOD0013	Cardiac Arrest (Time To Intervene)	Pending	Pending
NCEPOD0014	Bariatric Surgery (Too Lean A Service)	Pending	Not relevant

Code	Title	Status
NCEPOD0015	Alcoholic Liver Disease	Report to be published June 2013
NCEPOD0016	Subarachnoid Haemorrhage	Collecting data
NCEPOD0017	National Review of Asthma Deaths	Collecting data
NCEPOD0018	Tracheostomy Care Study	Collecting data

Scarborough NCEPOD is currently pending but the Clinical Effectiveness Team now have Clinical Leads and have received some baseline assessments for review.

Appendix 1 – Clinical Audits

York - Projects in progress 31/03/2013

Directorate	Continuous measurement	With completion date	Total
Anaesthetics	7	8	15
Child Health	3	7	10
Clinical Support Specialities	24	12	36
Community	0	0	0
Elderly Medicine	5	1	6
Emergency Department	1	2	3
General and Acute Medicine	13	7	20
General Surgery and Urology	9	5	14
Head & Neck	1	3	4
Nursing	15	2	17
Obstetrics & Gynaecology	1	11	12
Ophthalmology	2	1	3
Orthopaedics	3	2	5
Other	0	0	0
Sexual Health	0	2	2
Specialist Medicine	1	3	4
Grand Total	**85**	**66**	**151**

Scarborough - Projects in progress 31/03/2013

Directorate	Continuous measurement	With completion date	Total
Anaesthetics	2	3	5
Child Health	3	1	4
Clinical Support Specialities	0	3	3
Community	8	0	8
Elderly Medicine	1	3	4
Emergency Department	2	0	2
General and Acute Medicine	4	3	7
General Surgery and Urology	3	7	10
Head & Neck	0	0	0
Nursing	1	0	1
Obstetrics & Gynaecology	6	8	14
Ophthalmology	0	0	0
Orthopaedics	1	1	2
Other	0	0	0
Sexual Health	0	1	1
Specialist Medicine	0	2	2
Grand Total	**31**	**32**	**63**

York – Expected end date between 31/03/12 and 01/04/2013

Directorate	Not completed	Awaiting BriefCASE	BriefCASE received	Total
Anaesthetics	1	5	7	13
Child Health	2	9	11	22
Clinical Support Specialities	6	30	20	56
Community	0	2	0	2
Elderly Medicine	1	6	2	9
Emergency Department	0	3	6	9
General & Acute Medicine	2	21	14	37
General Surgery & Urology	1	16	5	22
Head & Neck	2	11	1	14
Nursing	1	14	12	27
Obstetrics & Gynaecology	3	11	5	19
Ophthalmology	0	10	4	14
Orthopaedics	2	4	4	10
Other	0	0	1	1
Sexual Health	0	9	8	17
Specialist Medicine	1	8	8	17
Grand Total	**22**	**159**	**108**	**289**

Scarborough – Expected end date between 31/03/2012 and 01/04/2013

Directorate	Not completed	Awaiting BriefCASE	BriefCASE received	Total
Anaesthetics	1	6	3	10
Child Health	2	15	1	18
Clinical Support Specialities	0	9	4	13
Community	0	2	0	2
Elderly Medicine	0	5	0	5
Emergency Department	0	4	1	5
General & Acute Medicine	1	6	3	10
General Surgery & Urology	0	9	1	10
Head & Neck	0	2	2	4
Nursing	0	1	0	1
Obstetrics & Gynaecology	1	15	5	21
Ophthalmology	0	0	1	1
Orthopaedics	1	0	3	4
Other	0	0	0	0
Sexual Health	0	0	0	0
Specialist Medicine	0	1	1	2
Grand Total	**6**	**75**	**25**	**106**

Projects registered financial Year 2012/13

Directorate	No. of Consultants May 13	York	No. of Consultants May 13	Scarborough
Anaesthetics	41	18	No Doctors List available	16
Child Health	12	25		23
Clinical Support Specialities	19	40		18
Community	0	2		10
Elderly Medicine	13	8		9
Emergency Department	10	13		8
General & Acute Medicine	33	35		19
General Surgery & Urology	26	25		22
Head & Neck	15	5		4
Nursing	0	22		2
Obstetrics & Gynaecology	11	19		39
Ophthalmology	12	11		1
Orthopaedics	11	11		8
Other	0	0		0
Sexual Health	2	17		1
Specialist Medicine	27	19		4
Grand Total	**232**	**270**		**184**

BriefCASEs received financial Year 2012/13

Directorate	York	Scarborough
Anaesthetics	9	4
Child Health	11	1
Clinical Support Specialities	23	4
Community	0	0
Elderly Medicine	5	0
Emergency Department	8	1
General & Acute Medicine	21	3
General Surgery & Urology	8	1
Head & Neck	6	2
Nursing	16	0
Obstetrics & Gynaecology	8	5
Ophthalmology	5	1
Orthopaedics	4	3
Other	1	0
Sexual Health	7	0
Specialist Medicine	10	1
Grand Total	**142**	**26**

Action plans received financial Year 2012/13

	York			
Directorate	**Not required**	**Required**	**Received**	**% received**
Anaesthetics	2	7	7	100%
Child Health	1	10	10	100%
Clinical Support Specialities	2	21	21	100%
Community	0	0	0	-
Elderly Medicine	0	5	5	100%
Emergency Department	1	7	7	100%
General & Acute Medicine	1	20	20	100%
General Surgery & Urology	0	8	8	100%
Head & Neck	1	5	5	100%
Nursing	0	17	17	100%
Obstetrics & Gynaecology	1	7	7	100%
Ophthalmology	3	2	2	100%
Orthopaedics	0	4	4	100%
Other	0	1	1	100%
Sexual Health	0	7	7	100%
Specialist Medicine	0	9	9	100%
Grand Total	**12**	**130**	**130**	**100%**

	Scarborough			
Directorate	**Not required**	**Required**	**Received**	**% received**
Anaesthetics	0	4	4	100%
Child Health	0	1	1	100%
Clinical Support Specialities	0	4	4	100%
Community	0	0	0	-
Elderly Medicine	0	0	0	-
Emergency Department	0	1	1	100%
General & Acute Medicine	0	3	3	100%
General Surgery & Urology	0	1	1	100%
Head & Neck	0	2	2	100%
Nursing	0	0	0	-
Obstetrics & Gynaecology	2	3	2	67%
Ophthalmology	1	0	0	-
Orthopaedics	0	3	3	100%
Other	0	0	0	-
Sexual Health	0	0	0	-
Specialist Medicine	1	0	0	-
Grand Total	**4**	**22**	**21**	**95%**

Action plans completed financial Year 2012/13

Directorate	York	Scarborough
Anaesthetics	5	0
Child Health	5	0
Clinical Support Specialities	12	1
Community	1	0
Elderly Medicine	6	0
Emergency Department	3	1
General & Acute Medicine	11	0
General Surgery & Urology	5	0
Head & Neck	4	0
Nursing	8	0
Obstetrics & Gynaecology	3	0
Ophthalmology	0	0
Orthopaedics	2	0
Other	0	0
Sexual Health	1	0
Specialist Medicine	3	0
Grand Total	**69**	**2**

Appendix 2 - National Guidance

York - Clinical Guideline (CG) current status on 31/03/2013

Directorate	Compliant with evidence	Compliant	Partial			Non Compliant		Pending	Total
			With Action Plan	No Action Plan Required	No Action Plan	With Action Plan	No Action Plan		
Anaesthetics	0	1	5	1	0	0	0	0	**7**
Child Health	4	6	2	0	0	0	0	1	**13**
Clinical Support	0	0	4	0	0	0	0	0	**4**
Elderly Medicine	1	2	2	0	0	0	0	0	**5**
Emergency Department	2	0	3	1	0	0	0	0	**6**
General & Acute Medicine	2	15	6	1	0	0	0	4	**28**
General Surgery & Urology	2	2	3	3	1	0	0	0	**11**
Head & Neck	0	1	0	0	0	0	0	0	**1**
Nursing	1	2	2	0	0	0	0	2	**7**
Obstetrics & Gynaecology	5	0	5	0	1	0	0	2	**13**
Ophthalmology	1	0	0	0	0	0	0	0	**1**
Orthopaedics	0	0	0	0	1	0	0	0	**1**
Sexual Health	1	0	0	0	0	0	0	0	**1**
Specialist Medicine	2	5	4	1	0	0	0	3	**15**
Other	0	2	0	0	0	0	0	0	**2**
Total	**21**	**36**	**36**	**7**	**3**	**0**	**0**	**12**	**115**

Scarborough - Clinical Guideline (CG) Current Status on 31/03/2013

Directorate	Compliant with evidence	Compliant	Partial			Non Compliant		Pending	Total
			With Action Plan	No Action Plan Required	No Action Plan	With Action Plan	No Action Plan		
Anaesthetics	1	0	0	0	0	0	0	6	**7**
Child Health	1	1	0	0	0	0	0	11	**13**
Clinical Support	1	0	0	0	0	0	0	2	**3**
Elderly Medicine	0	3	0	0	1	0	0	1	**5**
Emergency Department	2	1	0	0	1	0	0	2	**6**
General & Acute Medicine	7	2	2	0	6	0	0	5	**22**
General Surgery & Urology	0	2	0	0	0	0	0	8	**10**
Head & Neck	0	0	0	0	0	0	0	1	**1**
Nursing	2	0	0	0	0	0	0	3	**5**
Obstetrics & Gynaecology	2	0	0	0	1	0	0	10	**13**
Ophthalmology	0	0	0	0	0	0	0	1	**1**
Orthopaedics	0	1	0	0	0	0	0	0	**1**
Sexual Health	0	0	0	0	0	0	0	0	**0**
Specialist Medicine	0	1	0	0	2	0	0	9	**12**
Other	0	0	0	0	0	0	0	0	**0**
Total	**16**	**11**	**2**	**0**	**11**	**0**	**0**	**59**	**99**

York – Do Not Do's Status on 31/03/2013

Directorate	Compliant	Non Compliant			N/A	Pending	Total
		With Action Plan	No Action Plan Required	No Action Plan			
Anaesthetics	14	0	4	0	7	0	**25**
Child Health	89	0	0	0	0	1	**90**
Clinical Support	7	0	0	0	1	7	**15**
Elderly Medicine	4	0	1	0	0	0	**5**
Emergency Department	7	0	0	0	0	0	**7**
General & Acute Medicine	66	0	0	2	1	63	**132**
General Surgery & Urology	54	0	1	3	0	40	**98**
Head & Neck	10	0	0	1	0	0	**11**
Nursing	8	0	0	0	0	9	**17**
Obstetrics & Gynaecology	150	0	2	0	8	6	**166**
Ophthalmology	2	0	0	0	0	0	**2**
Orthopaedics	0	0	0	0	0	1	**1**
Sexual Health	0	0	0	0	0	0	**0**
Specialist Medicine	60	0	0	1	0	56	**117**
Other	0	0	0	0	0	11	**11**
Total	**471**	**0**	**8**	**7**	**17**	**194**	**697**

Scarborough – Do Not Do's Status on 31/03/2013

Directorate	Compliant	Non Compliant			N/A	Pending	Total
		With Action Plan	No Action Plan Required	No Action Plan			
Anaesthetics	12	0	0	0	0	13	**25**
Child Health	10	0	0	0	0	80	**90**
Clinical Support	1	0	0	0	4	10	**15**
Elderly Medicine	3	0	0	0	0	2	**5**
Emergency Department	7	0	0	0	0	0	**7**
General & Acute Medicine	70	0	0	0	25	37	**132**
General Surgery & Urology	32	0	0	9	1	56	**98**
Head & Neck	0	0	0	0	0	11	**11**
Nursing	1	0	0	0	2	14	**17**
Obstetrics & Gynaecology	0	0	0	0	0	166	**166**
Ophthalmology	0	0	0	0	0	2	**2**
Orthopaedics	0	0	0	0	0	1	**1**
Sexual Health	0	0	0	0	0	0	**0**
Specialist Medicine	29	0	0	0	2	86	**117**
Other	0	0	0	0	1	10	**11**
Total	**165**	**0**	**0**	**9**	**35**	**488**	**697**

York - Non Drug Technology Appraisal (TA) Current Status on 31/03/2013

Directorate	Compliant with evidence	Compliant	Partial			Non Compliant		Pending	Total
			With Action Plan	No Action Plan Required	No Action Plan	With Action Plan	No Action Plan		
Anaesthetics	0	2	0	0	0	0	0	0	**2**
Clinical Support	1	0	0	0	0	0	0	0	**1**
General & Acute Medicine	1	5	0	1	0	0	0	0	**7**
General Surgery & Urology	1	1	0	1	0	0	0	0	**3**
Head & Neck	0	1	0	0	0	0	0	0	**1**
Obstetrics & Gynaecology	0	1	0	0	0	0	0	0	**1**
Orthopaedics	0	3	0	0	0	0	0	0	**3**
Total	**3**	**13**	**0**	**2**	**0**	**0**	**0**	**0**	**18**

Scarborough - Non Drug Technology Appraisal (TA) Current Status on 31/03/2013

Directorate	Compliant with evidence	Compliant	Partial			Non Compliant		Pending	Total
			With Action Plan	No Action Plan Required	No Action Plan	With Action Plan	No Action Plan		
Anaesthetics	0	1	0	0	0	0	0	0	**1**
Clinical Support	1	0	0	0	0	0	0	0	**1**
General & Acute Medicine	1	1	0	0	0	0	0	4	**6**
General Surgery & Urology	0	1	0	0	0	0	0	2	**3**
Head & Neck	0	0	0	0	0	0	0	1	**1**
Obstetrics & Gynaecology	0	1	0	0	0	0	0	0	**1**
Orthopaedics	0	2	0	0	0	0	0	1	**3**
Total	**2**	**6**	**0**	**0**	**0**	**0**	**0**	**8**	**16**

York - Quality Standards (QS) Current Status on 31/03/2013

Directorate	Compliant with evidence	Compliant	Partial			Non Compliant		Pending	Total
			With Action Plan	No Action Plan Required	No Action Plan	With Action Plan	No Action Plan		
Child Health	1	0	0	0	0	0	0	2	**3**
Elderly Medicine	0	0	1	1	0	0	0	0	**2**
General & Acute Medicine	1	3	2	1	1	0	0	2	**10**
General Surgery & Urology	1	0	0	0	1	0	0	0	**2**
Nursing	0	0	1	0	0	0	0	3	**4**
Obstetrics & Gynaecology	0	0	0	0	0	0	0	2	**2**
Ophthalmology	0	0	1	0	0	0	0	0	**1**
Orthopaedics	0	0	0	0	0	0	0	1	**1**
Specialist Medicine	0	0	0	0	0	0	0	1	**1**
Total	**3**	**3**	**5**	**2**	**2**	**0**	**0**	**11**	**26**

Scarborough- Quality Standards (QS) Current Status on 31/03/2013

Directorate	Compliant with evidence	Compliant	Partial			Non Compliant		Pending	Total
			With Action Plan	No Action Plan Required	No Action Plan	With Action Plan	No Action Plan		
Child Health	0	0	0	0	0	0	0	3	**3**
Elderly Medicine	0	0	1	0	1	0	0	0	**2**
General & Acute Medicine	1	2	0	0	0	0	0	7	**10**
General Surgery & Urology	1	0	0	0	0	0	0	1	**2**
Nursing	0	1	0	0	1	0	0	2	**4**
Obstetrics & Gynaecology	0	0	0	0	0	0	0	2	**2**
Ophthalmology	0	0	0	0	0	0	0	1	**1**
Orthopaedics	0	1	0	0	0	0	0	0	**1**
Specialist Medicine	0	0	0	0	0	0	0	1	**1**
Total	**2**	**4**	**1**	**0**	**2**	**0**	**0**	**17**	**26**

York - Cancer Services Guidelines Current Status on 31/03/2013

Directorate	Compliant with evidence	Compliant	Partial			Non Compliant		Pending	Total
			With Action Plan	No Action Plan Required	No Action Plan	With Action Plan	No Action Plan		
Child Health	0	0	1	0	0	0	0	0	**1**
General Surgery & Urology	1	0	1	1	0	0	0	0	**3**
Head & Neck	0	0	0	1	0	0	0	0	**1**
Specialist Medicine	2	1	0	1	0	0	0	0	**4**
Total	**3**	**1**	**2**	**3**	**0**	**0**	**0**	**0**	**9**

Scarborough - Cancer Services Guidelines Current Status on 31/03/2013

Directorate	Compliant with evidence	Compliant	Partial			Non Compliant		Pending	Total
			With Action Plan	No Action Plan Required	No Action Plan	With Action Plan	No Action Plan		
Child Health	0	0	0	1	0	0	0	0	**1**
General Surgery & Urology	0	0	0	2	0	0	0	1	**3**
Head & Neck	0	0	0	1	0	0	0	0	**1**
Specialist Medicine	1	0	0	3	0	0	0	0	**4**
Total	**1**	**0**	**0**	**7**	**0**	**0**	**0**	**1**	**9**

York Medical Technologies (MT) Current Status on 31/03/2013

Directorate	Performed	Pending	Total
Anaesthetics	2	0	**2**
Clinical Support	0	1	**1**
General & Acute Medicine	1	2	**3**
General Surgery & Urology	1	0	**1**
Total	**4**	**3**	**7**

Scarborough Medical Technologies (MT) Current Status on 31/03/13

Directorate	Performed	Pending	Total
Anaesthetics	0	2	**2**
Clinical Support	0	1	**1**
General & Acute Medicine	0	3	**3**
General Surgery & Urology	0	1	**1**
Total	**0**	**7**	**7**

York Diagnostic Guidelines (DG) Current Status on 31/03/13

Directorate	Performed	Pending	Total
Anaesthetics	**0**	**1**	**1**
Clinical Support	**1**	**0**	**1**
Total	**1**	**1**	**2**

Scarborough Diagnostic Guidelines (DG) Current Status on 31/03/13

Directorate	Performed	Pending	Total
Anaesthetics	**0**	**1**	**1**
Clinical Support	**0**	**2**	**2**
Total	**0**	**3**	**3**

York Interventional Procedure Guidelines (IPG) Current Status on 31/03/13

Directorate	Not Performed	Performed	Pending	Total
Anaesthetics	9	4	0	**13**
Child Health	9	0	0	**9**
Clinical Support	12	4	4	**20**
Elderly Medicine	0	0	0	**0**
Emergency Department	0	0	0	**0**
General & Acute Medicine	82	5	2	**89**
General Surgery & Urology	88	11	2	**101**
Head & Neck	23	3	0	**26**
Nursing	0	0	0	**0**
Obstetrics & Gynaecology	24	7	0	**31**
Ophthalmology	20	9	0	**29**
Orthopaedics	41	5	0	**46**
Sexual Health	0	0	0	**0**
Specialist Medicine	31	2	1	**34**
Other	0	0	0	**0**
Total	339	50	9	**398**

Scarborough Intervention Procedure Guidelines (IPG) Current Status on 31/03/13

Directorate	Not Performed	Performed	Pending	Total
Anaesthetics	11	0	2	**13**
Child Health	9	0	0	**9**
Clinical Support	16	0	5	**21**
Elderly Medicine	0	0	0	**0**
Emergency Department	0	0	0	**0**
General & Acute Medicine	84	0	4	**88**
General Surgery & Urology	92	1	8	**101**
Head & Neck	24	1	1	**26**
Nursing	0	0	0	**0**
Obstetrics & Gynaecology	29	0	2	**31**
Ophthalmology	25	0	4	**29**
Orthopaedics	39	2	5	**46**
Sexual Health	0	0	0	**0**
Specialist Medicine	30	1	3	**34**
Other	0	0	0	**0**
Total	**359**	**5**	**34**	**398**

York NCEPOD (National Confidential Enquiries into Patient Outcome and Death)

Directorate	Compliant with evidence	Compliant	Partial			Non Compliant		Pending	Total
			With Action Plan	No Action Plan Required	No Action Plan	With Action Plan	No Action Plan		
Anaesthetics	0	0	1	0	0	0	0	0	**1**
Child Health	0	1	0	0	0	0	0	0	**1**
General & Acute Medicine	0	0	3	0	0	0	0	1	**4**
Emergency Department	0	0	1	0	0	0	0	1	**2**
General Surgery & Urology	0	0	1	0	0	0	0	1	**2**
Specialist Medicine	0	0	1	0	0	0	0	0	**1**
Total	**0**	**1**	**7**	**0**	**0**	**0**	**0**	**3**	**11**

Scarborough NCEPOD (National Confidential Enquiries into Patient Outcome and Death)

Directorate	Compliant with evidence	Compliant	Partial			Non Compliant		Pending	Total
			With Action Plan	No Action Plan Required	No Action Plan	With Action Plan	No Action Plan		
Anaesthetics	0	0	0	0	0	0	0	1	**1**
Child Health	0	0	0	0	0	0	0	1	**1**
Emergency Department	0	0	0	0	0	0	0	2	**2**
General & Acute Medicine	0	0	0	0	0	0	0	4	**3**
General Surgery & Urology	0	0	0	0	0	0	0	1	**1**
Specialist Medicine	0	0	0	0	0	0	0	1	**1**
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**10**	**10**

NCEPOD014 Bariatric Surgery (Too Lean a Service) is not relevant to Scarborough

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Finance and Performance Committee – 23rd July 2013 Classroom 5, Post Grad

Attendance: Mike Sweet, Chairman
Mike Keaney
Debbie Hollings-Tennant
Lucy Turner
Richard Mellor
Apologies: Andy Bertram
Graham Lamb
Anna Pridmore

	Agenda Item	AFW	Comments	Assurance	Attention to Board
	Attendance		It was agreed that Sarah Lovell will attend bi-monthly, but will attend or provide a paper for the intervening meetings if there are important items to bring to the committees attention.		
1	**Last Meeting Notes Minutes Dated 18th June 2013**		Corrections Item 2 – Assurance. Statement should read "Demonstrable progress has been made on the moving from a content driven strategy to an action based plan." Item 4 Para 5. Remove "in" from the end of the second line CQUIN Item 3 Para 1. The committee enquired whether additional resources had now been identified. It was confirmed that additional resources were being identified. The		

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			committee requested that the level of resource is kept under review. Para 4. An update was provided that the Trust will be submitting a position to the CCG this week showing that the Friends and Family requirements were met, by achieving a 15% collection rate within the quarter. Operation Report, Item 4 Para 2. It was confirmed that the 18 week target was met for May and that fines for 52+ weeks are levied at £5k / patient / month. Finance Report, Item 5 Para 1. It was reiterated that there is no clear view on what happens if CCG's have more contract activity than they can afford. The committee asked that the situation be kept under review.		
2	**Finance Report**	2.12 2.13	RM presented the report. He noted the overall financial position was a £0.2m surplus, ahead of the operational plan, and in line with the Monitor plan. The surplus is after the provision for fines – see below. Income is an estimate based on the May position and June activity levels, which still show an over-performance. The I&E statement now identifies the fines and penalties incorporated within the financial position. Actual penalties based on known 52 week breaches have been included. It was noted that a prudent financial view has been taken of the C-Diff penalties, which are £50k per case over trajectory, for all cases above a quarter of the annual trajectory. This assumes there is no reduction in the trend of cases over the year.	Demonstrates an open and transparent approach to such matters.	Highlight the provision for fines in the financial position, and the risk associated

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			An estimate of fines relating to 18 week penalties has been made. Despite meeting the aggregate 18 week target for Monitor, the contract also requires us to meet the target specialty by specialty. An estimate of total fines across specialties where the target may be breached has been made. Work is ongoing to define the actual fines. This will be calculated in arrears, as the level of fine is based on the distance from target, and the specialty income for that month. The committee was informed that some specialties are planning to fail, due to the costs of complying, and work is being done to understand the financial implications of failing, versus the cost of trying to comply.		with C-Diff performance in particular.
			It was noted that at this point there are no fines for the First : Follow up ratio, as the new ratios do not come into play until the 1st July. It was asked whether the Follow up plan would be amended for the new ratio. This needs to be confirmed, but practice has been to maintain the original plan. The estimate of fines will be updated in the Finance report on a monthly basis. MK asked whether the overspends were a consequence of the increased income from activity. The committee was informed that some of the costs would be related to the activity, but the additional income had also offset our below plan CIP performance.		Update to the Board on action to reduce the first : follow up ratio
			It was confirmed that the North Yorkshire 2012/13 outturn position has now been agreed, with no adverse implications for the Trust Contracts with CCG's are now signed. The outstanding contracts are now those with Local		

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			Authorities, which are low financial value, and interim payments are continuing to be made. The £15m capital support is being pursued, and it is expected to be received in quarter 2.		
3	**Efficiency Report**		It was reported that there had been a significant improvement in performance in June. Annual CIP achievement was now £6.7m against a £23.4m plan, which is broadly in line with last year. The variance reported for quarter 1 is, however, £1.9m behind the Monitor profile. Table 3. The non recurrent element to date is £4.2m, 63% of CIP's. This is again in line with last year's delivery. This is compounded by the fact that in June 76% of the savings were non-recurrent. MK asked about the nature of Efficiency plans and if there was a shift towards more transformational projects. DHT offered to provide an analysis of schemes for the next meeting; and referenced the role of the Efficiency Panels in supporting more politically sensitive or complex initiatives. The rest of the report was discussed in detail with note made that WTE still continued to increase. Four year planning has improved, in the month, by £1m and year 2 is now over planned. There may be scope for using some of the schemes identified in 2014/15 to manage in year risk. MS noted that there were several concerns over the information. Most of the benefit achieved in June was on recurrent (76%), and whilst most plans in table 5 are recurrent, this is not consistent with the performance to date. There was also a concern that effort was going into plans for 2014/15 when there	The committee received assurance that whereas the rate of achievement has clearly slowed considerable effort is being deployed at all levels to achieve both the 13 / 14 target and future targets and that the experience of others is being sought where appropriate	CIP performance very tight Concern over risk rating of 1 for delivery and

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			was still a gap in 2013/14. Finally, the risk profile in appendix 2 show a good profile for plans (risk rating 4) but a risk rating of 1 for both delivery and recurrent delivery against plan. DHT responded that the risks presenting for 2013/14 had been recognised at the start of the year and raised to the Efficiency Committee. This had resulted in the establishment of a new programme of Panel meetings with the Chief Executive. These have been initially targeted at the 10 worst performing Directorates. The first three of these have taken place; with the remainder planned by the end of October. MS noted that this was late for achieving delivery in 13/14, and it was agreed that actions this year may still be non recurrent with the aim of conversion to recurrent savings in 2014/5. Overall it was noted that CIP delivery needed to see a paradigm shift in expectations and delivery.		recurrent items
4	**CQUIN**		LT reported that the trust was trying to get CQUINS reported on Signal where possible. There were technical issues with some of them, where outcomes or RAG rating could not easily be defined numerically, and the report format may need to be changed. The summary report to F+P committee was to highlight by exception those CQUINS where we were RAG rating them at Amber or Red. The lists were split by financial impact, with list 1 being high financial impact, list 2 being all other CQUINs at risk. It was noted that this was to focus internal management, despite the fact that the clinical gains from CQUINs may have different priorities. LT cautioned that the RAG rating was a point in time score, as it could	The committee took assurance from the regular review if all the Red and Amber items by members of the executive and the presence of a Director Lead for each scheme.	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			change as actions were taken, or information became available. LT reminded the committee that in the early stages of all CQUINs the requirements and RAG ratings changed with considerable frequency and that matters were unlikely to settle until late in Q2. Stroke: There had been a lack of clarity over who will accredit the Scarborough stroke unit, which has contributed to the red rating. We now think we understand that the CCG supported by the Stroke network will undertake the assessment, and have confirmed that this can take place before December 2013. There are still risks about our proposed model, but we now know who we can discuss our approach with, and members of the York team (who have accreditation) are working with Scarborough on their model. Deteriorating patient: There were some disputes over the data, which are now resolved. We are struggling with achieving the 1 hour observation target, and also how to show the data. The latter point is now resolved, and risk rating is now Amber. Deteriorating patient (Cherry Ward): There is an issue with patients being seen on post take rounds within 12 hours, if they arrive around 5pm. Clerking time may mean that they are not clerked by the time of the ward round, and so are not seen until the following day. Options to ensure they are seen are being investigated. There is an issue at Scarborough due to lack of data. CPD for inpatients is currently being rolled out, and this will give the data that is required. Self Management plans: There have been difficulties in determining the clinical protocols for providing self management information - flow charts/ action points.		

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			This is now mainly completed, and the more straightforward task of working with SNS to write this into the system will be started. The new format report was received cautiously, although it was agreed that it would be used between quarterly full reports to give it time to be accepted. The committee considered that given the variability around CQUIN reporting during the early part of the year it should delay drawing any issues to the Board's attention until September.		
5	**Operational Report**		LT updated the committee that we had met the Q1 18 week target on aggregate. The 52 weeks outlier position was also better, with only one outstanding in June. There may be issues with getting this patient treated in July due to the clinical complexity of the treatment. Consequently there may be slippage on the aim of clearing all 52 week waits by July. First: Follow up ratio. It was noted that the Q1 ratio is still 1:2.1, so this was met as at May. There appears to have been a "cultural change" as we are now seeing an increase in the numbers of patients discharged following clinics. 31 day cancer – we only have small numbers, so the miss in month is due to two patients. We still expect to hit the target in Q1. Ambulance handover. It was clarified that the "target" time for ambulance handover is 15 minutes. From YAS side, the crews then have 15 minutes to ready themselves for a new call. The Trust will miss the		Update on the position regarding the new First:Follow up ratio target, and the financial and operational impact

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			target if the handover takes longer than 15 minutes, but fines will only be levied once the hospital element of the handover time extends over 30 minutes. LT highlighted that the data being used is from YAS, and there are concerns over its completeness, as counts of ambulances attending in ED show more ambulances than YAS data recorded. This is being worked on. MS requested that the run rate and trend of waits be reviewed to see the likely level of fines based on current data as there have clearly been improvements. C Diff: RCA has identified only 2 patients who were unavoidable within the cohort. There is a possible over-sampling of C Diff which is giving more hits than necessary. Whilst all but one (transferred in) patient have had drugs in line with our anti microbial policy, there is a view that the policy should be reviewed to see if it is still appropriate or needs amending. There is also consideration as to whether pro-biotics should be prescribed for appropriate patients.		See Q & S report.
6	**Monitor Report**		The Monitor report was received, and the FRR of 3 noted.		
7	**Work Programme**		MS asked that a 12/13 update to the Grant Thornton Benchmark report be added to the September meeting plan.		

G1

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 31 July 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 June 2013.

At the end of June, there is an Income and Expenditure surplus of £0.2m against a planned deficit for the period of £0.1m, and an actual cash balance of £18.95m. The Income and Expenditure position places the Trust ahead of 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	July 2013
Version number	Version 1

York Teaching Hospital NHS
NHS Foundation Trust

Briefing Note for the Finance & Performance Committee Meeting 23 July 2013
Briefing Note for the Board of Directors Meeting 31 July 2013

Subject: June 2013 Financial Position (Quarter 1)

From: Andrew Bertram, Finance Director

Summary Reported Position for June 2013

The attached income and expenditure account shows an actual £0.2m surplus of income over expenditure. This is ahead of the Trust's operation plan and in line with the fixed annual plan expectation submitted to Monitor.

Income Analysis

The income position is based on coded and costed April and May activity and an estimate has been used for June (based on reported activity levels but using average specialty costs). The actual income levels for April and May have been higher than both planned and contracted. Summary activity data for June suggests continued high levels. At this stage income is assessed to be £2.5m ahead of plan. This is of concern in terms of CCG affordability.

I have introduced a new line to the income and expenditure report this month to capture and disclose actual and potential fines/contract penalties. Included in the position for Q1 are anticipated penalties of £670k. This comprises actual penalties of £70k for 52-week breaches, a £100k assessment of likely 18-week penalties and a £500k prudent assessment of the impact of the excess c diff to trajectory for Q1 (10 cases above trajectory at £50k per case). 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.

Expenditure Analysis

Pay is reported as £0.1m overspent. The work started last month to identify pay pressures on operational budgets that are covered by planning provisions has continued with appropriate drawings now made. Typically these pressures include escalation facilities/beds with costs largely relating to agency costs associated with the maintenance of the additional 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.

Drug costs are over spent by £0.3m 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.

Clinical supplies and services are under spending against planned spend levels with other costs showing a small overspend pressure. At this stage no worrying trends have been identified and a varied number of small pressures are being discussed with directorates through the PMM process.

The report shows that the CIP programme is impacting adversely on the position by £1.9m. This is dealt with in the CIP report. This is consistent with the opening position in previous years.

2012/13 Contract Reconciliation

The 2012/13 contract outturn position has been agreed with the old NYY PCT. There are no adverse implications in this regard for the Trust. At the time of writing this report payment remained outstanding but I am being assured this is being managed through the Area Teams and that we can expect full payment imminently.

Contracting Matters

Contracts are now completed and signed with VOY/S&R CCG (and all associates), ER CCG and specialised commissioners.

Contracts with the Local Authorities remain unsigned and work continues to bring these to a close. These are low value contracts and payments continue to be made on account to the Trust.

Other Issues

With regard to the outstanding but agreed £15m capital support I can confirm that discussions continue to be active between the Trust and both the DH and the National Trust Development Authority (NTDA). As a reminder to the Board our plan assumes receipt in quarter 2 in line with the usual national PDC draw down timetable.

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

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

High Level Overview

* A net I&E surplus for the period of £0.2m means the Trust is £0.2m ahead of plan.

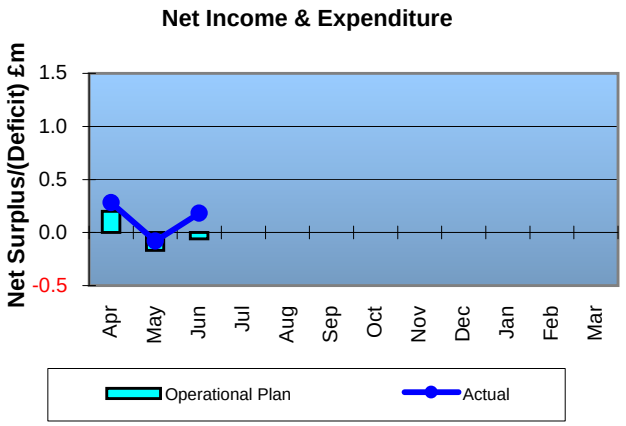
* CIPs achieved at the end of June total £6.7m. The CIP position is running £1.9m behind plan.

* Income from all contracts are assessed to be ahead of plan.

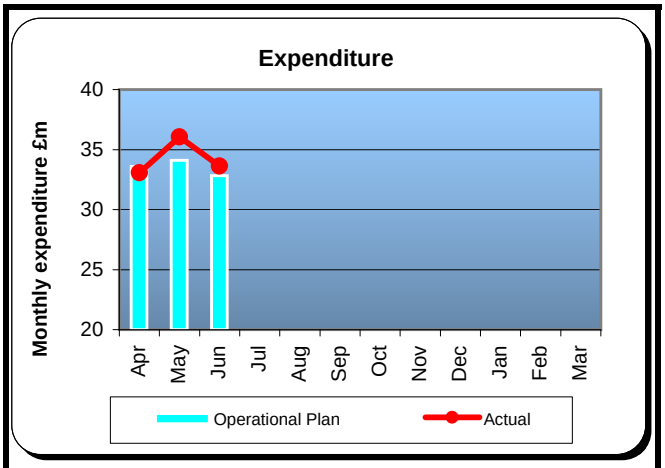
* Cash balance is £18.95m, and is ahead of plan.

* Capital spend totalled £1.94m, which is in line with plan.

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



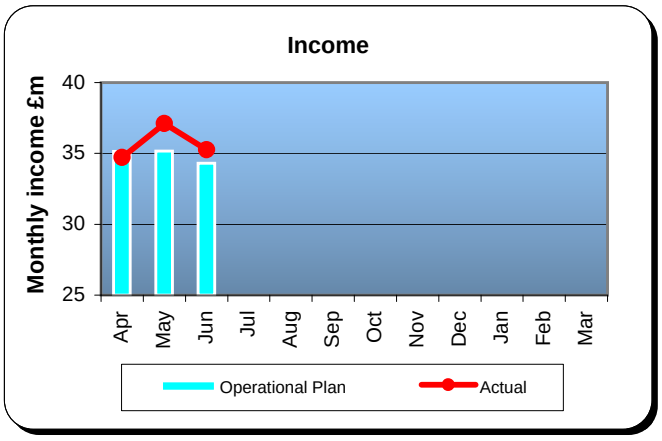
Key Period Operational Variances			
	Plan £m	Act.£m	Var. £m
Clin.Inc.(excl. Lucentis)	88.8	91.8	3.0
Clin.Inc.(Lucentis)	2.6	1.9	-0.6
Other Income	13.2	13.3	0.1
Pay	-71.3	-71.3	-0.1
Drugs	-8.8	-9.1	-0.3
Consumables	-9.9	-9.8	0.2
Other Expenditure	-10.5	-12.6	-2.0
	4.1	**4.3**	**0.2**



At the end of June there is an adverse variance against operational expenditure budgets of £2.245m. This comprises:-

- Operational pay being £0.051m overspent.
- Drugs £0.322m overspent, mainly due to pass through costs linked to drugs excluded from tariff.

- Clinical supplies £0.173m underspent.
- Other costs are £0.155m overspent
- CIPs are £1.890m behind plan.



At the end of June income is ahead of plan by an estimated £2.471m. This comprises:

- Elective and day case income are on plan for the period.

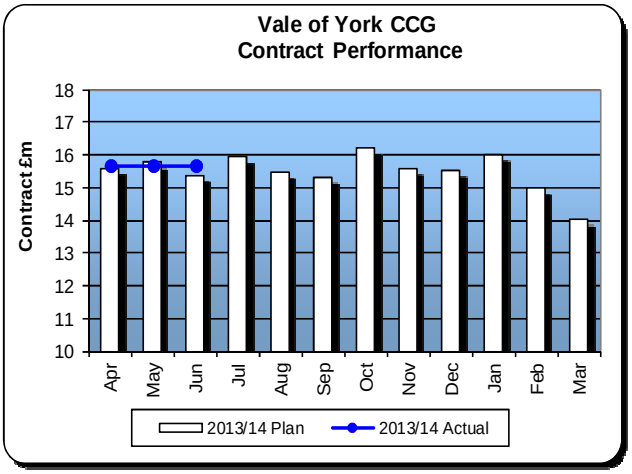
- Non elective income is ahead of plan by £2.4m.

- Out patient income is broadly on plan.

- A&E is ahead of plan (£0.2m). Other clinical income is ahead of plan by £0.4m Adult critical care by £0.3m, Neonatal critical care £0.6, masked by lucentis under plan by £.05m

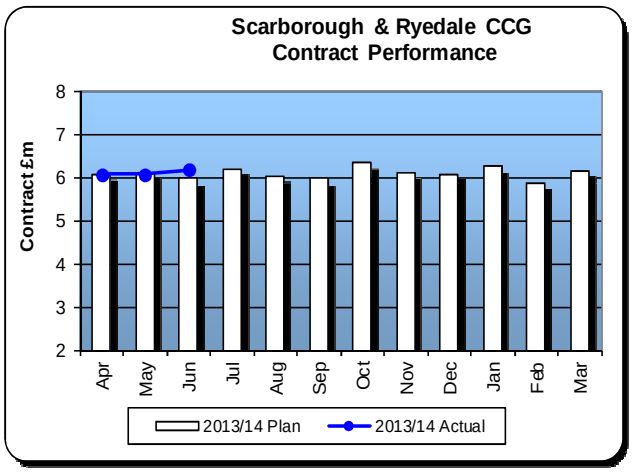
- Other income is £0.01m ahead of plan.

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



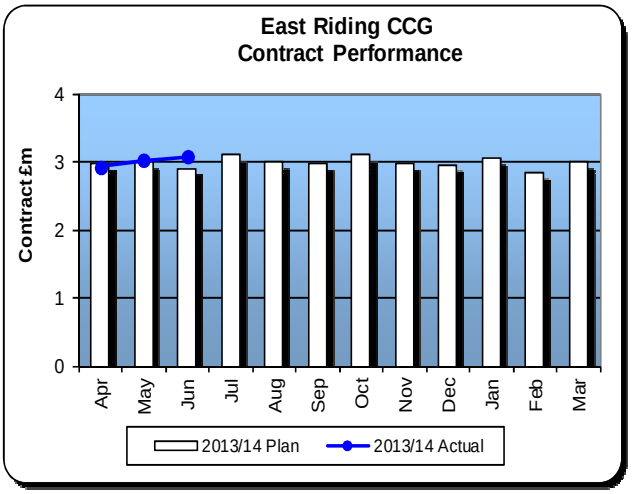
The signed contract value is £185.7m, and the graphs have been updated to reflect this.

The contract is marginally ahead of plan and includes estimates for the month of June.
The actual value has been reduced to take account of anticipated contract penalties. This is a marker at this stage, and corrective action may improve the position.



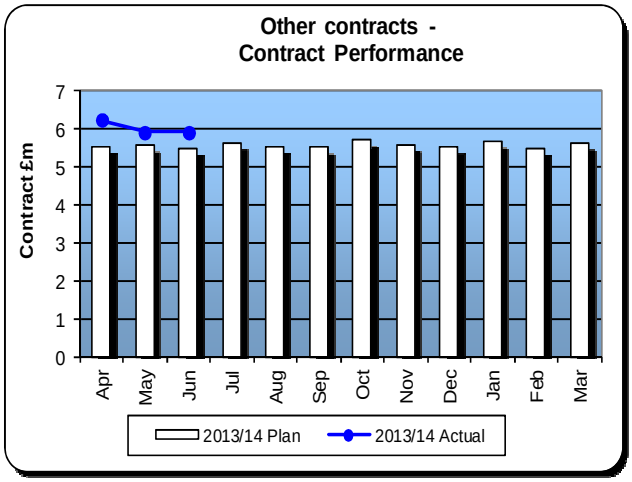
The signed contract value is £73.098m, and the graphs have been updated to reflect this.

The contract is marginally ahead of plan, and includes estimates and penalties, which may reduce if corrective action improves the position.



The signed contract value is £35.78m

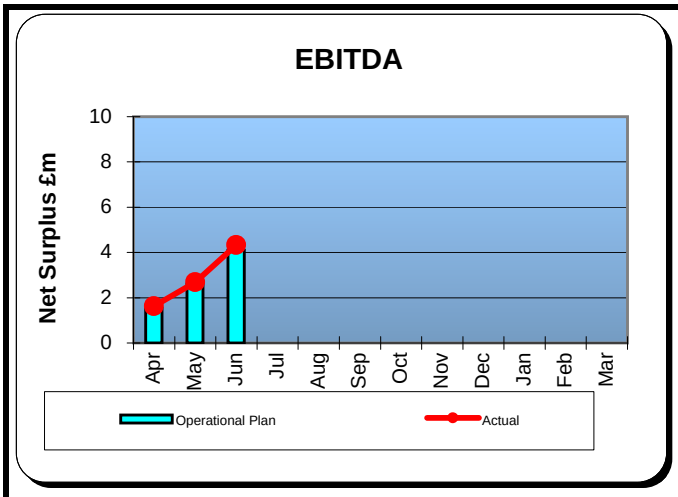
The contract is marginally ahead of plan, and includes estimates and penalties, which may reduce if corrective action improves the position.

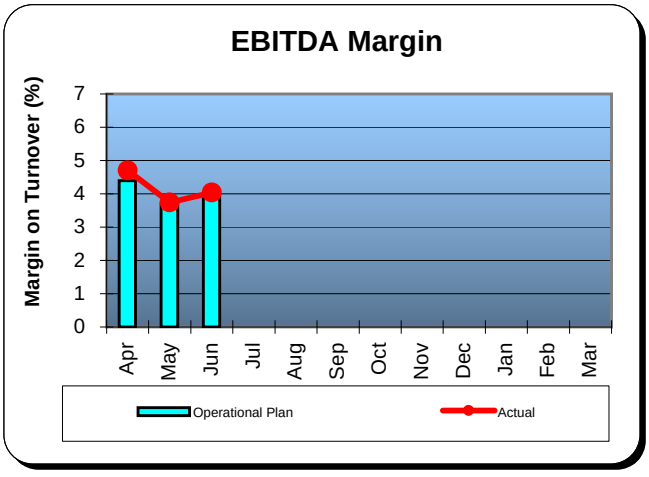


The signed contract value is £67.04m

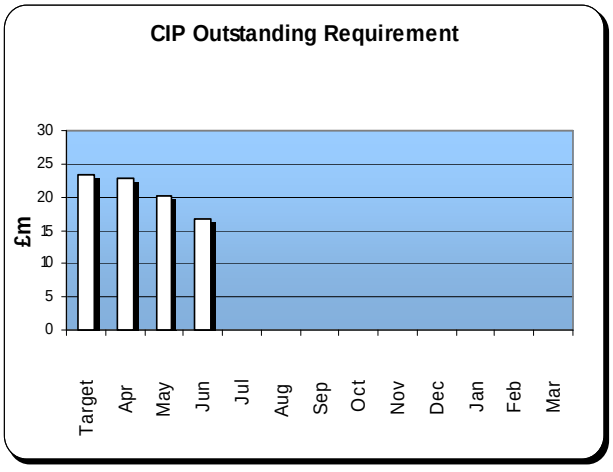
Contracts include small CCGs, NHS England and Local Authority contracts. Contracts are ahead of plan by an estimated £1.5m.

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

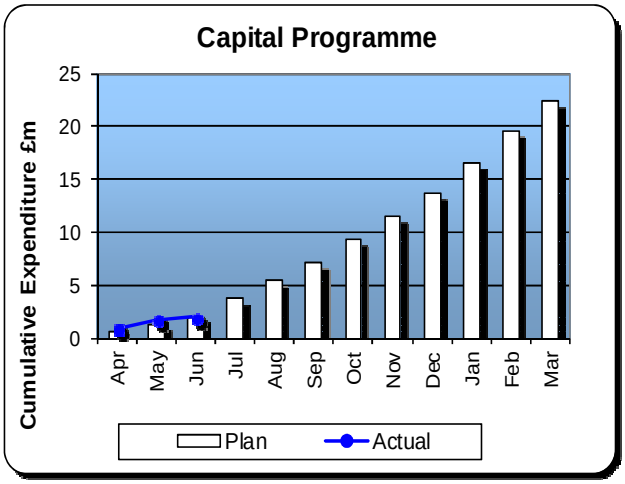




Actual EBITDA at the end of June is £4.33m (4.04%), compared to operational plan of £4.1m (3.92%), and is reflective of the overall I&E performance.



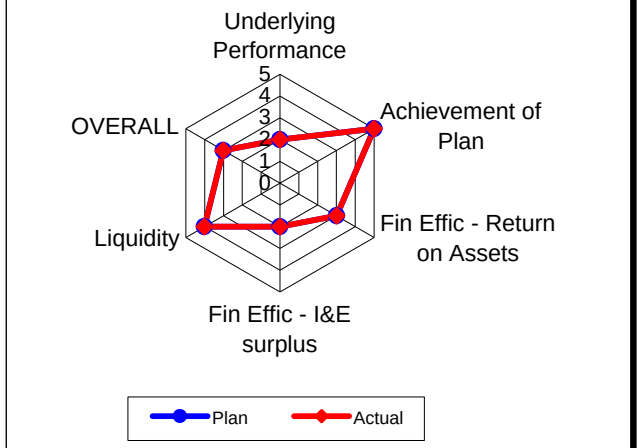
The full year efficiency requirement is £23.4m. At the end of June £6.7m has been cleared.



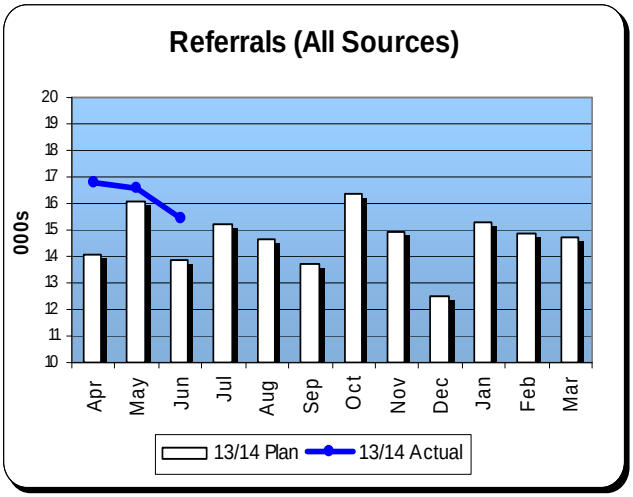
Capital expenditure to the end of June totalled £1.94m and is in line with the plan.

The capital programme for 2013/14 is yet to be finalised but ongoing schemes with significant in year spend include the pharmacy robot and the upgrade of ward kitchens in York.

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

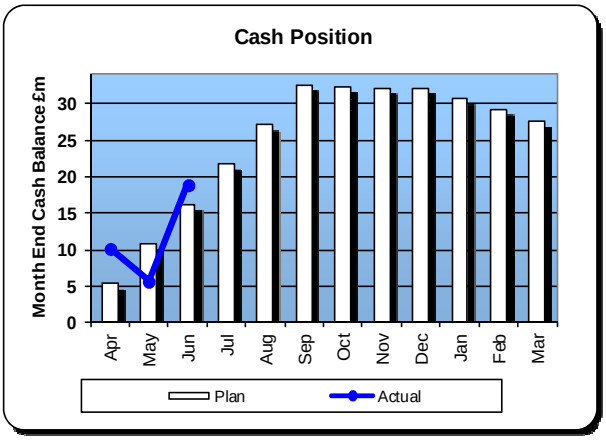


The Trust's provisional overall FRR for the year end is 3, which is in line with the plan submitted to Monitor.



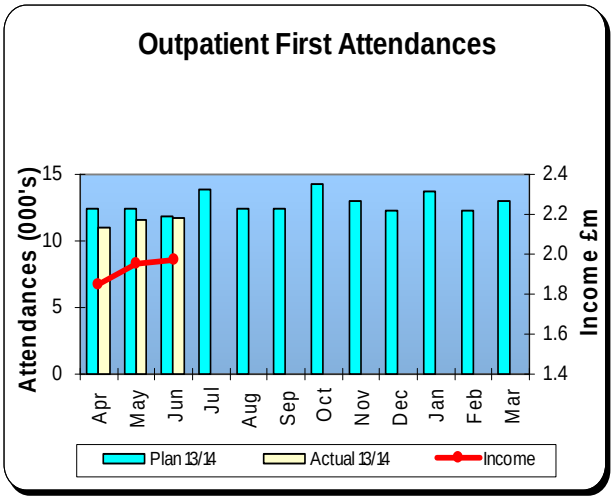
Annual plan 162,858 referrals (based on 2012/13 outturn)

Variance at end of June: +4,773 referrals (+11%)
GP referrals +3,317 (+13%)
Cons to Cons referrals +1,310 (+21%)
Other referrals +146 (+1%)



Cash balances at the end of June totalled £18.95m and is slightly ahead of the plan. The £12m transitional income support was received in June.

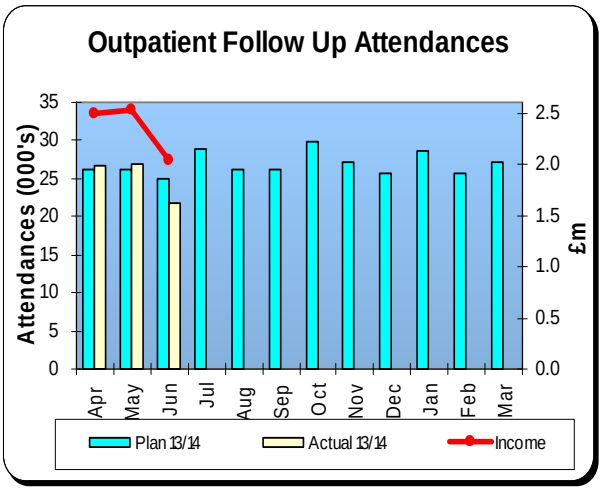
Monitor Liquidity Ratio					
Risk Rating	5	4	3	2	1
Days Cover	60	25	15	10	<10
Trust Actual Days		30			



Annual Plan (Attendances) 154,193

Variance at end of June: -2608 attendances (-6.7%).
York variances: T&O (+8%), Gynaecology (+1%), Dermatology (+9%) ahead of plan Anaesthetics (-5%), General Medicine (-22%), ENT (-10%) behind plan.

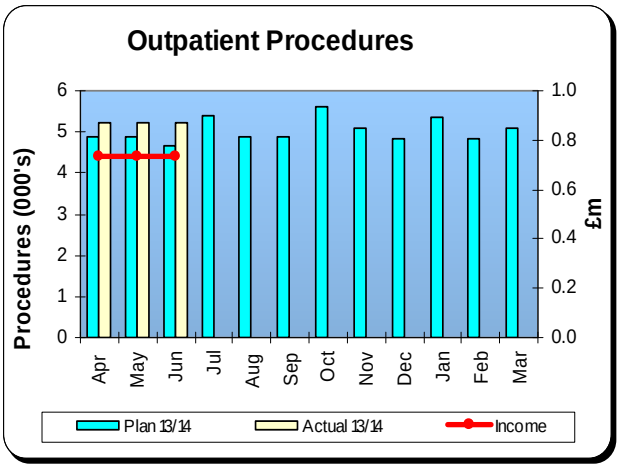
Scarborough variances: General Surgery (+69%), Gynaecology (+61%), ENT (+14%) ahead of plan. Elderly Medicine (-45%), Restorative Dentistry (-41%) behind plan



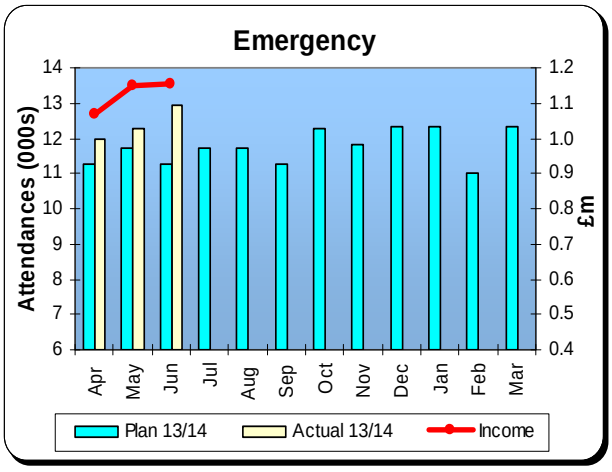
Annual Plan (Attendances) 322,679

Variance at end of June: -3,074 attendances (-12.5%).
York variances: Dermatology (+17%), Oncology (+70%), General Medicine (+5%), Paediatrics (+41%) ahead of plan. T&O (-5%), Urology (-22%), behind plan.

Scarborough variances: T&O (+13%) ahead of plan. Ophthalmology (-23%), Anaesthetics (-38%), Elderly Medicine (-43%) behind plan.

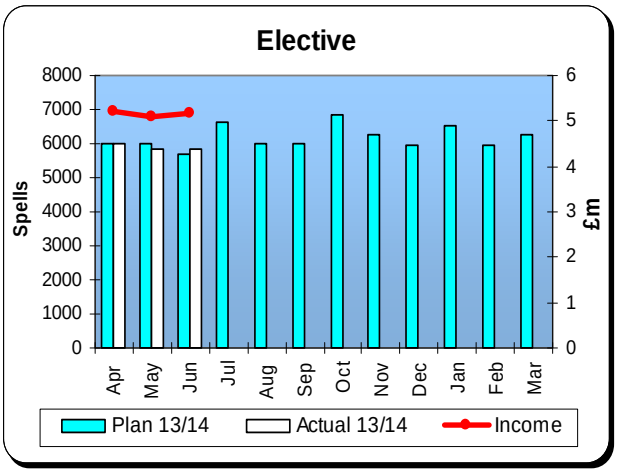


Annual Plan (Attendances) 61,816
Variance at end June: +1,235 procedures (+8.5%).



Annual Plan (Attendances) 140,970
Variance at end June: +2,965 (+8.7%).

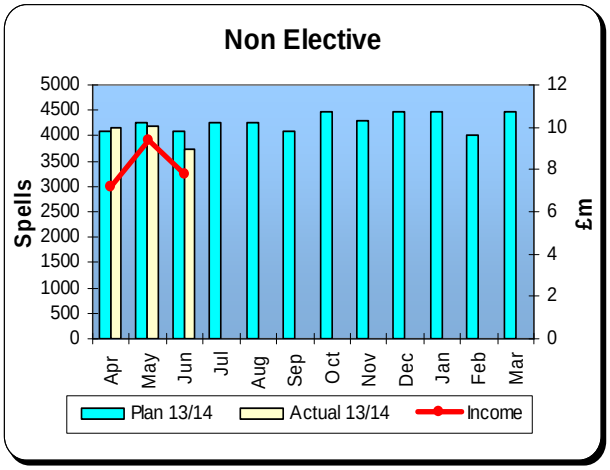
YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
Financial Report for the Period 1 April 2013 to 30 June 2013



Annual Plan (Spells) 74,036
Variance at end of June: -42 spells (-0.2%): inpatient +58; daycase -100

York variances: Gynaecology (+12%),Ophthalmology (+8%), Paediatrics (+15%), Anaesthetics (+2%) ahead of plan. General Surgery (-4%), Medicine for the Elderly (-53%) behind plan.

Scarborough variances: Urology (+17%), General Surgery (+16%),ahead of plan. Ophthalmology (-13%) Haematology (-5%), Neurology (-13%) behind plan.



Annual Plan (Spells) 51,746
Variance at end of June: -364 spells (-2.9%).

York variances: Trauma and Orthopaedics (+21%), Medicine for the Elderly (+15%), Ophthalmology (+9%) ahead of plan. General Surgery (-12%), Paediatrics (-17%) General Medicine (-13%),behind plan

Scarborough variances: General Surgery (+17%), T&O (+6%), Elderly Medicine (+11%) Gynaecology (+6%) ahead of plan. Anaesthetics (-67%), Urology (-8%) behind plan.

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
SUMMARY INCOME & EXPENDITURE POSITION
FOR THE PERIOD 1st APRIL 2013 to 30th JUNE 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	6,198	6,754	556
Non-tariff income	578	139	31	-108
Planned same day (Day cases)				
Tariff income	37,506	8,972	8,498	-474
Non-tariff income	525	125	167	42
Non-Elective Income				
Tariff income	89,072	21,646	24,117	2,471
Non-tariff income	1,537	375	276	-99
Outpatients				
Tariff income	56,164	14,607	15,500	893
Non-tariff income	5,611	1,342	1,372	30
A&E				
Tariff income	12,397	3,023	3,458	435
Non-tariff income	612	149	-88	-237
Community				
Tariff income	951	232	270	38
Non-tariff income	33,417	8,354	8,573	219
Other				
Non-tariff income	111,957	26,224	25,490	-734
Other				
fines and contract penalties			-670	-670
	376,236	**91,386**	**93,748**	**2,362**
				0
	376,236	**91,386**	**93,748**	**2,362**
Non-NHS Clinical Income				
Private Patient Income	1,088	272	253	-19
Other Non-protected Clinical Income	1,879	474	424	-49
	2,967	**746**	**678**	**-68**
Other Income				
Education & Training	13,804	3,451	3,510	59
Research & Development	8,027	2,007	2,075	68
Donations & Grants received of PPE & Intangible Assets	240	60	60	0
Other Income	16,280	3,974	4,024	50
Transition support	11,985	2,996	2,996	0
	50,335	**12,488**	**12,665**	**177**
Total Income	**429,538**	**104,620**	**107,091**	**2,471**
EXPENDITURE				
Pay costs	-293,714	-71,287	-71,338	-51
Drug costs	-35,547	-8,770	-9,092	-322
Clinical Supplies & Services	-42,918	-9,938	-9,765	173
Other costs (excluding Depreciation)	-54,714	-12,415	-12,570	-155
CIP	16,701	1,890	0	-1,890
Total Expenditure	**-410,192**	**-100,520**	**-102,765**	**-2,245**
EBITDA (see note)	**19,346**	**4,100**	**4,326**	**226**
Profit/ Loss on Asset Disposals	0	0	-5	-5
Fixed Asset Impairments	-300	0	0	0
Depreciation	-10,854	-2,713	-2,713	0
Interest Receivable/ Payable	65	16	18	2
Interest Payable on Loans & Leases	-265	-71	-53	18
PDC Dividend	-5,566	-1,391	-1,391	0
Taxation Payable	0	0	0	0
NET SURPLUS/ DEFICIT	**2,426**	**-59**	**182**	**241**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 31 July 2013

Efficiency Programme Update

Action requested/recommendation

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

Summary

This report provides a detailed overview of progress to date regarding delivery of the Trust's Efficiency Programme. Delivery in June has sustained, however the Monitor variance remains significantly behind plan by (£1.9m). There is also a planning shortfall of (£2.0m) 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

No reference to 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	July 2013
Version number	V.1

Board of Directors – 31 July 2013

Efficiency Position Update at June 2013

1. Executive Summary

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

In period 3 we have achieved £6,662k in full year terms.

In June 2013 we are behind the Trust plan to Monitor by **(£1,890k)**.

Table 1 below provides a high level summary of progress.

Table 1 – Executive Summary – June 2013	Total
	£'000
In year target	
In year target	**23,363**
In year delivery	
Delivery - recurrent	2,490
Delivery – non-recurrent	4,172
Total delivery	**6,662**
Delivery (gap)/ Over achievement	**(16,701)**
In year planning	
Further in year plans	**14,671**
In year planning (gap)/surplus	**(2,030)**
Part year Monitor position	**(1,890)**
Future planning	
4 year target	71,464
4 year plans total	56,742
4 year planning (gap)/surplus	**(14,722)**

2. Introduction and background

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

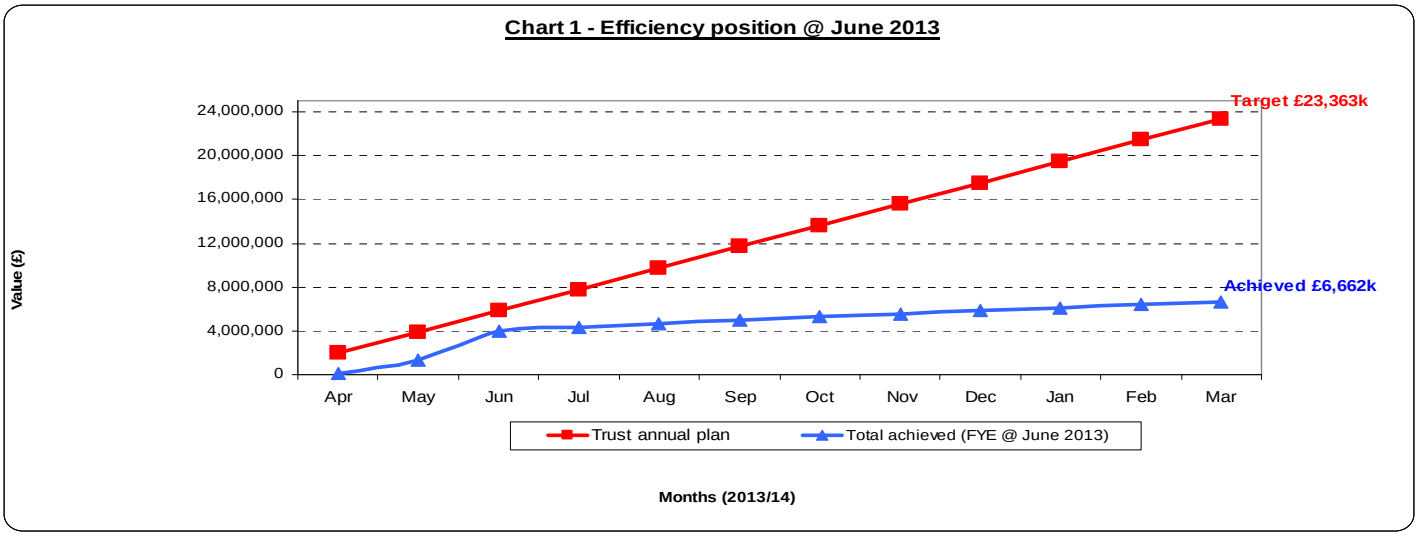
3. Efficiency position report

This report covers the period of 3 months to June 2013.

3.1 Trust plan to Monitor

The combined position is **(£1,890k)** behind the trust plan to Monitor as at June 2013; see Table 2 and Chart 1 below.

Table 2	YTD May	June 2013	**Total YTD**
		£,000	**£,000**
Trust plan	**3,894**	1,947	**5,841**
Achieved	**1,356**	2,594	**3,950**
Variance	**(2,538)**	**647**	**(1,890)**



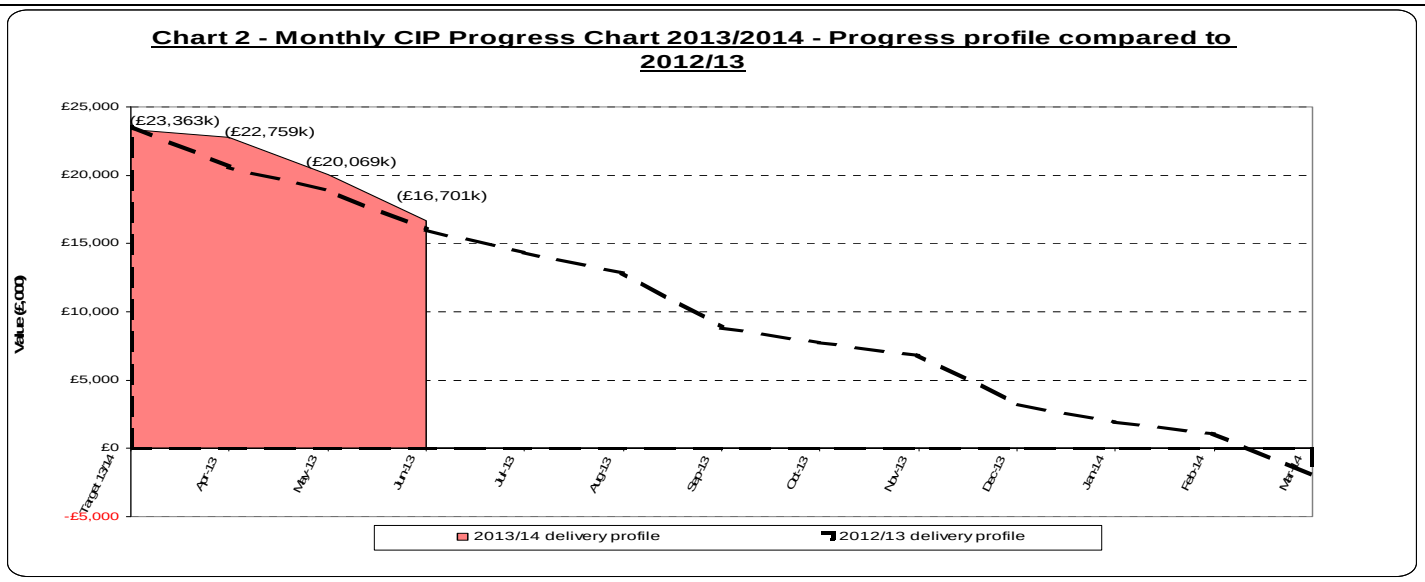
3.2 Full year position summary

As at June 2013, £6,662k has been achieved in full year terms against the plan of £23,363k (see Table 3 below). This is made up of £2,490k of recurrent and £4,172k non-recurrent schemes.

Table 3	**May 2013**	**June 2013**	**Change**
	£,000	**£,000**	**£,000**
Expenditure plan – 13/14	23,363	23,363	0
Target – 2013/14	**23,363**	**23,363**	**0**
Achieved - recurrently	1,667	2,490	823
Achieved - non-recurrently	1,627	4,172	2,545
Total achieved	**3,294**	**6,662**	**3,368**
Gap to achieve	**(20,069)**	**(16,701)**	**3,368**
Further plans	17,859	14,671	(3,188)
(Gap)/Surplus in plans	**(2,210)**	**(2,030)**	**180**

3.3 Delivery profile and further plans

The current full year deficit is £ (16,701k). Savings achieved by month are shown in Chart 2 below. The broken line shows delivery in 2012/13 which has been added for information.



Further plans have been formulated amounting to £14,671k. These are summarised in Table 4 below.

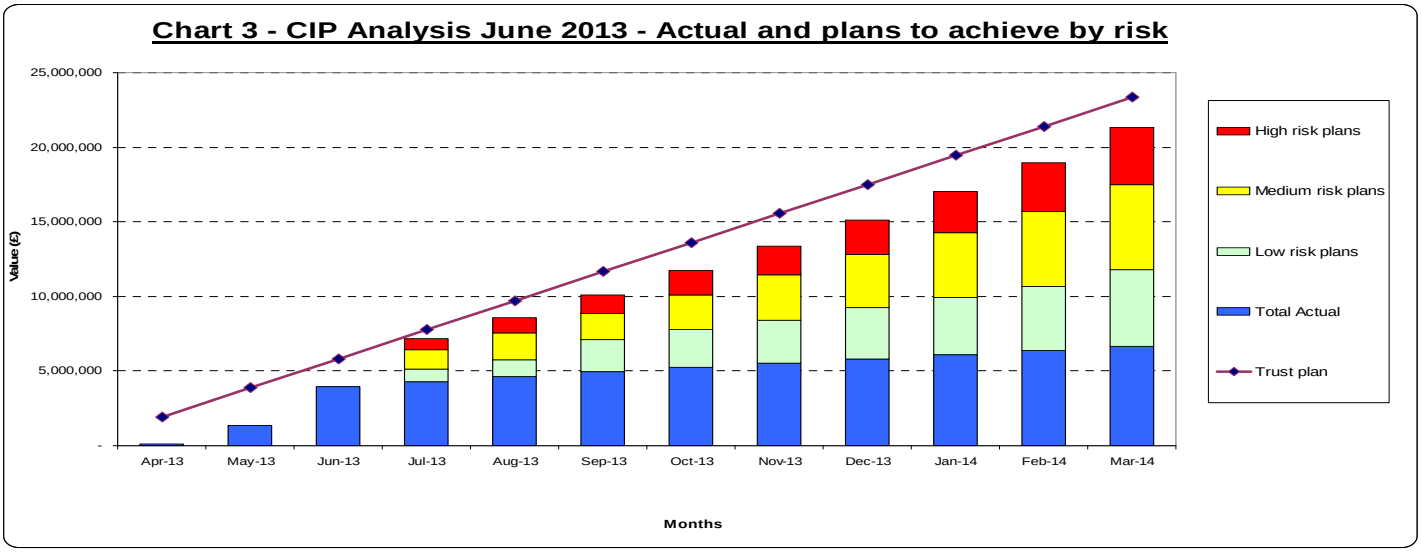
Table 4 – Further plans 2012/13

Risk	Gap Full Year	Plans - Recurrent	Plans - Non Recurrent	**Plans Total**	Shortfall in plans
	£'000	**£'000**	**£'000**	**£'000**	**£'000**
Low		4,212	936	**5,148**	
Medium		5,423	269	**5,692**	
High		3,993	-163	**3,830**	
Total	**(16,701)**	**13,628**	**1,042**	**14,671**	**(2,030)**

3.4 Risk profile of further plans and forecast risk to delivery

Directorate plans are each assigned a risk rating.

The overall June 2013 position is summarised in Chart 3 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 is continually carried out to re-assess, remove or re-profile plans to ensure an up to date position.

3.5 Four year plans

Directorates are required to develop four year plans and Table 5 below summarises this position. There is currently a shortfall of (£14,722k) 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 5 - 4 Year efficiency plan summary – June 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	21,333	19,071	7,549	8,789	**56,742**
Variance	**(2,030)**	**2,707**	**(8,320)**	**(7,079)**	**(14,722)**

3.6 Risk position

In year delivery is behind the same point last year with £6,662k (28%) delivered in June 2013 against £7,645k (32%) in June 2012.

4. Conclusion

Delivery in June 2013 has been sustained with £6,662k (28%) of full year schemes being delivered against the Trust plan of £23,361k; this compares with £7,645k (32%) in June 2012. This progress is significantly behind our Monitor profile by (£1,890k) in month 3.

We currently have a planning deficit in year of (£2,030k), which is an improvement of £180k from the May position.

The 4 year planning position highlights a shortfall in base plans of (£14,722k), this is high risk.

5. Recommendation

The Board is asked to note the June 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	**July 2013**

G3

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 31 July 2013

Corporate Dashboard

Action requested/recommendation

The Board is asked to note the report.

Summary

NB – 18 week data are still being validated and a verbal update will be given to the Board. The Corporate dashboards on Signal will be updated when the data is submitted to the DH.
It is anticipated that:

- *All 3 targets will be met at aggregate level*
- *We may report 1 incomplete pathway greater than 52 weeks*

In terms of performance, the following targets were not achieved by the Trust:

First to follow up ratios – target 1:1.5 : Combined achieved 2.06

31 day Cancer - Subsequent Treatment Surgery – target 94%: Combined performance 93.75%. This relates to 4 urology patients on the York site. Cancer targets are monitored on a quarterly basis and it is anticipated that the target will be met for Q1.

Ambulance handovers greater than 30 mins – target 0: Combined position 192. York 98, Scarborough 94.

CDiff : yearly target 43, quarter target 11: Combined site position 21. York site 16. It is now clear that the Trust will breach the Q2 threshold also.

The following national CQUINs have been RAG rated Red

[some based in project plans rather than data thus reflected in the scorecards]

Pressure Ulcers: Very challenging nationally set trajectory which needs to be hit by Sept 2013 and maintained through Q3 & 4.

VTE Risk Assessment - target 95% & VTE Route Cause Analysis – target 95% by Q4: Investment is needed to achieve the second element of this indicator.

The following local CQUINs have been RAG rated Red

[some based in project plans rather than data thus reflected in the scorecards]

Consultant Post-take ward round in 12 hrs – target 80%: York performance currently 68.99%. 80% target is to be met at both sites by Q4.

% Patients with PAR/NEWs who have observations in 1hr of prescribed time – target month on month improvement: data for York site only at present until CPD IP roll out at Scarborough. Scarborough site will be assessed from Q3 only.

% patients with PAR/NEWS score trip with escalation in 15 mins: data for York site only at present until CPD IP roll out at Scarborough. Scarborough site will be assessed from Q3 only.

Reduction in elderly LoS York Hospital – target 9 days in Q4

Reduction in elderly LoS Scarborough Hospital – target 9.65 days in Q4

Reduction in elderly LoS WXC & SH – target 50 days in Q4

Nursing Risk Assessments on Discharge – target 80% by Q4: No defined forum for managing this CQUIN identified and project plan for delivery still in development.

Stroke Level 2 Accreditation at Scarborough Hospital: Indicator split into 2 elements. End Q" report to be submitted detailing progress on accreditation. Level 2 accreditation to be achieved by end Q4.

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

No reference to CQC outcomes.

Progress of report	This report is only produced for the Executive Board and Board of Directors.
Risk	No risk.
Resource implications	No resource implications.
Owner	Michael Proctor, Deputy Chief Executive
Author	Lucy Turner, Deputy Director of Performance
Date of paper	11 July 2013
Version number	Version 1

Targets - YTHFT & SNEY

18 Weeks (Acute and Community) and Access Targets

Metric	Target	Status	Sparkline	May-13	Jun-13
18 Week Admitted (M C)	90%	Green		90.33%	
18 Week Non-Admitted (M C)	95%	Green		95.07%	
18 Week Total Backlog (M C)	92%	Green		92.01%	
Number of Incomplete RTT pathways greater than 52 weeks (M C)	0	Red		3	
18 Week Audiology (C)	95%	Green		100%	99.87%
Diagnostics - 6 Week Wait (C)	99%	Green		99.27%	99.02%
Outpatient Clinics - First to Follow Up Ratio (YTD) (C)	1.5	Red		2.07	2.06

Cancer

Metric	Target	Status	Sparkline	May-13	Jun-13
14 Day Fast Track (M C)	93%	Green		94.92%	
14 Day Breast Symptomatic (M C)	93%	Green		96.67%	
31 Day 1st Treatment - Cancer (M C)	96%	Green		99.46%	
31 Day Subsequent Treatment - Anti Cancer Drug (M C)	98%	Green		100%	
31 Day Subsequent Treatment - Surgery (M C)	94%	Red		93.75%	
62 Day Cancer (M C)	85%	Green		95.89%	
62 Day Cancer - Screening (M C)	90%	Green		100%	

Emergency Department (Type 1 and Type 3)

Metric	Target	Status	Sparkline	May-13	Jun-13
ED 4 Hour Target - All Types (M)	95%	Green		97.2%	96.79%
ED 4 Hour Target - Type 1 Only	95%	Green		96.35%	95.56%
Number of 12 Hour Trolley Waits	0	Green		0	0
Number of Ambulances with handover greater than 30 mins	0	Red		192	192

Infection Prevention and Control

Metric	Target	Status	Sparkline	May-13	Jun-13
MRSA Bacteraemia >48hrs (YTD) (C)	3	Green		0	0
CDIFF >72hrs (YTD) (M C)	11	Red		12	21
MSSA >48hrs (YTD) (C)				5	10
E-Coli >48hrs (YTD) (C)				11	17

Inpatient

Metric	Target	Status	Sparkline	May-13	Jun-13
Elective Operations Cancelled On The Day For Non-Clinical Reasons Not Readmitted within 28 days (C)	0	Green		0	0
Number of Urgent Elective Operations cancelled for a 2nd time (C)	0	Green		0	0
Breaches of Mixed Sex Accommodation (M C)	0	Green		0	0

Care Quality Indicators (CQUINS)

Metric	Target	Status	Sparkline	May-13	Jun-13
Acute - VTE Risk Assessment (M C)	95%	Green		94.97%	95%
Safety Thermometer - Pressure Ulcers - Acute	2.9%	Red		5.48%	4.63%
Safety Thermometer - Pressure Ulcers - Community	3.95%	Red		9.83%	9.83%
Dementia case finding question asked	90%	Green		93.1%	95.6%
Dementia inpatients with completed diagnostic assessment	90%	Green		100%	100%
Dementia inpatients who have had a diagnostic assessment referred for further diagnostic advice or follow up	90%	Green		96.7%	100%
Admissions through AMU will be reviewed within 4 hours of admission	80%	Green		81.5%	85.4%
Patients admitted through AMU to have a Consultant post take ward round consultation within 12 hours of arrival	80%	Red		67.69%	68.99%
Percentage of patients who have observations recorded producing PAR or NEWS score within 1 hour of prescribed time.	67.27%	Red		67.27%	66.66%
Percentage of patients with PAR/NEWS score trip with escalation of care within 15 minutes to appropriate clinician	70.84%	Red		70.84%	70.41%
Friends and Family Test - Increased Response Rate	15%	Green		6.18%	19.81%

Targets - YTHFT

18 Weeks (Acute and Community) and Access Targets

Metric	Target	Status	Sparkline	May-13	Jun-13
18 Week Admitted (M C)	90%	Green		91.62%	
18 Week Non-Admitted (M C)	95%	Green		96.34%	
18 Week Total Backlog (M C)	92%	Green		93.3%	
Number of Incomplete RTT pathways greater than 52 weeks (M C)	0	Red		1	
18 Week Audiology (C)	95%	Green		100%	99.87%
Diagnostics - 6 Week Wait (C)	99%	Green		99.34%	99%

Cancer

Metric	Target	Status	Sparkline	May-13	Jun-13
14 Day Fast Track (M C)	93%	Green		94.34%	
14 Day Breast Symptomatic (M C)	93%	Green		96.12%	
31 Day 1st Treatment - Cancer (M C)	96%	Green		99.26%	
31 Day Subsequent Treatment - Anti Cancer Drug (M C)	98%	Green		100%	
31 Day Subsequent Treatment - Surgery (M C)	94%	Red		92%	

Emergency Department (Type 1 and Type 3)

Metric	Target	Status	Sparkline	May-13	Jun-13
ED 4 Hour Target - All Types (M)	95%	Green		97.5%	96.56%
ED 4 Hour Target - Type 1 Only	95%	Green		96.92%	95.69%
Number of 12 Hour Trolley Waits	0	Green		0	0
Number of Ambulances with handover greater than 30 mins	0	Red		69	98

Infection Prevention and Control

Metric	Target	Status	Sparkline	May-13	Jun-13
MRSA Bacteraemia >48hrs (YTD) (C)	2	Green		0	0
CDIFF >72hrs (YTD) (M C)	7	Red		9	16
CDIFF >72hrs Monthly	2.2	Red		3	7
MSSA >48hrs (YTD) (C)				4	8
E-Coli >48hrs (YTD) (C)				9	14

Inpatient

Metric	Target	Status	Sparkline	May-13	Jun-13
Elective Operations Cancelled On The Day For Non-Clinical Reasons Not Readmitted within 28 days (C)	0	Green		0	0
Number of Urgent Elective Operations cancelled for a 2nd time (C)	0	Green		0	0
Breaches of Mixed Sex Accommodation (M C)	0	Green		0	0

Care Quality Indicators (CQUINS)

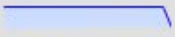
Metric	Target	Status	Sparkline	May-13	Jun-13
Acute - VTE Risk Assessment (M C)	95%	Red		94.58%	94.21%
Dementia case finding question asked	90%	Green		92.36%	93.64%
Dementia inpatients with completed diagnostic assessment	90%	Green		100%	100%
Dementia inpatients who have had a diagnostic assessment referred for further diagnostic advice or follow up	90%	Green		100%	100%
Acute Admissions seen by decision making clinician within 4 hours of admission - Acute Medical Unit (AMU)	80%	Green		81.5%	85.4%
Reduction in Average Length of Stay in York Hospital Elderly Bed Base (Days)	9	Red		9.76	9.23
Reduction in Average Length of Stay in Elderly Bed Base WXC and St Helens (Days)	50	Red		51.1	53.9
Improved utilisation of the Elderly Bed Base in Community Hospitals	85%	Green		91.11%	92.63%

Targets - SNEY

18 Weeks (Acute and Community) and Access Targets

Metric	Target	Status	Sparkline	May-13	Jun-13
18 Week Admitted (M C)	90%	Red		87.74%	
18 Week Non-Admitted (M C)	95%	Red		93.18%	
18 Week Total Backlog (M C)	92%	Red		89.86%	
Number of Incomplete RTT pathways greater than 52 weeks	0	Red		2	
Diagnostics - 6 Week Wait (C)	99%	Green		99.19%	99.2%

Cancer

Metric	Target	Status	Sparkline	May-13	Jun-13
14 Day Fast Track (M C)	93%	Green		96.92%	
14 Day Breast Symptomatic (M C)	93%	Green		98.04%	
31 Day 1st Treatment - Cancer (M C)	96%	Green		100%	
31 Day Subsequent Treatment - Anti Cancer Drug (M C)	98%	Green		100%	
31 Day Subsequent Treatment - Surgery (M C)	94%	Green		100%	

Emergency Department (Type 1 and Type 3)

Metric	Target	Status	Sparkline	May-13	Jun-13
ED 4 Hour Target - All Types (M)	95%	Green		96.73%	97.11%
ED 4 Hour Target - Type 1 Only	95%	Green		95.35%	95.33%
Number of 12 Hour Trolley Waits	0	Green		0	0
Number of Ambulances with handover greater than 30 mins	0	Red		123	94

Infection Prevention and Control

Metric	Target	Status	Sparkline	May-13	Jun-13
MRSA Bacteraemia >48hrs (YTD) (C)	1	Green		0	0
CDIFF >72hrs (YTD) (M C)	4	Red		3	5
CDIFF >72hrs Monthly	1.5	Red		2	2
MSSA >48hrs (YTD) (C)				1	2
E-Coli >48hrs (YTD) (C)				2	3

Inpatient

Metric	Target	Status	Sparkline	May-13	Jun-13
Elective Operations Cancelled On The Day For Non-Clinical Reasons Not Readmitted within 28 days (C)	0	Green		0	0
Number of Urgent Elective Operations cancelled for a 2nd time (C)	0	Green		0	0
Breaches of Mixed Sex Accommodation (M C)	0	Green		0	0

Care Quality Indicators (CQUINS)

Metric	Target	Status	Sparkline	May-13	Jun-13
Acute - VTE Risk Assessment (M C)	95%	Green		95.77%	96.55%
Dementia case finding question asked	90%	Green		94.25%	98.39%
Dementia inpatients with completed diagnostic assessment	90%	Green		92.5%	98.11%
Dementia inpatients who have had a diagnostic assessment referred for further diagnostic advice or follow up	90%	Green		100%	100%
Reduction in Average Length of Stay in Scarborough Hospital Elderly Bed Base (Days)	9.65	Red		10.72	9.8

Targets - Community

Community Infection Control

Metric	Target	Status	Sparkline	May-13	Jun-13
MRSA Bacteraemia >48hrs (YTD) (M C)				0	0
MSSA >48hrs (YTD) (C)				0	0
CDIFF >72hrs (YTD) (M C)				1	2
E-Coli >48hrs (YTD) (C)				0	0

Community Inpatient

Metric	Target	Status	Sparkline	May-13	Jun-13
Admissions - Ordinary				191	191
Admissions - Day				544	497
Average Length of Stay (Days) - Archways				20.8	26.3
Average Length of Stay (Days) - Bridlington				20.6	14.9
Average Length of Stay (Days) - Malton				24.1	19.1
Average Length of Stay (Days) - St Monicas				15.2	30.4
Average Length of Stay (Days) - Selby War Memorial Hospital				29.1	22.5
Average Length of Stay (Days) - Whitby				20.5	15.9

Community Outpatient

Metric	Target	Status	Sparkline	May-13	Jun-13
Outpatient Attendances - First				2549	2848
Outpatient Attendances - Subsequent				5171	5481
Outpatient Attendances - Total				7720	8329
Outpatient DNA Rate				7.67%	8.25%

Community Referrals

Metric	Target	Status	Sparkline	May-13	Jun-13
GP Referral				321	307
Self Referral				43	52
Social Services				14	10
York Hospital / Scarborough Acute Services				115	124
Community Hospital				16	8
Other				190	165
Rejected				0	0

Monthly Data on ambulance handover times from YAS

TRUST TOTALS									
Potential Cost			£166,800	£261,000	£21,000	£448,800			
Month	Handover time not recorded	Handover under 30 Minutes	Handover between 30 & 60 Minutes	Handover Between 1 and 2 Hours	Handover Greater than 2 Hours	Trust Total of Ambulance Handovers	**Trust total: handover >30m**	Proportion of handovers > 30 mins	Percentage of handovers with a time recorded
Mar-13	0	1775	239	126	20	2160	**385**	17.8%	
Apr-13	809	2259	269	77	1	3415	**347**	10.2%	76.3%
May-13	457	2597	162	30	0	3246	**192**	5.9%	85.9%
Jun-13	499	2643	164	28	0	3334	**192**	5.8%	85.0%
Jul-13						0	**0**		
Aug-13						0	**0**		
Sep-13						0	**0**		
Oct-13						0	**0**		
Nov-13						0	**0**		
Dec-13						0	**0**		
Jan-14						0	**0**		
Feb-14						0	**0**		
Mar-14						0	**0**		

YORK A&E							
Potential Cost			£88,600	£134,000	£9,000	**£231,600**	
Month	Handover time not recorded	Handover under 30 Minutes	Handover between 30 & 60 Minutes	Handover Between 1 and 2 Hours	Handover Greater than 2 Hours	**York total: handover >30m**	**York, % over 30 min**
Mar-13		790	134	66	8	**208**	**20.8%**
Apr-13	426	1274	173	37	1	**211**	**11.0%**
May-13	226	1522	60	9	0	**69**	**3.8%**
Jun-13	220	1516	76	22	0	**98**	**5.3%**
Jul-13						**0**	
Aug-13						**0**	
Sep-13						**0**	
Oct-13						**0**	
Nov-13						**0**	
Dec-13						**0**	
Jan-14						**0**	
Feb-14						**0**	
Mar-14						**0**	

SCARBOROUGH A&E							
Potential Cost			£78,200	£127,000	£12,000	**£217,200**	
Month	Handover time not recorded	Handover under 30 Minutes	Handover between 30 & 60 Minutes	Handover Between 1 and 2 Hours	Handover Greater than 2 Hours	**SGH total: handover >30m**	**SGH, % over 30 min**
Mar-13		985	105	60	12	**177**	**15.2%**
Apr-13	383	985	96	40	0	**136**	**9.0%**
May-13	231	1075	102	21	0	**123**	**8.6%**
Jun-13	279	1127	88	6	0	**94**	**6.3%**
Jul-13						**0**	
Aug-13						**0**	
Sep-13						**0**	
Oct-13						**0**	
Nov-13						**0**	
Dec-13						**0**	
Jan-14						**0**	
Feb-14						**0**	
Mar-14						**0**	

From 'Everyone Counts 2013/14 p21:

Target: To help support the integration of services at the point a patient arrives at an A&E Department in an ambulance, we are setting the expectation that:

- all handovers between an ambulance and A&E Department must take place within 15 minutes and crews should be ready to accept new calls within a further 15 minutes; with
- a contractual fine for all delays over 30 minutes, in both situations, and a further fine for delays over an hour, in both situations.

Application of the financial penalty will not be imposed until Q3*.

Target: Recording of compliance with patient handover arrangements in A&E Q1 85%, Q2 90%, Q3 95%. On-going compliance of 95% will be expected.

Application of this penalty of £5 per patient not recorded will commence from Q3 onwards*

Data Definition:
The number of handover delays of longer than 30 minutes & over one hour.
Clock start - arrival to handover performance (acute trusts):
When an ambulance wheels stop in the patient offloading bay (handbrake applied and 'Red at Hospital' button is pressed on the MDT)
Clock stop - Patient Handover / Trolley Clear performance (acute trusts):
The time at which clinical handover has been fully completed and the patient has been physically transferred onto hospital apparatus. Ambulance apparatus must have been returned, enabling the ambulance crew to leave the department.

With regard to York Trust these fines will be set aside to be invested solely at the Provider to enable handover targets to be met. Investment plans will be agreed between the commissioner and the provider, with consideration of the impact of other providers on the achievement of the target. Sums not required to be invested to improve handover efficiency will be invested **in full in the Trust in accordance with this contract.*

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 31 July 2013

Initial Impact of the NHS 111 Telephone Triage Service

Action requested/recommendation

The Board is asked to note the report.

Summary

NHS 111 was launched in its entirety within North Yorkshire on Tuesday 2nd July 2013. The number had previously been in use to a degree but the official launch had been postponed twice. NHS 111 will replace NHS Direct in its entirety as the new system is rolled out.

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	This report has only been written for the Board.
Risk	No risk.
Resource implications	There are no resources implications.
Owner	Michael Proctor, Deputy Chief Executive
Author	Wendy Quinn, Directorate Manager for York ED
Date of paper	July 2013

Version number	Version 1

Board of Directors – 31 July 2013

Initial Impact of the NHS 111 Telephone Triage Service

1. Introduction and background

NHS 111 was launched in its entirety within North Yorkshire on Tuesday 2nd July 2013. The number had previously been in use to a degree but the official launch had been postponed twice. NHS 111 will replace NHS Direct in its entirety as the new system is rolled out.

Yorkshire Ambulance Service (YAS) is the provider of NHS 111 in Yorkshire, the Humber, Bassetlaw, North Lincolnshire and North East Lincolnshire and the West Yorkshire Urgent Care service in partnership with Local Care Direct (LCD).

York Teaching Hospital NHS Foundation Trust has a range of services profiled on the Directory of Service (DoS) including Emergency Departments, Minor Injury Units, Urgent Care Centre (UCC) and Community Services, all of which are profiled to receive referrals from the NHS 111 services. The Dos is currently under review with representatives from the CCG and some alterations have been requested to both the UCC DoS and the York / Scarborough DoS. Feedback is still awaited on those requests.

Each DoS is protocol driven and there are many levels of referral contained within each one. Most of the ED referrals have protocols for referral prior to ED which, in many cases, is the referral place of choice when no other referral is deemed appropriate. A significant learning curve is anticipated in the early days for the call handlers with a projected rise in ED attendances from early implementation. Assurance is given that this should not be the norm going forward and that the benefit of NHS 111 will be to ensure appropriate places of referral for users of the service. This remains to be seen and will be formally evaluated at some point in the future by YAS.

In order to address early concerns there is a daily Sitrep call number which can be accessed by all providers if required or an e mail contact which can be used to report concerns 24/7. In addition there is a 'Scarborough/Ryedale and Vale of York Clinical Governance and Quality Assurance Group' which meets, either face to face or via a conference call, each month.

2. Early Findings for York ED

Week commencing	Attendances	NHS111 Referrals	% which are NHS111	Comments
22-Apr-13	1684	2	0.1%	
29-Apr-13	1681	8	0.5%	
06-May-13	1667	22	1.3%	
13-May-13	1601	20	1.2%	
20-May-13	1595	16	1.0%	
27-May-13	1665	32	1.9%	
03-Jun-13	1672	19	1.1%	
10-Jun-13	1678	10	0.6%	
17-Jun-13	1590	13	0.8%	

24-Jun-13	1631	18	1.1%	
01-Jul-13	1701	49	2.9%	
08-Jul-13	968	24	2.5%	Mon – Thurs only

As can be seen from the table, although the numbers are small, there is early evidence of a week on week increase in referrals sent to ED.

YAS information showed that GP OOH saw a marked reduction in the number of GP OOH attendances in the first week following launch of the service;

Scarborough ED – 30% reduction in GP OOH referrals
York ED – 70% reduction in GP OOH referrals.

(10-07-13)

It is currently too early to be able to ascertain any long term effect that NHS 111 has had on the number of attendances to ED. Figures for York, however, suggest that there has been a steady increase in the number of attendances and number of ambulance arrivals over the last 4 weeks up to and including W/C 8th July 2013 (see table below). Whether this is coincidental or related to the NHS 111 launch, is currently unknown.

W/C date	Number of attendances	Number of breaches to 4 hour standard	Number of ambulance arrivals To ED	Comments
17th June 2013	1627	54	370	
24th June 2013	1664	83	418	
1st July 2013	1726	58	502	Launch of NHS 111 (2nd July)
8th July 2013	1755	98	478	

As part of a national specification, NHS 111 is required to provide information to a patient's GP on their contact with the service. This is known as a post event message (PEM) and whenever NHS 111 performs an assessment via NHS Pathways, and when appropriate, a PEM will be sent to the patient's GP surgery.

GP OOH for York has put on extra reception staff to deal with an anticipated rise in the number of calls taken from NHS 111 patient referrals. Staff running this service are part of the Governance and QA Group and will report on their call patterns and attendances there.

The Yorkshire Ambulance Service will work with us to investigate concerns and issues about NHS 111 where patient care is delivered across a number of organisations. In relation to person-identifiable data, this will only be shared between the NHS 111 service and partner organisations to facilitate the appropriate investigation, management and resolution of incidents and complaints. Wherever possible, records will be anonymised/de-identified following the Caldicott Principles at all times.

It is assumed that similar trends to those from the 4 pilot sites for NHS 111 will be found following the launch of NHS 111 on 2nd July 2013 within North Yorkshire. The 4 pilot sites for NHS 111 measured the impact on the emergency and urgent care systems and the following results were obtained.

- There was no evidence that NHS 111 changed perceptions of urgent care for recent users of emergency and urgent care (based on perceptions of 2237 recent users of emergency and urgent care).
- The population surveys showed no change in satisfaction with urgent care or the NHS following the introduction of NHS 111 (based on perceptions of 28,071 members of the general population).
- The population surveys showed a high level of awareness about the new service in two pilot sites (>70% of the population had heard of NHS 111) with much lower awareness in the other two sites (<50 % of the population had heard of NHS 111)
- Impact on the emergency and urgent care system was assessed by measuring monthly activity for five key services: For all sites combined, there was no statistically significant change in emergency ambulance calls, emergency department attendances or urgent care contacts/attendances. However there was a statistically significant reduction in calls to NHS Direct of 193 calls per 1000.
- There was an increase in emergency ambulance service incidents of 29 additional incidents per 1000 NHS 111 triaged calls per month.
- For individual sites, there was a statistically significant reduction in calls to NHS Direct in three sites, a reduction in urgent care contacts/attendances in one site, a reduction in ambulance calls in one site and increase in one site and an increase in emergency ambulance service incidents in one site.

Whilst it is expected that the results of the 4 pilot sites will be replicated across North Yorkshire with the launch of NHS 111 there is insufficient evidence currently to endorse this.

3. Actions within YTH NHS FT

1. Daily data collection in ED to identify:

   a. Number of calls from NHS 111 referrals
   b. Number of attendances at reception redirected to another part of the system
   c. Outcome of reception redirection (e.g. to GP, GPOOH service or HNS111 as appropriate.)
   d. Identification for ambulance arrivals if the source of referral is 111 prior to ambulance despatch.

2. Daily sitrep reporting if necessary

3. Daily reporting via governance e mail helpline if necessary.

4. Monthly attendance at NHS 111 Governance and Quality Assurance Meetings / Calls

5. Review of ED and UCC DoS with Rebecca Bowen

4. Recommendation

The Board is asked to note the report.

Author	**Wendy Quinn, Directorate Manager for York ED**
Owner	**Michael Proctor, Deputy Chief Executive**
Date	**July 2013**

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 31 July 2013

Chairman's Report

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

Any strategy development the Board may undertake considers the implications of equality and development.

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	There are no risks.
Resource implications	There are no resource implications.
Owner	Alan Rose, Chairman
Author	Alan Rose, Chairman
Date of paper	July 2013
Version number	Version 1

Board of Directors – 31 July 2013

Chairman's Report

1. Strategy and Context

The national media coverage of the NHS continues apace – if anything, the last month or so has been greater than usual – with a predominantly critical tone. The Keogh Reviews are combining with proposals for a refreshed hospital inspection regime, which will impact us. The Liverpool Care Pathway, which our Trust has worked hard to properly implement and adapt to our enlarged responsibilities, has received a bashing, despite the essentially appropriate key principles involved – no doubt we will need to react to renewed proposals. 111 is receiving poor reviews, but in North Yorkshire the "soft go" (since the beginning of July, but with minimal publicity) is actually progressing satisfactorily. FYI, there were 1,500 calls in the VoY CCG area, and 450 calls in the Scarborough & Ryedale CCG area, in the first two weeks. The analysis indicates that referrals to the OOH services have dropped by 30%, but there is some uplift in Emergency Department demand – but this has been blurred by the "heatwave" effect.

At the strategic level, NHS England is gradually beginning to flex its untested muscles. We should expect the imposition of "top-slices" on the future CCG allocations, which will inevitably impact our acute income in the years ahead. Some of this will be aimed at driving integration with social services. A recent development in York will hopefully assist in making this work positively -- the appointment of our Director of Public Health to also head Adult Social Services for the City. He clearly understands that all stakeholders in the local health and social care economy should not be destabilised by sudden changes, but the trajectory here is becoming clearer. We must continue to support and help drive the pilots and changes required to make this work for the benefit of our patients and strengthening of the chain that links the CCG/Acute/Community Services/Social Services.

Nationally, the imperatives that drive further mergers and acquisition activity across the Trusts is continuing, despite the ambiguities and confusions surrounding the competition and collaboration policies of Monitor and the OFT; in London, almost every Trust is now involved in some such changes, as the entire sector reconfigures into 3-4 major clusters of integrated provision. I believe it is inevitable that we will see further examples of this, whether through alliancing or corporately, in the Yorkshire/Humber region. As always, a smart of combination of medium-term strategy and opportunism will be required if we are to remain a successful and sustainable part of the Service.

2. Governance, Governors and Community

As has been advised, and as fits quite well with our "one year on" listening exercise/review of our progress following the acquisition, we will welcome some increased interaction with Monitor later this Summer and in the Autumn. This will focus on our governance of Quality and Safety issues, but in practice represents a more holistic appraisal of the way we are progressing as Trust, following the significant development of our responsibilities in the last year or two. I feel the continuing evolution of our governance processes will stand up well to scrutiny and I am pleased that we never rest in trying to make them more effective.

Meanwhile, the regulatory and scrutiny machines continue to evolve and we will have to adapt to each of these. As mentioned, the Care Quality Commission (CQC) is redesigning its hospital

inspection processes. We have had introductory meetings with the three new local new HealthWatch organisations and look forward to a positive and co-operative relationship with them. Kay Gamble, our PPI lead, will be our main conduit to them. Several of our Governors will be in active liaison with our local HealthWatches, which I think is a positive development. Regulatory and other pressures are causing continued changes at nearby Trusts, such as Leeds (LTHT) and North Lincs. (NLAG) – the latter being in a soft form of "special measures" following the Keogh Review into Hospital mortality.

"Openness" is becoming an increasingly touted mantra, and we are seeing this all around us; take a look at the Patient Choices website – a range of our consultants now have their data on activity, types of procedures, mortality and more listed in absolute and comparative detail; the volume and form of this available data will grow exponentially in the coming years – and the public are increasingly being encouraged to seek it out – warts and all! Our refreshed wave of Open Events, tailored to individual sites, is in progress, with generally good response and feedback. The new website is now live, with positive reviews, and now increasingly contains links to specialty-level micro-sites, related reports, videos, etc.. Congratulations to the Comms team and all the contributors.

The Friends of York Hospital (FoYH) recently celebrated its 60th anniversary at a special event at the Bishopthorpe Palace, with Archbishop Sentamu endorsing their (and our) good works – they continue to be a major complement to our Teaching Hospital charitable fundraising and subsequent expenditure. We met recently with the Friends of Bridlington Hospital – a smaller group, but one which equally is committed to supporting the emerging new investments and development at that site.

The Board and Trust will be saying thank you to our Chief Nurse, Libby McManus, this month, as she departs after some ten years in York to a new and exciting appointment as Chief Nurse at the Chelsea & Westminster Hospital in London (one of the ones likely to expand through acquisition, as mentioned above). Thank you, Libby, for what your have given to the Service in your time with us and the contributions you have made to our Director team, nursing workforce, our patients and the Trust as a whole. The very best for success in your new role.

3. Recommendation

The Board of Directors is asked to note the report.

Author	**Alan Rose, Chairman**
Owner	**Alan Rose, Chairman**
Date	**July 2013**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 31 July 2013

Chief Executive Report

Action requested/recommendation

The Board is asked to note the report.

Summary

This report is designed to provide a summary of the operational issues the Chief Executive would like to draw to the attention of the Board of Directors.

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

Implications for equality and diversity

None directly identified at this stage.

Reference to CQC outcomes

No reference to CQC outcomes.

Progress of report	Prepared for presentation to the Board of Directors meeting.
Risk	There are no specific risks for escalation.
Resource implications	There are no resource implications.
Owner	Patrick Crowley, Chief Executive
Author	Patrick Crowley, Chief Executive
Date of paper	July 2013
Version number	Version 1

Board of Directors – 31 July 2013

Chief Executive Report

1. Introduction

As we approach the summer period I am once again struck by the changing nature of our business with no reduction in pressure on our clinical services in what has previously been our "quiet" season. Without doubt the complexity that we are dealing with continues to make huge demands on us all and the appropriate but intense scrutiny on the hospital sector following Francis, Keogh and Richards, in addition to our own increasing level of expectation, only serves to compound this. One to watch.

I attended the Health & Well Being Board in York earlier this month and would like to thank Bev Geary, Deputy Chief Nurse, for leading a presentation to the Board on the health systems response to the Francis report. This was well received and demonstrated the open and transparent manner in which we as an organisation choose to work. The Board also received two presentations by Carers that supported the Boards consideration as to whether it would endorse and sign up to both the City of York Charter for Disabled Children 2013-16 and the York Carers Charter. This was duly agreed and I have attached both documents for your information and our collective consideration in due course.

You will by now be aware that Libby McManus, Chief Nurse, has decided to take an opportunity at the Chelsea and Westminster Hospital Foundation Trust and I would like to put on my record my thanks to Libby for her leadership, hard work and commitment to developing our services here in York over the last ten years. I am sure she will prove a great success in her new role and wish her all the best for the future.

1. Improve Quality and Safety

1a. Implementing CPD in Scarborough and Community Hospitals

During the preparatory phase prior to the acquisition of Scarborough, Hospital Board members will recall receiving a report presented by CSC, the NPFIT local service provider that confirmed the resilience, functionality and scalability of the core patient database (CPD) in York. CSC recommended its deployment across the enlarged organisation to support the delivery of the electronic patient record that is the keystone of our IT strategy. Over the past 10 months our System and Network Services (SNS) team, under Sue Rushbrook's leadership, has been rolling out the electronic patient record starting back in September with the implementation of Case Note Library and the Cancer module. In January the outpatient module was deployed that was shortly followed by the Emergency Department.

Importantly, on the 21st July the inpatient module was implemented across Scarborough and Bridlington Hospitals. Similarly with previous deployments this has been very well received with, in this case, the team of matrons taking a significant lead in all aspects of its delivery. This implementation provides the ability to monitor and assure ourselves that we are delivering safe and effective healthcare and in the coming weeks we will deploy CPD into the remaining community hospitals of Malton and Whitby by which time we will have one single electronic patient record across the totality of our inpatient, outpatient and ED/MIU services. I cannot underestimate either the size or significance of this achievement. In relative terms this deployment has been achieved at minimal cost with a minimum disruption to services.

This has been achieved by the single minded approach of the whole SNS team, working selflessly around the clock, and a workforce in Scarborough and community services that has been hugely receptive to both the need for change and the process of managing that change positively.

I truly believe this to be one of the most significant achievements in the history of the organisation and would like the whole Board to endorse our appreciation of this to all involved.

1b. Development of our acute services

You will recall that as an organisation we have been committed for some time to the continual development of our acute services with the aim to improve the way we deliver care for our most acutely ill patients, establishing this as our highest priority for the foreseeable future.

Importantly, the vision for our acute services, as set out by our Acute Board, wholly reflects and supports the national context and the tone of the recommendations made in a number of recently published reports.

This work is now gaining momentum with a renewed vigour, with six working groups charged by the Acute Board, to address a number of specific challenges:

1. what would a large and effective acute assessment area look like? This is essential to delivering an effective acute service.
2. how can we simplify pathways and documentation for acute patients?
3. what are the medical staffing requirements to enable us to provide senior decision makers 24/7
4. based on successful further development of acute physician practise/practice how will this be supported by a needs-based approach to care without ageism?
5. what ward-based resources are required to best meet patient needs and allow our staff to provide the care they want to. Crucial to this is the identification of the deteriorating patient but also the provision of an appropriate MDT, 24/7, to meet their needs.
6. what does the needs-based environment look like?

All staff have been invited to share their views or get involved in this work and I would ask that all Board members reinforce the importance of this far reaching and significant work at every opportunity to demonstrate our commitment to ensuring our support for this work and the delivery of change that will be required to see this through.

2. Create a culture of continuous improvement

Both our major hospitals have been busy in July with a continued high level of non elective demand coupled with the need to focus on managing our longest waiters and planned care access times overall.

Both Emergency Departments have experienced deterioration in the 4 hour target performance in July due to high levels of attendance. This may have been at least in part associated with the introduction of the 111 service although further analysis is being undertaken to establish whether that was the case or not. Turn round times continue to be a key focus and improving overall.

The Deputy Chief Executive will brief you more fully at the Board Meeting.

2a The Trust one year on - listening exercise

Over the summer we will be carrying out a 'one-year on' review of the acquisition which will nicely complement the "Staff Voice" initiative and confirmation that our governance processes will be subject to a Stage 2 review as part of the Annual Planning Cycle managed by Monitor, see below. I believe taking all three together will provide an excellent platform for assessing the progress we have made post-acquisition and the further pace and momentum we need to establish to ensure we deliver the benefits we all aspire to as we grow and evolve as an organisation.

We are inviting all staff to contribute their thoughts and insights as part of the listening exercise to inform this and Board Members are invited to offer their thoughts on how we might construct this prior to communicating the details of this across the organisation in the next few weeks.

3. Develop and enable strong partnerships

3a Annual Plan Review

The Chair and I were informed last week that Monitor has decided to subject us to a Stage 2 review as part of the Annual Planning assurance process. They have engaged KPMG who will contact us in a couple weeks to set out the process but we know that this will be what they describe as a high level quality review, focusing on our safety and quality governance and assurance processes and importantly the flow of information up and down the organisation. We anticipate them attending the Board Meeting in September in addition to observing various other meetings and interviewing a cross section of staff during August and September. They also intend to engage with the CCGs as part of the process although the form this will take is not yet clear.

It is clear that this review is in part to seek further reassurance of our performance overall following the acquisition of Scarborough but also because of our Q4 performance against the ED target and CDiff trajectory. Details will be communicated to us formally in the next week or so. I believe this will prove a good opportunity to objectively assess and as appropriate redefine our processes at a key moment in our development and one we should embrace.

3b Strategic Alliances

We continue to develop our strategic alliances with both Hull and Harrogate and have agreed with both partners a number of reviews that will ensure we engage our clinical teams in the next stage of this work. The agenda with Harrogate continues to focus primarily on a review of our planned and acute services that we jointly committed to in the North Yorkshire Review. The work with Hull is at a more exploratory but perhaps positive phase and there is a huge enthusiasm developing as we plan for our "Building The Future" conference with colleagues in Hull in November.

I will of course keep Board Members briefed as things develop overall but in the meantime would like you to pencil in the conference date of 8th November as you will be most welcome to attend. The Chair and I have also approached the steering group with a view to a more active involvement of non executives from both organizations and will of course be happy to receive your thoughts on this.

4. Improve our facilities and protect our environment

93 Union Terrace, a Trust owned property, continues to be monitored by the Trust Capital Team and structural engineers following a serious incidence of ground subsidence. The

property was vacated following cracks appearing in some of the walls, this has deteriorated subsequently and temporary shoring has been erected. The cause is thought to be a change in subterranean ground conditions brought about by the adjacent works being undertaken by Yorkshire Water. It is anticipated that it will take several weeks for the situation to be stabilised, following this it is likely that the gable end of the house will need to be rebuilt before it can be reoccupied in about 6 months time. The cost of the remedial works will be borne in full by Yorkshire Water and their contractors. The property was occupied by CYC social workers, who are now temporarily housed in other Trust and CYC facilities.

5. Recommendation

The Board is asked to note the report.

Author	**Patrick Crowley, Chief Executive**
Owner	**Patrick Crowley, Chief Executive**
Date	**July 2013**

York Carers Charter

'Our vision in York is to work towards developing a local community where carers' needs are identified and supported by all public services and other organisations.' York Carers Strategy 2011 - 2015

A carer is someone who unpaid, looks after or supports someone in their family, a friend or neighbour who has an illness, is disabled, or is affected by mental ill-health or substance misuse. Carers can be any age, including young carers (8-18yrs) children and young adults (18 – 25yrs) whose quality of life and future can be affected significantly by their caring role.

Organisations signed up to this charter are committed to:

- **Supporting you in your caring role**
- **Enabling you to access an age appropriate service**
- **Recognising and respecting your unique perspective and skills**
- **Providing you with up to date information about sources of support, including opportunities to take a break from your caring role**
- **Informing you about your right to a carers' assessment and referral processes**
- **Supporting your choice about the level and extent of care you offer**
- **Recognising your health needs in order to support your physical and emotional well-being**
- **Providing you with opportunity to engage and comment on service planning and evaluation at a strategic level**

If you need more information about this charter please contact: Frances Perry, Carers and Strategic Policy Manager, City of York Council frances.perry@york.gov.uk **01904 554188**

Include details of organisations who have signed up to the charter

City of York Charter for Disabled Children 2013 – 2016

In York, through our YorOK partnership, we promise to:

1. Listen carefully to you and create improved choice by engaging you in the design of great services.
2. Offer you access to personal budgets and direct payments.
3. Introduce single plans to coordinate the best support for you to meet your education, health and care needs.
4. Provide clear information to support your choice. Our Local Offer booklet explains how we provide specialist services and also make all universal services accessible.
5. Continue to work with your parent/carers in partnership with voluntary agencies including CANDI, York's parent carer forum. Together we will develop and review services and promote your choice and control.
6. Make sure all staff have access to disability equality training written and delivered by you, together with professionals. This will help staff to respond effectively to your needs.
7. Support you to access leisure and positive activities in York so you can contribute to your community.
8. Provide personalised short breaks for you, if you have complex needs. Our short break statement explains how to access these.
9. Provide you with a named member of staff to help coordinate the support you need.
10. Support you as you move into adult life by providing access to employment, volunteering and education or training.

In York, our partnership will work hard to make York a more inclusive city.

Signed:

Cllr Janet Looker

Cabinet Member for Education,
Children and Young People's Services
Chair of the YorOK Board

York!
Working together with Children, Young People and Families

For more information contact:
Jess Haslam. Tel: 01904 554322
Email: jessica.haslam@york.gov.uk

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 31 July 2013

Monitor's Q1 return

Action requested/recommendation

The Board of Directors is asked to approve self-certification for quarter 1.

Summary

Attached is the Board Declaration for Monitor to be submitted by the end of the month.

The Board is asked to note that the governance declaration is amber-red and a provisional financial risk rating is 3.

Strategic Aims	**Please cross as appropriate**
1. Improve quality and safety	☒
2. Improve out effectiveness, capacity and capability	☒
3. Develop stronger citizenship through our working with partners	☒
4. Improve our facilities and protect the environment	☒

Implications for equality and diversity

This report has been prepared as part of the quarterly information to be submitted to Monitor. No detailed analysis has been undertaken around the protected charateristics as this data is not asked for by Monitor.

Reference to CQC outcomes

The report refers to the CQC outcomes and shows that the Trust is fully compliant with all outcomes.

Progress of report	This report has been prepared for the Board of Directors meeting.
Risk	The Board should note that as a result of the managed failure on the admitted patients the Trust will be amber-green rated.
Resource implications	There are no specific resource implications identified in the report.

Owner	Patrick Crowley, Chief Executive
Author	Patrick Crowley, Chief Executive Andrew Bertram, Director of Finance
Date of paper	July 2013
Version number	Version 1

		Reported Quarter to30-Jun-13	Reported YTD to30-Jun-13
Underlying performance			
EBITDA YTD	*from SoCI*	4.322	4.322
Operating Revenue for EBITDA YTD	*from SoCI*	107.089	107.089
EBITDA Margin metric		4.0%	4.0%
EBITDA Margin rating		2	2
Achievement of plan			
Actual EBITDA from SoCI		4.322	4.322
Planned EBITDA from SoCI (APR Plan)		4.166	4.166
EBITDA % of plan achived metric		103.8%	103.8%
EBITDA % of plan achived rating		5	5
Financial Efficiency			
Net return after financing costs, YTD	*from SoCI*	0.183	0.183
Opening Financing	*from SoFP*	181.645	181.645
Closing Financing	*from SoFP*	205.451	205.451
Net return after Financing metric		0.4%	0.4%
Net return after financing rating		3	3
Surplus / (deficit) YTD	*from SoCI*	0.178	0.178
Gain / (loss) on asset disposals	*from SoCI*	(0.005)	(0.005)
Gain / (loss) on transfers by absorption	*from SoCI*	-	-
I & R (Impairments & restructuring) expenses	*from SoCI*	-	-
Total IFRS Operating Revenue YTD	*from SoCI*	107.089	107.089
IS Surplus margin metric		0.2%	0.2%
IS Surplus margin rating		2	2
Financial Efficiency rating		3	3
Liquidity			
Cash for liquidity purposes	*from SoFP*	35.150	35.150
Operating expenditure within EBITDA YTD	*from SoCI*	102.766	102.766
WCF in terms of Operating Expenditure YTD		28.6	28.6
Liquidity days metric (WCF limited to 30 days)		30.8	30.8
Liquidity rating		4	4
Weighted Average Rating		3.00	3.00
Overriding rules			
3 Return submitted on time			YES
3 Return submitted complete and correct			YES
2 PDC dividend not paid in full	NO		
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
2 One financial criteria scored at '1'			FALSE
2 Two financial criteria scored at '2'			FALSE
1 Two financial criteria scored at '1'			FALSE
2 Unplanned breach of PBC ratios			FALSE
4 Less than 1 year as an Foundation Trust			FALSE
Limit due to overriding rules		3	3
Financial Risk Rating		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

Worksheet "Summary"

Click to go to index

High level summary of financial plan of YORKHOSPITAL

Financial Summary	Previous YE	Current Quarter			YTD			FY
£m	Actual	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Operating Revenue for EBITDA	403.7	103.8	107.1	3.3	103.8	107.1	3.3	428.0
Employee Expenses	(262.5)	(69.5)	(71.3)	(1.8)	(69.5)	(71.3)	(1.8)	(284.3)
Drugs	(30.5)	(7.5)	(8.2)	(0.7)	(7.5)	(8.2)	(0.7)	(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)	(22.6)	(23.2)	(0.6)	(22.6)	(23.2)	(0.6)	(94.0)
Clinical supplies	(40.4)	(11.0)	(10.6)	0.4	(11.0)	(10.6)	0.4	(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)	(1.7)	(1.8)	(0.1)	(6.9)
Cost of Secondary Commissioning of mandatory services	(3.3)	(1.1)	(0.7)	0.5	(1.1)	(0.7)	0.5	(4.6)
Research & Development expense	(4.4)	(1.2)	(1.0)	0.2	(1.2)	(1.0)	0.2	(4.9)
Education and training expense	(1.0)	(0.3)	(0.2)	0.2	(0.3)	(0.2)	0.2	(1.3)
Misc. other Operating expenses	(34.9)	(6.9)	(8.8)	(1.9)	(6.9)	(8.8)	(1.9)	(30.3)
EBITDA	19.1	4.2	4.3	0.2	4.2	4.3	0.2	18.9
Donations of PPE & intangible assets	0.5	0.1	0.0	(0.1)	0.1	0.0	(0.1)	0.5
Depreciation and amortisation	(8.8)	(2.7)	(2.7)	0.0	(2.7)	(2.7)	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	0.0	0.0	0.0	0.0	0.0	0.0
Operating Surplus	6.5	1.6	1.6	0.0	1.6	1.6	0.0	8.2
Net interest	(0.1)	(0.0)	(0.0)	0.0	(0.0)	(0.0)	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)	**(1.4)**	**(1.4)**	**(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	*(1.4)*	*(1.4)*	*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**	**0.1**	**0.2**	**0.0**	**0.1**	**0.2**	**0.0**	**2.4**
EBITDA % Income	4.7%	4.0%	4.0%	0.0%	4.0%	4.0%	0.0%	4.4%
CIP% of Op.Exp. less PFI Exp.	5.7%	5.5%	3.7%	-1.8%	5.5%	3.7%	-1.8%	5.4%
Pay CIPs as % Pay Costs	-5.8%	-6.3%	-4.3%	2.0%	-6.3%	-4.3%	2.0%	-6.2%
Net Surplus / (Deficit)	70.4	0.1	0.2	0.0	0.1	0.2	0.0	2.4
Change in working capital	1.8	0.0	2.7	2.7	0.0	2.7	2.7	(1.0)
(Increase)/decrease in inventories	*(3.5)*	*0.0*	*0.1*	0.1	*0.0*	*0.1*	*0.1*	*0.0*
(Increase)/decrease in tax receivable	*0.0*	*0.0*	*0.3*	0.3	*0.0*	*0.3*	*0.3*	*0.0*
(Increase)/decrease in NHS Trade Receivables	*(4.0)*	*0.0*	*(4.8)*	(4.8)	*0.0*	*(4.8)*	*(4.8)*	*(1.0)*
(Increase)/decrease in Non NHS Trade Receivables	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
(Increase)/decrease in other related party receivables	*(0.8)*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
(Increase)/decrease in other receivables	*(0.5)*	*0.0*	*0.9*	0.9	*0.0*	*0.9*	*0.9*	*0.0*
(Increase)/decrease in accrued income	*0.4*	*0.0*	*(0.2)*	(0.2)	*0.0*	*(0.2)*	*(0.2)*	*0.0*
(Increase)/decrease in other financial assets	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
(Increase)/decrease in prepayments	*(0.3)*	*0.0*	*(1.0)*	(1.0)	*0.0*	*(1.0)*	*(1.0)*	*0.0*
(Increase)/decrease in Other assets	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Increase/(decrease) in Deferred Income (excl. Donated Assets)	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Increase/(decrease) in Deferred Income (Donated Assets)	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Increase/(decrease) in Current provisions	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Increase/(decrease) in post-employment benefit obligations	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Increase/(decrease) in tax payable	*0.0*	*0.0*	*(0.1)*	(0.1)	*0.0*	*(0.1)*	*(0.1)*	*0.0*
Increase/(decrease) in Trade Creditors	*4.4*	*0.0*	*(4.9)*	(4.9)	*0.0*	*(4.9)*	*(4.9)*	*0.0*
Increase/(decrease) in Other Creditors	*3.8*	*0.0*	*0.7*	0.7	*0.0*	*0.7*	*0.7*	*0.0*
Increase/(decrease) in accruals	*2.3*	*0.0*	*3.0*	3.0	*0.0*	*3.0*	*3.0*	*0.0*
Increase/(decrease) in other Financial liabilities	*0.0*	*0.0*	*8.9*	8.9	*0.0*	*8.9*	*8.9*	*0.0*
Increase/(decrease) in Other liabilities	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Increase/(decrease) in Non Current provisions	*0.4*	*0.0*	*(0.0)*	(0.0)	*0.0*	*(0.0)*	*(0.0)*	*0.0*
Non cash I&E items	(51.5)	4.0	4.2	0.1	4.0	4.2	0.1	16.7
Tax expense	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Finance income/charges	*0.1*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*

Finance income/charges	*0.1*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Share of profit/(loss) from equity accounted investments net of cash distributi	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Donations & Grants received of PPE & intangible assets	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Other operating non-cash movements	*0.1*	*(0.1)*	*0.1*	0.1	*(0.1)*	*0.1*	*0.1*	*(0.1)*
Depreciation and amortisation, total	*8.8*	*2.7*	*2.7*	(0.0)	*2.7*	*2.7*	*(0.0)*	*10.9*
Impairment losses/(reversals)	*3.5*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.3*
Unrealised (gains)/losses on foreign currency exchange	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Gain/(loss) on disposal of property plant and equipment	*(0.0)*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Gain/(loss) on disposal of intangible assets	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Share of profit/(loss) loss from investments	*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	*1.4*	*1.4*	*0.0*	*5.6*
Other increases/(decreases) to reconcile to profit/(loss) from operations	*(68.9)*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Cashflow from operations	**21.1**	**4.2**	**7.1**	2.9	**4.2**	**7.1**	**2.9**	**18.1**
Cashflow from investing activities	(17.5)	(2.0)	(2.2)	(0.2)	(2.0)	(2.2)	(0.2)	(22.3)
Property, plant and equipment - maintenance expenditure	*(6.7)*	*(1.0)*	*(1.3)*	(0.3)	*(1.0)*	*(1.3)*	*(0.3)*	*(8.2)*
Property, plant and equipment - non-maintenance expenditure	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*(3.2)*
Plant and equipment - Information Technology	*(2.9)*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Plant and equipment - Other	*(1.8)*	*(0.1)*	*(0.1)*	0.0	*(0.1)*	*(0.1)*	*0.0*	*(7.6)*
Property, plant and equipment - other expenditure	*0.0*	*(0.9)*	*(0.8)*	0.1	*(0.9)*	*(0.8)*	*0.1*	*(3.3)*
Proceeds on disposal of property, plant and equipment	*0.1*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Purchase of investment property	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Proceeds on disposal of investment property	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Purchase of intangible assets	*(0.0)*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Proceeds on disposal of intangible assets	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Expenditure on capitalised development	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Increase/(decrease) in Capital Creditors	*(0.4)*	*0.0*	*(0.0)*	(0.0)	*0.0*	*(0.0)*	*(0.0)*	*0.0*
Payments for other capitalised costs	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Purchase of subsidiaries net of cash acquired	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Net bank balance acquired with subsidiaries	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Proceeds from disposal of subsidiaries net of cash disposed	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Net bank balance disposed with subsidiaries	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Purchase of associates net of cash acquired	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Net bank balance acquired with associates	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Proceeds from disposal of associates net of cash disposed	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Net bank balance disposed with associates	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Purchase of joint ventures net of cash acquired	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Net bank balance acquired with associates	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Proceeds from disposal of joint ventures net of cash disposed	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Net bank balance disposed with joint venture	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Government grants received	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Deposits and investments made	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Deposits and investments liquidated	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Other cash flows from investing activities	*(5.7)*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Cashflow before financing	**3.6**	**2.2**	**4.9**	2.7	**2.2**	**4.9**	**2.7**	**(4.2)**
Cashflow from financing activities	1.6	1.3	1.3	(0.0)	1.3	1.3	(0.0)	19.1
Public Dividend Capital received	*7.1*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*15.0*
Public Dividend Capital repaid	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
PDC Dividends paid	*(4.9)*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*(5.6)*
Interest (paid) on bridging loans	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Interest (paid) on commercial loans	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Interest (paid) on non-commercial loans	*(0.2)*	*(0.1)*	*(0.1)*	0.0	*(0.1)*	*(0.1)*	*0.0*	*(0.3)*
Interest (paid) on bank overdrafts	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Interest element of finance lease rental payments - other	*(0.0)*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Interest element of finance lease rental payments - On-balance sheet PFI	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Capital element of finance lease rental payments - other	*(0.1)*	*0.0*	*(0.1)*	(0.1)	*0.0*	*(0.1)*	*(0.1)*	*0.0*
Capital element of finance lease rental payments - On-balance sheet PFI	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Interest received on cash and cash equivalents	*0.2*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.1*
Movement in Other grants/Capital received	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Donations received in cash	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Drawdown of bridging loans	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Repayment of bridging loans	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Drawdown of non-commercial loans	*0.0*	*1.7*	*1.7*	0.0	*1.7*	*1.7*	*0.0*	*10.4*
Repayment of non-commercial loans	*(0.5)*	*(0.2)*	*(0.2)*	(0.0)	*(0.2)*	*(0.2)*	*(0.0)*	*(0.5)*
Drawdown of commercial loans	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Repayment of commercial loans	*(0.0)*	*(0.0)*	*0.0*	0.0	*(0.0)*	*0.0*	*0.0*	*(0.0)*
(Increase)/decrease in non-current receivables	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Increase/(decrease) in non-current payables	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Other cash flows from financing activities	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Net increase/(decrease) in cash	**5.2**	**3.5**	**6.2**	**2.7**	**3.5**	**6.2**	**2.7**	**14.9**
Cash at period end	**12.8**	**16.3**	**19.0**	**2.7**	**16.3**	**19.0**	**2.7**	**27.7**
Cash and Cash equivalents at period end	12.8	16.3	19.0	2.7	16.3	19.0	2.7	27.7

Detailed Financial Summary	**Previous YE**	**Current Quarter**			**YTD**			**FY**
£m	**Actual**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**
Community								
Co Cost & volume contract revenue	0.0	0.5	0.4	(0.1)	0.5	0.4	(0.1)	2.2
Co Block contract revenue	34.7	8.0	8.4	0.3	8.0	8.4	0.3	32.2
Ambulance								
Am Cost & volume contract revenue	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Am Block contract revenue	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Am Other clinical MS revenue	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Mental Health								

Mental Health								
Mh Cost & volume contract revenue	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Mh Block contract revenue	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Mh Clinical partnership (s31) revenue	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Mh Secondary commissioning revenue	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Mh Other clinical MS revenue	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Acute								
Ac Elective revenue	57.5	15.4	15.5	0.0	15.4	15.5	0.0	64.5
Ac Non-Elective revenue	95.8	22.1	23.7	1.6	22.1	23.7	1.6	90.6
Ac Outpatient revenue	60.1	14.7	16.9	2.1	14.7	16.9	2.1	61.7
Ac A&E revenue	12.0	3.2	3.4	0.2	3.2	3.4	0.2	13.0
Ac other revenue	83.0	26.8	25.5	(1.3)	26.8	25.5	(1.3)	112.0
Private patient revenue	1.0	0.3	0.3	(0.0)	0.3	0.3	(0.0)	3.0
Grants and donations in cash	0.2	0.0	0.1	0.0	0.0	0.1	0.0	0.2
Other operating revenues	59.4	12.7	13.0	0.4	12.7	13.0	0.4	48.7
Total operating revenue for EBITDA	403.7	103.8	107.1	3.3	103.8	107.1	3.3	428.0
Grants and donations of PPE and intangible assets	0.5	0.1	0.0	(0.1)	0.1	0.0	(0.1)	0.5
Total operating revenue	**404.2**	**103.9**	**107.1**	**3.2**	**103.9**	**107.1**	**3.2**	**428.4**
Employee Expenses	(262.5)	(69.5)	(71.3)	(1.8)	(69.5)	(71.3)	(1.8)	(284.3)
Drugs expense	(30.5)	(7.5)	(8.2)	(0.7)	(7.5)	(8.2)	(0.7)	(30.8)
Supplies (clinical & non-clinical)	(46.8)	(12.7)	(12.4)	0.2	(12.7)	(12.4)	0.2	(51.9)
Clinical supplies	*(40.4)*	*(11.0)*	*(10.6)*	*0.4*	*(11.0)*	*(10.6)*	*0.4*	*(45.1)*
Non-clinical supplies	*(6.4)*	*(1.7)*	*(1.8)*	*(0.1)*	*(1.7)*	*(1.8)*	*(0.1)*	*(6.9)*
PFI expenses	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other expenses	(44.9)	(9.9)	(10.7)	(0.9)	(9.9)	(10.7)	(0.9)	(42.1)
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*
Cost of Secondary Commissioning of mandatory services	*(3.3)*	*(1.1)*	*(0.7)*	*0.5*	*(1.1)*	*(0.7)*	*0.5*	*(4.6)*
Research & Development expense	*(4.4)*	*(1.2)*	*(1.0)*	*0.2*	*(1.2)*	*(1.0)*	*0.2*	*(4.9)*
Education and training expense	*(1.0)*	*(0.3)*	*(0.2)*	*0.2*	*(0.3)*	*(0.2)*	*0.2*	*(1.3)*
Misc. other Operating expenses	*(34.9)*	*(6.9)*	*(8.8)*	*(1.9)*	*(6.9)*	*(8.8)*	*(1.9)*	*(30.3)*
Total operating expenses within EBITDA	**(384.6)**	**(99.6)**	**(102.8)**	**(3.2)**	**(99.6)**	**(102.8)**	**(3.2)**	**(409.1)**
EBITDA	**19.1**	**4.2**	**4.3**	**0.2**	**4.2**	**4.3**	**0.2**	**18.9**
Depreciation and amortisation	(8.8)	(2.7)	(2.7)	0.0	(2.7)	(2.7)	0.0	(10.9)
Impairments & Restructuring	*(4.3)*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*(0.3)*
Total operating expenses	**(397.7)**	**(102.3)**	**(105.5)**	**(3.2)**	**(102.3)**	**(105.5)**	**(3.2)**	**(420.3)**
Operating Surplus (Deficit)	**6.5**	**1.6**	**1.6**	**0.0**	**1.6**	**1.6**	**0.0**	**8.2**
Profit (loss) on asset disposal	0.0	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0
Net interest	(0.1)	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.2)
Taxation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PDC dividend	(5.0)	(1.4)	(1.4)	0.0	(1.4)	(1.4)	0.0	(5.6)
Other non-operating items	69.4	0.1	0.0	(0.1)	0.1	0.0	(0.1)	0.5
Net Surplus / (Deficit)	**70.4**	**0.1**	**0.2**	**0.0**	**0.1**	**0.2**	**0.0**	**2.4**
EBITDA % of Op. revenue	4.7%	4.0%	4.0%	0.0%	4.0%	4.0%	0.0%	4.4%
EBITDA	**19.1**	**4.2**	**4.3**	**0.2**	**4.2**	**4.3**	**0.2**	**18.9**
Change in Current Receivables	(5.4)	0.0	(3.7)	(3.7)	0.0	(3.7)	(3.7)	(1.0)
Change in Current Payables	8.2	0.0	(4.3)	(4.3)	0.0	(4.3)	(4.3)	0.0
Other changes in WC	(1.0)	0.0	10.7	10.7	0.0	10.7	10.7	0.0
Change in Non Current Provisions	0.4	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0
Other non-cash items	(0.3)	0.0	0.1	0.0	0.0	0.1	0.0	0.2
Cashflow from operating activities	21.1	4.2	7.1	2.9	4.2	7.1	2.9	18.1
Capital expenditure (accurals basis)	0.0	(2.0)	(2.2)	(0.2)	(2.0)	(2.2)	(0.2)	(22.3)
Asset sale proceeds	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0
other Investing cash flows	(17.5)	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0
Cashflow before financing	3.6	2.2	4.9	2.7	2.2	4.9	2.7	(4.2)
Net interest	(0.2)	(0.1)	(0.1)	0.0	(0.1)	(0.1)	0.0	(0.3)
PDC dividends (paid)	(4.9)	0.0	0.0	0.0	0.0	0.0	0.0	(5.6)
Movement in loans	(0.5)	1.4	1.5	0.0	1.4	1.5	0.0	9.9
PDC received/(repaid)	7.1	0.0	0.0	0.0	0.0	0.0	0.0	15.0
Donations received in cash	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
other financing cashflows	0.1	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.1
Net cash inflow (outflow)	**5.2**	**3.5**	**6.2**	**2.7**	**3.5**	**6.2**	**2.7**	**14.9**
Cash at period end	**12.8**	**16.3**	**19.0**	**2.7**	**16.3**	**19.0**	**2.7**	**27.7**
Cash and Cash equivalents at period end	**12.8**	**16.3**	**19.0**	**2.7**	**16.3**	**19.0**	**2.7**	**27.7**
Non Safe Harbour Investments at period end	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**