York Teaching Hospital NHS
NHS Foundation Trust

The programme for the next meeting of the Council of Governors which will take place:

On: **Wednesday 21st December 2011**

At: **Social Club, White Cross Road, York YO31 8JR**

Time	Meeting	Attendees
3.15pm – 4.00pm	Private meeting of the Council of Governors	Governors with Chairman and Foundation Trust Secretary
4.00pm – 6.00pm	**Council of Governors meeting**	**Governors and public**

York Teaching Hospital NHS
NHS Foundation Trust

The next general meeting of the **Trust's Council of Governors** meeting will take place

on: **Wednesday 21st December 2011**

at: **4.00pm – 6.00pm**

in: **Social Club, White Cross Road, York YO31 8JR**

A G E N D A				
No'	*Item*	*Lead*	*Paper*	*Page*
Part One: 4.00pm - 4.20pm				
1.	**Chairman's introduction** The Chairman will introduce the meeting, welcoming any members of public who are in attendance.	Chairman		
2.	**Apologies for absence** To receive any apologies for absence:	Foundation Trust Secretary		
3.	**Declaration of interests** To receive confirmation of any amendments to the declaration of interests.	Chairman	A	5
4.	**Minutes of the meeting held on 12th October 2011** To receive and approve the minutes of the meeting of the Council held on 12th October 2011.	Chairman	B	11
5.	**Matters arising from the minutes** To consider any matters arising from the minutes.	Chairman		
Part Two: 4.20pm – 6.00pm **General Business**				
6.	**Update from the private meeting** To receive an update from the Chairman on the decisions of the business discussed in the private meeting.	Chairman	Verbal	

7.	**Sub-committees and other Governor Reports** To receive reports from Chairs of the Sub Committees and others: • Lead Governor report • Patient Focus Group • Community & Membership Engagement Group • Nutrition project • Other	 Lead Governor Paul Baines Jane Dalton Helen Butterworth	Verbal	
8.	**Summary of the Board of Directors minutes** To receive summary minutes from the Board of Directors meeting held from September - November 2011.	Chairman	C	19
9.	**Clinical Quality** Discussion on the following items: • CQC reports • Dr Foster and mortality metrics • Patient Association Report	Medical Director & Chief Nurse	 Verbal D Verbal	 43
10.	**Local Care Delivery** Discussion on the following items: • North Yorkshire Review • 'Levels of care' – proposal regarding increased community services • Urgent Care Centre at York Hospital	Chief Executive & Chief Nurse	Verbal	
11.	**Membership Report** To receive an updated membership report.	Chairman	F	91
12.	**Acquisition** To receive an update on the planned acquisition.	Chief Executive	Verbal	
13.	**Half year performance** To receive information on the 6 month position of the Trust for: • Finance • Operations	Chief Executive	Verbal	
14.	**Star appeal** To receive information on the Star appeal.	Fundraising Manager	Verbal	

15.	**Dates of meetings for 2012** To receive the dates for the meetings for 2012.	Chairman	E	89
16.	**Time and Date of next meeting** Wednesday 22nd February 2012, White Cross Social Club, White Cross Road, YO31 8JR. 3.15pm.			
17.	**Any other business** To consider any other items of business.			

Register of Governors' interests
December 2011

York Teaching Hospital NHS
NHS Foundation Trust

Changes to the Register of Governors' interests:

A

New declarations
No new declarations

Removal from declaration
No removals.

Amendment to an existing declaration

Governor	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 Paul Baines *(Public: City of York)*	Nil	Nil	Nil	Nil	Nil	Nil
Cllr John Batt *(Partner: NYCC)*	TBA	TBA	TBA	TBA	TBA	TBA
Dr Lee Bond *(Staff: Consultant)*	Nil	Nil	Nil	Nil	Nil	Nil
Mrs Helen Butterworth *(Public: York)*	Nil	Nil	Nil	Nil	Nil	Nil
Mr Phil Chapman *(Patient/Carer)*	Nil	Nil	Nil	Nil	Nil	Nil
Dr Jane Dalton *(Public: Hambleton*	Nil	Nil	Nil	Nil	Nil	**Researcher—**Health and Social Care, University of York
Cllr Alexander Fraser *(City of York Council)*	Nil	Nil	Nil	**Appointee —**City of York Council , non-voting participating observer on York CVS Trustees	**Appointee —**City of York Council , non-voting participating observer on York CVS Trustees	Nil

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	Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation trust including but not limited to, lenders or banks
Mrs Alison MacDonald *(Staff: Nursing & Midwifery Class)*	Director and Company Secretary—Health and Safety Consultancy	Nil	Nil	Nil	Nil	Nil
Mrs Helen Mackman *(Public: City of York)*	Nil	Nil	Nil	Nil	Nil	Nil
Mrs Mandy McGale *(Staff: Non-Clinical)*	Nil	Nil	Nil	Nil	Nil	Nil
Dr Jennifer Moreton *(Patients/Carer)*	Nil	Nil	Nil	Nil	**Member—**CQC Registration Involvement Group	**Researcher—**Health and Social Care, University of York
Mr Nevil Parkinson *Public: Selby District)*	Nil	Nil	Nil	**Director—**West Riding Masonic Charities Ltd	Nil	Nil
Cllr Caroline Patmore *(North Yorkshire County Council)*	Nil	Nil	Nil	Nil	**Councillor—**North Yorkshire County Council	**Councillor—**North Yorkshire County Council
Mrs Anne Penny *(Staff: Nursing)*	Nil	Nil	Nil	Nil	Nil	Nil

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Mr James Porteous *(Public: York)*	**Trustee—**Notions Business and Marketing Consultants	Nil	Nil	**President—**British Polio Fellowship - Yorkshire Region, Leeds and North Yorkshire Region British Polio Fellowship	Nil	Nil
Mr Geoff Rennie *(Patient: Carer)*	Nil	Nil	Nil	Nil	Nil	Nil
Mrs Dianne Rhodes *(Public: Selby)*	**Director & Company Secretary—**Health & Safety Consultancy	Nil	Nil	Nil	Nil	Nil
Cllr Joseph Richies *(City of York Council)*	TBA	TBA	TBA	TBA	TBA	TBA
Mr David Robson *(Public: York)*	Nil	Nil	Nil	**Member** - Management Committee for York Blind or Partially Sighted Society	Nil	Nil
Mr Martin Skelton *(Staff: Clinical Professional)*	Nil	Nil	Nil	Nil	Nil	Nil
Ms Catherine Surtees *(York CVS)*	Nil	Nil	Nil	Partnership Manager—York CVS	Partnership Manager—York CVS	Nil

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Mr Robert Thomas *(Public: Selby District)*	Nil	Nil	Nil	Nil	Nil	Nil
Mr Brian Thompson *(Patient: Carer)*	**Trustee—**Thompson's of Helmsley Ltd	Nil	Nil	Nil	Nil	Nil
Mr Bob Towner *(Public: City of York)*	Nil	Nil	Nil	**Vice Chairman—**York Older Peoples Assembly	**Vice Chairman—**York Older Peoples Assembly **Member**—York Health Group Public and Patient Forum	Nil
Cllr Sian Wiseman *(Public: City of York)*	Nil	Nil	Nil	Nil	**Vice Chairman—**CYC Health Overview and Scrutiny Committee	Nil

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York Teaching Hospital NHS

NHS Foundation Trust

Minutes of the meeting of the York Teaching Hospital NHS Foundation Trust Council of Governors held on 12th October 2011, in the Social Club, White Cross Road, York.

Present:	Chairman of the meeting, Alan Rose
Public:	Mr Paul Baines, Public Governor, City of York Mrs Helen Butterworth, Public Governor, City of York Dr Jane Dalton, Public Governor, Hambleton Mr Jim Porteous, Public Governor, City of York Mrs Diane Rhodes, Public Governor, Selby District Mr Bob Thomas, Public Governor, Selby District Mr Bob Towner, Public Governor, City of York Councillor Sian Wiseman, Public Governor, City of York
Patient/Carer:	Mr Philip Chapman, Patient/Carer Governor Dr Jenny Moreton, Patient/Carer Governor Mr Geoffrey Rennie, Patient/Carer Governor Mr Brian Thompson, Patient/Carer Governor
Partner:	Councillor John Batt, Appointed Governor, North Yorkshire County Council Councillor Caroline Patmore, Appointed Governor, North Yorkshire CC Councillor Joseph Riches, Appointed Governor, City of York Council
Staff:	Mr Lee Bond, Staff Governor, Medical Mrs Mandy McGale, Staff Governor, Non-clinical Mr Martin Skelton, Staff Governor, Clinical Professional Mrs Alison MacDonald, Staff Governor
Apologies:	Mrs Anne Penny, Staff Governor, Nursing Councillor Sandy Fraser, Partner Governor, City of York Council Mrs Helen Mackman, Public Governor, City of York Mr Nevil Parkinson, Public Governor, Selby District Mr David Robson, Public Governor, City of York Mrs Catherine Surtees, Appointed Governor, York CVS
Attendance:	Mr Patrick Crowley, Chief Executive Mrs Anna Pridmore, Foundation Trust Secretary Mr Michael Sweet, Non-executive Director Ms Linda Palazzo, Non-executive Director Professor Dianne Willcocks, Non-executive Director
Members of the public:	3 members of the public attended the meeting.

11/38 Chairman's Introduction

Mr Rose welcomed three members of the public to the meeting.

11/39 Apologies for Absence

The apologies were noted.

11/40 Questions from the public

Mr Yates (a member of the public) asked if the Executive Directors ever gave any feedback on stakeholder groups the trust was involved with. Mr Rose advised that feedback was received from the Directors, but it wasn't a very formal system. Mr Yates suggested that it would be helpful to hear the feedback. Mr Crowley gave the example of the Elderly People's Liaison group and how the feedback into the organisation worked for that group. He explained that the group acted as a conduit for feedback through the Elderly Directorate. Another example was the Governors' Patient Focus Group. Mr Crowley advised that feedback from this group goes through to the governors and from the governors through the Board of Directors, who will respond back on any proposed made. Mr Crowley further explained that meetings of groups where the Trust attends are recorded by the Trust representatives and actions are taken identified and taken.

Mr Rose thanked Mr Yates for his question.

11/41 Declaration of Interests

The Council of Governors considered the declaration of interests and asked Mrs Pridmore to review the document as there seem to be some changes that have not been picked-up. Mrs Pridmore confirmed she would undertake a review.

11/42 Minutes of the Meeting held on 2nd September 2011

The minutes were considered by the Council of Governors and were considered as a true record of the meeting.

11/43 Matters arising from the minutes

Mr Towner asked if there had been any developments on the car park and Travel and Transport Committee. Mr Rose confirmed that he had received comment from Mr Golding who has executive responsibility for the area. The comment he'd received stated that currently the Travel and Transport Committee was being re-established and would include car park issues in its terms of reference.

11/22 Update from the Private Meeting

Mr Rose updated the Council of Governors on the transactions of the private meeting held prior to this meeting. He advised that the Council of Governors had confirmed an extension of term of office for Professor Hutton. His term of office

would finish at the end of March 2012. He advised that the Council of Governors has approved changes to the remuneration for the Non-executive Directors and Chairman, and advised that governors had considered the amendments to the Constitution and Standing Orders and had approved the proposed changes to both documents. The Council of Governors confirmed the comments made.

11/23 Sub-Committee and other Governors Reports

Lead Governor Report

Mr Rose advised that the Lead Governor report had been included in the paper along with her speech from the Trust AGM. Mr Rose felt that the speech was a valuable document that described the role of the Lead Governor very well and that it would be an excellent document to use if anyone was considering standing for Lead Governor in future. It also gave a good summary of the variety of roles played by the Council of Governors in the past year.

Patient Focus Group

The report was noted. Mr Rose thanked Mr Baines for all his help and leadership in the group over the last 18 months and congratulated Mr Chapman on being appointed as the next chair to the group. The Council of Governors discussed briefly the changes to the Patient Focus Group that had been proposed, around their more detailed involvement with the Patient Experience Department and making sure that those links are made stronger and governors have more real involvement in the actions being undertaken.

It was agreed that a further update will be brought back to the next Council of Governors meeting.

Action: discussion at the next Council of Governors meeting.

Community and Membership Engagement Group

Dr Dalton advised that she had been reappointed as chair to the group. She advised that there was increasingly more “leg-work” going on in the group and more debate with the Membership Manager on recruitment of members. She also reported that more work was going on with LINks and its proposed successor: HealthWatch.

Equality and Diversity

Mr Porteous reported that the committee had a wide breadth of subjects it covered and was very interesting for him to be a member of. He advised that they had looked at workforce monitoring information at the most recent meeting and the “Equality Delivery System” (the name given to the range of issues related to equality and diversity to be progressed). The system will be reviewed by the Board of Directors at the November meeting. He added that he was struck by the use of the “big word” as a translation system and fascinated at the ability for the big word to be a more economic way of providing translation services. Professor Willcocks added that it was an excellent summary from Mr Porteous and the annual report demonstrated huge progress and allowed the committee to develop its work programme for next year.

The Council of Governors thanked Professor Willcocks and Mr Porteous for their comments.

Nutrition Project

Mr Rose asked Mrs Butterworth to comment on the nutrition project that she is involved with. Mrs Butterworth advised that the purpose of the project was to identify the provision of catering service going forward. She advised that they had taken samples of food from outside caterers who were bidding for the contract, as part of the evaluation process. A blind-tasting would be taking place during November, at which one of the bidders would be taken forward for a final evaluation between them and the current (in-house) provider.

The Council of Governors enquired who the food was to be provided to. Mrs Butterworth advised that the food would be provided for patients, staff and visitors and the contract would include the redesign of the catering and restaurant facilities, as well as food. Mrs Butterworth added that it was 12 years ago since the catering facilities were designed and so overdue for a refresh and redesign. She also added that there were 1,650 meals provided by the hospital each day.

Mrs Wiseman enquired about the James Martin programme that had been recently aired on the television about Scarborough Hospital. Mr Crowley advised that Scarborough had a very poor facility for catering and that as a result of the James Martin programme things had improved, although there was still further evaluation to do and further improvements to make.

Sustainability Steering Group

Mr Rose advised that Mr Robson was a member of this group and that the group discussed the use of sustainable resources such as energy supplies. He advised that David Robson would report back at the next Council of Governors.

Home Team

Mrs Palazzo was welcomed to the meeting and commented that the Home Team (HT) was working well and that the meetings were valuable and useful to the Board. They also cut down the time spent on specific detailed issues at the Board of Directors meetings. The Home Team ensured that more scrutiny of specific activities in York was undertaken prior to the Board Meetings and exceptions taken forward.

A number of items had recently been focused on by the HT, the first one being hospital mortality; she advised that there were still issues that were being resolved by the Executive Directors, but the BoD were keeping quite a close eye on progress.

Mrs Palazzo advised that there has been significant progress on the psychiatric liaison work, which means that the Trust will be able to, with the support from the Mental Health Trust, provide better psychiatric liaison support on elderly ward and at the Emergency Department (the two areas of the hospital where they are most likely to be required).

In relation to finance, the income is slightly down but GP referrals are up significantly and it is expected that income will come back into line. The cost efficiency programme (CIP) is being watched carefully to ensure that it continues to meet its targets.

The 18-week backlog was also discussed at the HT meeting. There has been a noticeable increase in the number of patients waiting for treatment. The Board has asked for a paper on what action is being taken which will be presented to the November Board meeting (we should be able to provide an update at the 21/12 CoG meeting).

Mrs Palazzo also commented on the winter plans, when the hospital will get busier. She advised that the winter ward had been opened, to support any additional pressures which may be coming through.

In relation to infection control target, Mrs Palazzo advised that the HT would keep a watchful eye on the achievements of performance against the trajectory set by Monitor.

Mrs Palazzo went on to mention the Open Day. She advised that there had been a meeting to assess the event. Mrs Palazzo asked for any feedback comments the governors may have to be sent to herself or Penny Goff.

Mrs Palazzo went on to discuss the launch of a charitable appeal through the hospital, the appeal was intended to raise £300,000 to refresh the Stroke Rehabilitation Ward (the STAR Appeal).

Mr Rose thanked Mrs Palazzo for her comments and asked Mr Crowley if he had anything he would like to add. Mr Crowley advised that the August performance had been expected to be a downturn, due to holidays and the general resistance for patients to attend during the holiday season.

He advised that the Trust was £1m behind the year's trajectory, £1.4m behind the CIP target, and the capital spend was £500,000 under spent.

<u>Website</u>

The Council of Governors enquired if there had been any development on the website improvement. Mr Crowley advised that Mrs Brown, Head of Communications, was working on this as part of the work related to the acquisition and it was expected that Mrs Brown would be in touch with those governors that have shown an interest in the development of the website. Mr Crowley reminded the Governors that the current design of the website had been there for some time and it had always been the view that the management costs for proactively maintaining the website were very significant. Mrs Brown was the first dedicated communications expert the Trust had invested in. She is now building her team for York and Scarborough and in the future he would expect, under Mrs Brown's management, that website will be upgraded and managed more proactively. The Governors agreed they would be contacted by Mrs Brown when she started the work. The Council of Governors added that they felt that the Trust should not under-value the website and the other opportunities to

communicate through media such as Twitter and Facebook should also be explored.

Mrs Patmore agreed that she would pick this up with Mrs Brown outside the meeting and ensure she was involved in the development.

11/25 Summary of the Board of Directors Minutes

Mr Towner enquired about the item referring to DNACPR and advised that this was included in the elderly assembly group meeting as part of their agenda and he felt that it would be useful if there was some further debate between the Trust and the group. He added that he noted it was also an issue picked up by the CQC in their report. Mr Crowley noted the comments and advised that work was ongoing in the Trust in relation to the DNACPR issues and that been picked up by the CQC. He added that he was aware that it was part of the elderly assembly agenda and the overview and scrutiny agenda and believed that the agendas were working together. The Council of Governors noted the summary board minutes. (CQC report will be discussed at the next meeting).

11/25 Chief Executive Report

Mr Crowley covered a number of items in his report and highlighted a number of key points:

<u>The North Yorkshire Review</u>
He advised that this document had been circulated and the key point for the Acute sector was the proposed reduction of about 200 beds across the county. He assured the Council of Governors that this was consistent with the developments that the organisation had been planning. He also assured the governors that it would be of primary importance that the Trust not take 200 beds out of the system without being assured that there were an appropriate 200 beds (or equivalent), and related care, elsewhere in the community. Mr Crowley advised that he had recently attended a meeting where the Chief Executives of all organisations involved in the North Yorkshire Review had agreed the direction of travel and that there had been a commitment to support all the recommendations coming out of the North Yorkshire Review. This would include a commitment from all partner organisations to liaise regarding an overarching governance on leadership and implementation. He added that the two Local Authorities, North Yorkshire CC and the City of York Council, would be working together to ensure this overarching governance was in place. He advised that at the meeting held by the SHA, it was agreed that some support would be provided to ensure there was clarity about what change belonged with which organisation.

Mr Crowley went on to advise that the Board of Directors had committed to supporting this view at its last board and that the discussion had been held to ensure that our plans following the acquisition did fulfil the expectations of the North Yorkshire Review. Dr Bond reminded Mr Crowley that the bed occupancy in the Trust was already too high and reducing the level of occupancy in bed would be difficult as demand continued to grow. He enquired if the report had taken into account demographic growth in North Yorkshire and looked at the

financial projections. Mr Crowley provided assurance that the report had taken into account demographic growth and financial projections. Regular updates would be given to the CoG. The Council of Governors noted the comments.

MSK (Musculo-skeletal) Tender

Mr Crowley advised that the Trust had received, along with the PCT, a formal challenge to the MSK service that had been recently opened. The challenge accused the Trust of "predatory pricing" in its bid and had been made to the Co-operation and Competition panel (CCP). The challenge had also been made regarding the PCT for not following due process. The Trust and the PCT were required to respond in a short time-line and the responses have been published on the CCP website and are in the public domain. The Council of Governors discussed the claim. They were assured by Mr Crowley there was no foundation to the claim. Mr Sweet added that he had reviewed the quality and price in the tender document and was clear that there had been no predatory pricing. Members of the Council of Governors advised that the opening of the MSK service was an excellent event and that there was a high quality of service being delivered there. Mr Crowley advised that the CCP have no legal power to put aside the awarded tender but do have power to give a view on the process and if the Trust had undertaken predatory pricing in their opinion.

CQC

Mr Crowley advised that the CQC had visited the Trust during July. They had visited York Hospital, St Helen's and White Cross Court. He added that the reports are due for publication in the near future. There were a number of issues the report identified at all the sites visited, but the key issue at York Hospital was the 'do not resuscitate' (DNACPR) issue (as referred to in 11/25 above). This was specifically around documentation management, not the quality of clinical decision-making. He advised that, since the visit, processes have been changed to ensure better compliance with the policy. Mr Crowley added that Dr Turnbull was working with a group to ensure effective training was undertaken regarding the issues. The other points raised by CQC were more minor findings. Mr Crowley suggested that any further comments should be raised with Libby McManus. He confirmed that once the reports are published they would be made available to the Governors.

SNEY Acquisition

Mr Crowley reported that the due diligence and the economic "fair value" of the Trust details were being finalised. The debate is being led with the SHA by Mr Bertram and Mr Crowley. He advised that an additional tranche of capital was being discussed as part of the package.

Professor Willcocks added that the Acquisition Assurance Board, a NED-led committee set up to review the transaction, has followed the due diligence undertaken, both the legal and financial and the pricing deal, and has received regular reports on the negotiations undertaken by Mr Bertram and Mr Crowley. The Acquisition Assurance Board is assured with the progress and the work undertaken by Mr Bertram and Mr Crowley. The Trust now is awaiting the approval of the Department of Health through the SHA, before a decision can be made by the Board of Directors around continuing with the acquisition.

The Council of Governors thanked Mr Crowley for his comments and his report.

11/26 Discussion on Council of Governors Appraisal

Mr Rose advised that there had been a discussion about the Council of Governor's appraisal at the private meeting. The Council of Governors appraisal would be distributed for input next month. Governors will be asked to complete the appraisal document when they receive it and return the document to Mr Rose. The results will be summarised and discussed in the New Year and will help the development of the Council for the expected transitional year ahead.

11/27 Any Other Business

There was no other business.

11/28 Date and time of next meeting

The next meeting of the Council of Governors will be held (in public) on 21st December, 2011 (3.15pm – 6.00pm) in the Social Club, White Cross Road, York YO31 8JR.

Summary of Board of Directors minutes

This report provides the Council of Governors with a summary of the discussions held at the Board of Directors.

Summary of the minutes of the Board meeting held on 28th September 2011

Chief Nurse Report

Ms McManus presented the report and highlighted that there had been a detailed discussion about the report with the 'home team'.

Ms McManus advised that the Trust had now received the three reports in draft from the Care Quality Commission (CQC). She reminded the Board that the CQC had visited the Trust on 4th July. Ms McManus explained that the CQC had produced three reports, one for York, one for St Helens and one for White Cross Court. The draft report for York was released earlier this month and following some discussions with the CQC it has been finalised. The report, for the York Hospital, in its final report state, identified a major concern, two medium concerns and two minor concerns. She added that the other two reports are still in draft and discussions are underway with CQC to finalise the reports, although the same themes had been identified. The Trust has been advised that all three reports will be published together on the CQC website with a statement confirming that the CQC considers York to be a good hospital with some areas for improvement. No date had been given for the publication.

The Board **noted** the comments and thanked all those involved in the visit and the discussions about the final report.

Mr Rose invited Ms Raper to comment on the Chief Nurse Report. Ms Raper commented that the construction of the report continues to improve. Ms Raper summarised the conversations the 'home team' had and confirmed that they had discussed the report in detail. She drew the Board's attention to appendix 1, Nursing Care Indicators – and specifically falls and nutrition, where the 'home team' had identified that there seemed to be an issue with the trend line. As agreed at the August Board, Mr Sweet and Ms McManus were arranging to meet to discuss the detail behind that report.

The Board **noted** the assurance given by Ms Raper on behalf of the 'home team' and the additional meeting Mr Sweet and Ms McManus will hold.

Medical Director Report

Dr Turnbull informed the Board that it had been confirmed that the new mortality measure will be Summary Hospital-level Mortality Indicator (SHMI). The definition has not been finalised and there are still some internal discussions being held. At the end of September the NHS Information Centre (IC) would publish the methodology. By 10 October, Trusts will receive their own SHMI scores; these will be restricted until the end of October when the SHMI scores will be published for all Trusts on the

NHS Choices website.

CHKS are intent on developing a more detailed analysis of performance and trends throughout different levels of the Trust down to patient level.

Dr Turnbull advised that he will continue to give the Board of Directors the crude mortality rate in the hospital along with the SHMI rate.

Mr Rose asked if the SHMI rate would be just the York hospital-based figures or include community too. Dr Turnbull advised that initially it will be just the York hospital, as the Trust does not code community hospitals at present.

The Board **noted** the comments.

Dr Turnbull advised that since the report had been prepared a further consultant appointment has been made. Mr Thompson was appointed as Vascular Surgeon. This appointment supports the vascular service; the next appointment required to support the service would be the Intervention Radiologist. The Board discussed the service and was reminded that it was a service across three Trusts – York, Scarborough and Hull.

Dr Turnbull added that the Trust is starting to work closer with Hull and there is starting to be more alignment of services with Hull.

The Board **noted** the appointments.

Mr Rose enquired what involvement the commissioners have in such alignment.

Mr Crowley explained that meetings are held with the commissioners to provide assurance about the services. The commissioners are able to comment and make suggestions, but it is for the Trusts to decide how they arrange themselves. It does not affect the functioning of the contracts held by the Trusts.

Dr Turnbull said that he had been asked to provide an update on the flu vaccination plan this year. Dr Turnbull advised that last year the mean uptake in the NHS was 37%. The Trust's performance was the fourth highest in the country at 83%. Generally the members of staff that did not receive the vaccination were doctors. 37% of PCT received the vaccination. The Trust now have the community staff as part of the complement of staff of the Trust, so it has been recognised that there would be some significant work to do with community staff to help them understand and support the vaccination programme.

The vaccines will be received by the Trust over the next couple of weeks and the programme will start on 17th October. The members of the Executive Board will be invited to receive their vaccinations on 19th October. The Board discussed the vaccine programme and understood the Trust would use the roving teams again and that there would be some concentrated effort in ensuring community staff are included. Ms Hayward added that the new Head of Occupational Health has experience from a previous job and would be using that experience to help encourage community staff.

The Board **noted** the comments.

Mr Rose invited Mrs Palazzo to comment on the report. Mrs Palazzo advised that, like the Chief Nurse report, the report is developing very well and they like the additional deep dive on important

issues that is undertaken in the report. The 'home team' looked at this report in detail and would like Dr Turnbull to comment on two aspects in his report: mental health liaison and deteriorating patients.

Mental health liaison

Dr Turnbull referred to his report and advised that the issue was at last being progressed. It has now been recognised as a problem and everyone involved has committed to resolving the issues as far as possible. He added that it had now been agreed that enhanced liaison would be implemented in the elderly department and emergency department and alcohol and drug abuse. The plan is to bring in an advanced nurse specialist to implement a system that will help reduce the alcohol and drug abuse.

The Board discussed the progress made and noted that a business case was being prepared and that a 6 month trial would be carried out in the elderly wards.

The Board **noted** the comments.

Deteriorating patients

Dr Turnbull advised that a significant amount of work had been undertaken in the hospital to improve the systems in place to identify the deteriorating patient. Patient at risk (PAR) score are a simple score taken by nursing staff and are a means to an end. Once a nurse sees deterioration in the score a doctor is called to review the patient. There is a second issue that the PAR score does not address which is when medical staff does not attend fast enough or the action taken is not an appropriate response to the problem. Salford Hospital has an electronic PAR system which alerts the appropriate medical team when a patient is deteriorating, and SNEY has a similar system. The Trust is now developing a similar system; the issue the system will not address is the speed and response given by the clinical team, so separate work is being undertaken to address those issues.

The Board **noted** the comments.

Chairman's items

Mr Rose raised a concern he had about the number of meetings and the coverage the Corporate Directors and Non-executive Directors are undertaking. The Board discussed the issue and agreed that it was for a limited period of time and that the energy and enthusiasm was there to maintain the pace. It was agreed, however, that following the proposed acquisition the approach to community and other meetings would need to be broadened and revisited.

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

The Board received a presentation from the Director of HR, Ms Hayward, on the Corporate Global Challenge including the award the Trust had received for completing the highest total mileage of any organisation in the world (in the 50-100 teams category).

Chief Executive Report

Mr Crowley referred to the negotiations with the Strategic Health Authority (SHA) and advised that the meeting referred to in his report to be held on 29th September had been cancelled following the challenge meeting held with the SHA. Mr Crowley and Mr Bertram had instead been asked to attend the SHA to discuss the requirements. The fair value for the Trust has been established from the work Ernst and Young has done, including the due diligence. The fair value has three elements – capital,

liquidity and revenue. In terms of Scarborough's formal debt liability and once the Trust makes the final payment at the end of this financial year there will be no further liability.

The SHA have reviewed the figures and are reviewing how others should become engaged in the discussions.

The Board **noted** the comments.

MSK review

Mr Bertram explained that the Co-operation and Competition Panel (CCP) has received a complaint from a company about the MSK service. The complaint is against the PCT and the Trust. The complaint is published on the CCP's website. The Trust has taken some legal advice informally. The issue for the Trust is one of affecting our reputation if it is found by the CCP that the Trust has not behaved properly. The CCP has no legal powers to amend the contract. Mr Bertram added that he has been contacted by the Health Service Journal (HSJ).

The PCT had undertaken a number of checks before the contract was let and significant testing was undertaken to demonstrate that the Trust had not undertaken predatory pricing (which is the basis of the complaint). The Trust is required to submit a response by 10th October 2011.

The Board **noted** the issues.

Carer's needs

Mr Crowley drew the Board's attention to the section in his report on carer's needs. He felt the development of the modules was an excellent demonstration of the Trust working beyond its remit and supporting people in other areas of their life.

The Board **noted** the report.

North Yorkshire Review

Mr Crowley explained the background to the review. Mr Crowley informed the Board that he had attended a meeting with a number of other Trusts at the SHA where the governance and commitment to the review were discussed. Each of the Trusts confirmed that they were fully committed to the implementation of the action plan. The SHA had proposed a sub-committee of the Health and Well-being Boards should be developed to take on leadership of the implementation of the review. He added that the SHA had committed to providing some analysis about where the actions fit within organisations and when the actions should be undertaken.

Mr Crowley added that all the work the Trust has been undertaking and the approach fits with the ethos of the review.

The Board discussed the review and noted that it was disappointing that there was no reference in the review to the System Management Executive (SME) and the work it has done.

The Board agreed that the Trust should wait for the sub-committee to be formed and the analysis to be undertaken before any further action can be taken by the Trust. It was agreed that an update would be received by the Board of Directors on a quarterly basis.

Action: A quarterly update to be received by the Board of Directors on a quarterly basis.

Operational Performance Report

Mr Cooney presented the Operational Performance Report and advised that the 'home team' had considered the detail in the report. Mr Cooney commented on the performance in the Emergency Department. He advised that the performance had been maintained and as a result Mr Cooney believes the Trust will achieve the targets for Q2. The bigger risk to the Trust is how the Trust manages the backlog. Mr Cooney advised that there was an action plan in place and he would report back to the Board of Directors on progress as appropriate.

Action: Include in the performance report, when appropriate, the progress on the management of the backlog.

Mr Cooney referred to the winter resilience plan. He advised that a business case had been approved and the infrastructure to manage the plan was being put in place. The winter ward would be opened in October, but at this stage the Trust is not expecting an epidemic.

Mr Cooney referred to the 18-week backlogs. He advised that the Trust had been quieter in August and slightly better in September. The data for September is unadjusted, so it is possible that there will be fewer long waiters. Mr Cooney added that it is not the intention to eliminate the backlog completely because the Trust is required to achieve a target of 98%, but to get it to a reasonable level where patients in the main are being treated within a reasonable period of time. He added that there will always be a number of patients that remain on the backlog for reasons such as the complex nature of the care needed or because they have not been able to attend appointments. Within General Surgery there has been an increase in demand which has resulted in a build up of the backlog. Mr Cooney advised that he has asked the Directorate Managers to implement various plans and is undertaking a review of the activity profiles with the Directorates. Mr Cooney added that one of the other options the Trust has is to use Ramsey. Currently Ramsey has some spare capacity and there could be opportunity to discuss a deal with them.

The Board **noted** the report.

Finance Report

Mr Bertram presented the report. He advised that the Income and Expenditure (I&E) report is not as good as he would have liked. The reason for the dip in the I&E is because the activity during August was below that which was projected. This was due to patients not being available and the Trust traditionally being quieter in August. Mr Bertram advised the Board that he did not believe there was any remedial work that should be undertaken at this stage.
Ms Raper advised that the 'home team' had reviewed the report and she would like to congratulate the finance department as they have resolved the overdue debts and the Trust now has no overdue debts. Ms Raper added that she felt the EBITDA report would become increasingly important in the discussions held at Board and 'home team'.

Ms Raper referred to the efficiency report and asked if Mr Bertram was concerned about the increased number of Directorates showing red.

Mr Bertram advised that support was being given to the Directorates who were finding it difficult. The Directorate Management team is being used to share their methods of making efficiencies and NHS Elect have developed a programme that would help to identify efficiencies. Work is also being

undertaken with the elderly department and the emergency department on the variation in the length of stay and the case mix in the department.

Mr Sweet asked if Mr Bertram thought the PCT would achieve their QIPP targets. Mr Bertram felt that it would be very difficult for them to achieve the target, although there is much better engagement with QIPP.

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

Service Line Reporting (SLR)

Mr Bertram outlined the progress in the project. He advised that Bellis Jones Hill (the company used by the Trust) had been asked by Monitor to support them in some work in their new role as the financial/economic regulator. As a result, Bellis Jones Hill had asked the Trust to provide them with some assistance.

Mr Bertram added that SNEY are in the process of implementing a different SLR system. As a result, a piece of work will be undertaken following the acquisition of SNEY to evaluate the two systems. Mr Bertram added that he would expect two systems to run for the first six to twelve months to ensure the availability of SLR information for all sites. The decision on the adoption of one system is based on a number of other decisions about systems, including SNEY using CPD, and therefore alignment on Service Line Management (SLM) should be enabled.

Mr Ashton added that the link between the Data Quality work group and systems must not be under estimated.

The Board discussed the issue and noted that there would be good clinical reasons why SNEY should adopt CPD.

The Board **noted** the report and asked for a further update to be presented to the Board when it is appropriate.

The role of the Board in maintaining high professional standards in the modern NHS

Professor Willcocks commented on the report. She said that she felt the report demonstrated that the right systems are in place for Board and it is useful to see how the escalation process works.

The Board discussed the paper and Dr Turnbull suggested that he should continue to advise the Board on any exclusions. Dr Turnbull added that the Responsible Officer (RO) should also be informed about the exclusions as it would impact on his work as RO.

It was **agreed** that the use of NEDs on the two current cases was fully consistent with the official standards recommended.

The Board **agreed** with the proposals made by Dr Turnbull and in the paper.

Summary of the minutes of the Board meeting held on 26th October 2011

Chief Nurse Report

Ms McManus advised that the 'Home Team' had discussed the report in detail.

The ‘Home Team’ (HT) consists of three Non-executive Directors who meet with the Executive Directors prior to the Board of Directors meeting to discuss the key performance reports – Chief Nurse Report, Medical Director Report, Operational Report and Finance Report. This additional meeting has been arranged to ensure the Board continues to be fully involved in the current activities in the Trust while the acquisition transaction is continuing.

Mr Sweet, a member of the HT, confirmed that the HT had discussed the report in detail and he advised he had been assured by the information discussed at the meeting. Mr Sweet commented on the presentation of the nursing care indicator (NCI) data. He advised that work was ongoing to ensure the presentation of the data in the report was as effective as possible.

Mr Sweet asked Ms McManus to comment on the issues around Ward 37 and Ward 25. Ms McManus explained that there had been some unacceptable risks identified on Ward 37 which had resulted in some specific actions, including a change of leadership on the ward. The issues had been identified through feedback and performance management.

Ward 25 was originally a surgical ward which was transferred to the Elderly Directorate and became a jointly managed ward. The ward retained its case mix, but was staffed on the basis of an elderly ward. This has meant that the level of staffing was lower; this has been identified as an issue and is now being addressed.

The Board discussed the Emergency Department (ED) redesign. Mr Cooney explained that there had been a rapid improvement event (RIE) exercise which had the potential to made vast improvements to the minor injuries. He added that the support from the Governors and LINKs had been excellent.

Ms McManus referred to the Care Quality Commission (CQC) reports. She advised that there were a number of actions to be undertaken as a result of the reports. Ms McManus advised that the Trust had been alerted to the imminent publication of the reports. They will be published on 26th October 2011 on the CQC website. Ms McManus advised that she was disappointed with the draft press release the Trust had received from the CQC and as a result the Trust had developed a press statement that will be released at the same time as the CQC statement. It was **agreed** that a copy of both press statements along with an electronic version of the reports would be forwarded to Governors, with an option for Governors to receive hard copy reports if they require them.

The Board discussed the possible effect the CQC message could have internally. The Board recognised staff had worked very hard to ensure the required standards were always maintained and that the visit was successful. Staff continue to work hard to undertake the actions that need to be put in place as a result of the reports. Professor Hutton added that he knew that staff understood how important the CQC were and he was sure that the next time CQC visit the Trust, staff would be working very hard to ensure there would be no conditions. The Board **agreed** with the comments made.

Ms McManus reminded the Board that the major concern related to ‘do not attempt resuscitate’ (DNAR) issues. She advised that this was a national issue. The Trust had introduced the new system and was working on ensuring it was in place in all areas.

Professor Willcocks added that she was in the Trust on the first day of the CQC visit and was impressed with the way staff continued to work as normal and everyone just got on with their work.

Professor Willcocks added that she felt the complaints data the Board received was not sufficient in

terms of the level of analysis of where the complaints relate to. She asked if there could be further analysis for the Board around the % of complaints made by the elderly.

Mr Sweet commented that he felt the appended report on the extracting of meaningful information from complaints was a good honest report and identified a better way of managing the data.

Ms McManus **noted** the comments made about the complaints information and **agreed** that further work would be undertaken.

Ms McManus added that the Trust was one of the finalists for an award from the Nursing Times. She would be attending the event in the near future. The Board enquired which initiative the award related to. Ms McManus advised it was for the pressure ulcer work. The Board wished her luck.

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

Director of Infection Prevention and Control quarterly report

Ms McManus advised that this report was the usual quarterly report which provided assurance to the Board that the Trust is complying with the standards outlined in the 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).

She advised that again the HT had considered the report in detail. Mr Sweet confirmed that the HT had discussed the report. He advised that the HT had discussed the significance of Methicillin Sensitive Staphylococcus Aureus (MSSA) and E-Coli and understood that at this stage the significance was not fully known in terms of trajectories and targets, but the Trust has ensured there are systems in place to ensure appropriate management. The Department of Health (DoH) require the Trust to report the number of MSSA infections and E-Coli , but at this stage there is no threshold applied to the North Yorkshire and York (NYY) PCT contract.

Mr Sweet asked Ms McManus to comment on the Clostridium difficile infection (CDI) numbers. Ms McManus advised that the threshold in the NYYPCT contract is 55 cases. Ms McManus asked the Board to look at the appendix 1a in the report. This appendix shows that since April 2011 there have been 17 toxin positive CDI cases and 25 symptomatic PCR (second stage testing).

Ms McManus referred to Hygiene Code Criterion 10 ‘Duty to ensure that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.’ She advised that the training was being split into two types, training for those that are new to the Trust and refresher training for existing staff.

The Board **noted** the change to training.

Sir Michael (Chairman of SNEY) asked Ms McManus what were the two or three things introduced that solved the problems of infection control in York.

Ms McManus advised that there was no one thing, it was a combination of initiatives, for example hand hygiene, upping cleaning standards. What was also critical to the success was the introduction of the narrower antimicrobial formulary.

Sir Michael added that his concern was about the attributing of the cases to the Trust, particularly admission from care homes after 6pm and at weekends. The Board agreed that there was a concern

about care homes, but the Trust did provide advice and training to care homes. Dr Turnbull added that the antimicrobial formulary had caused significant clinical debate because there was the risk that it may have gone too far the other way and the Trust could be creating a risk of more wound infections. This was being kept under review. Dr Turnbull added that the Trust is now working with three large groups of GPs with the antimicrobial formulary and was now starting to work with specific individuals around rolling-out the formulary across the whole of the community area.

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

Medical Director Report

Dr Turnbull advised that, as had been discussed in the Chief Nurse report, the HT had reviewed the Medical Directors report prior to the Board meeting.

Dr Turnbull commented on the key items in his report.

SHMI/HSMR

Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) are two measure of mortality. Until the introduction of SHMI this month, the Trust has used HSMR. Dr Turnbull advised that the difference between the two measures was outlined in his report. Dr Turnbull advised that the Trust's SHMI rate showed the Trust to be an outlier, on the high side The Trust is looking at the data, which is derived from elective admissions and it has now been established that the elective admissions data from St Leonard's Hospice has been incorrectly included with ours, so giving a higher than expected SHMI. Discussions are being held with the NHS Information Centre to resolve the issue. Dr Turnbull added that additionally the SHMI figure may also be included in the Dr Foster reports that are due for publication towards the end of November. Dr Turnbull added that the Trust continues to aspire to continue to reduce the SHMI figure. Dr Turnbull gave an overview of the Dr Foster information, (the presentation is attached to the minutes). The presentation showed that the Trust was within the expected range for all the HSMR sub categories, but the Trust is above the tolerance limits overall. He added that the figures in the Dr Foster report are based on 2010/11 statistics. Dr Turnbull also identified that there were concerns about the length of stay. Mr Ashton asked if there was a relationship between the higher length of stay and the long term outcome for patients. Dr Turnbull confirmed that the outcome is very good in terms of mortality and pneumonia. Acute Myocardial Infarction (AMI) statistics are falling within expected range.

The Board discussed the complex public relations issue the Dr Foster report raises for the Trust when it is published at the end of November.

Mr Crowley added that there is a significant amount of planning being undertaken by the Communications department to ensure there are clear messages prepared for the publication of the report. He added that any specific issues would be dealt with by Dr Turnbull, Ms McManus and Mr Crowley.

It was **agreed** that Dr Turnbull would attend the Council of Governors meeting on 21 December 2011 to cover this issue.

Professor Hutton added that it is difficult for the Trust to defend against poor figures, especially if consideration is given to the Mid Staffs situation. What assurance mechanisms does the Trust have in place? Dr Turnbull advised that he also provides the Board with the number of actual deaths during the month and case note reviews are undertaken to consider the quality of clinical coding. He added

that the Trust had in the past not been very effective at ensuring palliative care coding was correct and used in the same why as other Trusts use it. He advised that this issue has now been addressed.

The issue with St Leonard's Hospice was as a result of a computing error. It was believed that the error had been corrected, but this latest information shows that it has not been.

Mrs Palazzo added that she was delighted to see the excellent news around CQUIN. Mrs Palazzo asked Dr Turnbull to comment on the ward round checklist. Dr Turnbull advised that clinicians are asked to complete the document during ward rounds. The check list works better in some areas than others, as can be seen from the table included in the report. Completion of the document has received a mixed reception, with some clinicians feeling they are being closely managed.

Dr Turnbull drew the Board's attention to the Quest data included in the report. He explained that the data was giving comparative figures drawn over the last 5 months of the readmission rate in York. The figures showed there was a fall in the readmission rate to 5.16%, placing the Trust amongst the best performers and well ahead of the national average. Dr Turnbull added that the Trust had established a group working on avoiding un-necessary readmission, rather than on just reducing readmissions. He referred to some evidence from a study conducted in America which showed that it was hard to achieve and maintain the avoidance of unnecessary readmissions.

The Board **thanked** Dr Turnbull for the report.

Chairman's items

The Chairman presented his report and highlighted that Ms Goff led the recruitment of over 500 members in the new areas, which meant that the Trust now had the minimum number of members required to run a Governor election where required.

Mr Rose mentioned that he had attended a lunch and meeting with Monitor the previous day. The discussions with Monitor had been around the role of the governor, constitution and role of the CCP. He advised that Monitor had appointed PWC to undertake a piece of work around the tariff system and block contracts. They advised that they work in a 3-5 year cycle. PWC are looking at the number of block contracts and the quality added through the tariff system. This study is not expected to affect the Trust until 2013/14 or 2014/15. Mr Rose also advised that he had met the Chair from Basingstoke. Basingstoke is undertaking a similar transaction to York and SNEY and the Chair invited members of the Trust to come and visit Basingstoke. Their transaction is running about four or five months ahead of the SNEY transaction.

Mr Rose advised that the Trust has a new Monitor portfolio manager, Mr Robert Davidson, who would be visiting the Trust in the near future.

The Board **noted** the report.

Draft proposal on new board sub committees

Mr Rose presented the report. He advised that the Non-executive Directors had discussed some of the proposals which were included in the paper. The proposal was that there should be three additional Board sub-committees, one relating to finance and performance, one for quality and safety and one specific to workforce strategy. Mr Rose asked the Board to comment on the proposals. A number of points were made by the Board members; in summary, the Board thought the idea of a

finance and performance report was an excellent idea, it was the natural development of the HT work that had been undertaken and would ensure the Non-executive Directors would have more time to consider the detail more carefully. The Board also supported the introduction of the quality and safety committee for similar reasons.

Mr Rose asked Ms Hayward to comment on her suggestion for the workforce group. Ms Hayward advised that she felt it would be an opportunity for Board members to become more involved with the workforce issues and strategy, she suggested that the meeting should be held on a quarterly basis and would be around strategy and assurance. Focus would be on planning of the future workforce, utilization of the workforce, including links with the efficiency agenda, and providing assurance through workforce monitoring. She did expect that it would require the creation of additional information not currently reviewed by the Board. In addition to this sub committee Ms Hayward suggested the forming of a health and wellbeing committee to bring together a number of current agendas, and it would be useful if a Non Executive could join this group, although it would not be a Board sub committee.

Ms Raper enquired if the workforce meeting would be more of a task and finish group while the integration work was underway. Ms Hayward felt it would not be a task and finish group as the issues would remain after the integration was completed.

Mrs Palazzo commented that she felt the proposals had been something the Board would benefit from and was fully supportive of the introduction of all three committees.

Sir Michael asked if agency work and locums would be included in the work of the workforce committee. Ms Hayward confirmed issues of temporary workforce utilization, including the processes used would be included.

Professor Hutton expressed the view that he could see the value of the finance and performance committee and the quality and safety committee, but did not feel the workforce committee would be focused enough to provide the assurance the Board members would be seeking.

Mr Rose suggested that he would meet with the Non-executive Directors to discuss how their membership on the committees should be evolved. Mr Rose also suggested that Ms Hayward and Mrs Holden should meet to discuss the development of the Workforce Committee, which would combine issues from each Director's portfolio.

The Board discussed the use of Non-executive Directors in other more executive committees and **agreed** that there should be a focus on the areas where the Board members would gain the most assurance.

Dr Turnbull added that he valued the membership of a Non-executive Director at the Clinical Quality and Safety Committee, as it seemed to add more gravitas to the meeting and ensure there was a better understanding of the issues.

Professor Willcocks add that she felt it was important for the Trust to be clear why any specific committee was being formed and what the Board wanted from the committee, especially due to the perception of increasing Director Workloads.

Mr Ashton suggested that if these new committees were formed, then a review of the Non-executive Director linkages should be undertaken.

Mrs Palazzo made a general comment that she felt it was important that the proposal that the chair of the committee should be rotated on an annual basis should be changed to allowing a Non-executive Director to develop some sense of history and understanding of the issues.

The Board **noted** the comments and the proposed actions. The Chairman will progress the committee proposals.

Chief Executive Report

Mr Crowley asked Mr Bertram to update the Board on the progress with the MSK issue. Mr Bertram advised that the Trust had responded to the CCP request and was now waiting for the CCP panel to meet and conclude its judgment on the complaint.

Mr Crowley referred the Board to the Risk and Assurance Committee item included in his report. He advised that he was proposing that the Risk and Assurance Committee would meet on a quarterly basis instead of every six weeks.

The Board discussed the change and **agreed** it was the right time to change the timing of the committee.

Mr Crowley asked Ms Hayward to update the Board on the proposed industrial action on 30th November. Ms Hayward advised that there had been no further developments that updated the information in the report. The analysis that had been undertaken showed that the action could include about 850 staff although Ms Hayward was expecting other unions to comment and advise if staff would be on strike. Ms Hayward advised that it had been suggested that Trust should be treating the day as a bank holiday with clinics being cancelled and emergency planning would be put in place. Ms Hayward added that the Trust is also not allowed to employ agency staff for the day as it is illegal to do so to specifically replace staff who are on strike.

The Board **noted** the comments.

Operational Performance Report

Mr Cooney presented his report and explained that this was the second quarter corporate scorecard and the most significant risk around performance was the 18 week backlog. He added at present the Trust had achieved delivery, but it was becoming challenging. He added that if the backlog continues to increase then he projected that by the end of the financial year the Trust would be in breach of the target.

Mr Cooney was asked to explain the backlog figures included in the report. Mr Cooney explained that the total waiting list for the Trust was 3052 patients. There are 2306 patients waiting between 0-17 weeks. Mr Cooney added that there is expected to be a high level of referrals from the GPs in quarter 4. He advised that he would bring a report back to the Board that would assess the risk of an increase in the backlog and the work being undertaken to resolve the issues.

Action: Mr Cooney to present a report on the 18-week backlog at the November Board of Directors

Mr Sweet commented that the HT feels the report is developing well. Mrs Palazzo referred to the dashboard included in the report and asked for some additional clarity to be added to the amber items, to ensure it was clear which items the Board should be concentrating on.

Mr Sweet asked Mr Cooney to comment on the 1st referral and follow up ratio. Mr Cooney advised that as stated in the report this is the third month in a row that the Trust is slightly above the PCTs threshold. This has meant that the Trust has been required by the PCT to pay a penalty of £28,000 in the first quarter.

Mr Sweet asked Mr Cooney to comment on the diagnostic waits. Mr Cooney advised that 5 patients out of 3,261 had been waiting longer than 6 weeks. This was he believed a failure of not applying enough attention to the detail and had already taken action to rectify the issue.

Dr Turnbull commented about the 2-week cancer waits and advised that there is an additional challenge for the Trust. He explained that the use of the 2-week appointments was completely up to the GP and was arbitrarily used by them. There are occasions when a GP has sent a patient under the 2-week rule, and that patient would be considered to be low risk. This has the effect of disadvantaging other patients.

Mr Cooney commented that he had no concerns about the ambulance turn round times. Mr Cooney referred to the walk in centre and advised that the TUPE consultation was now underway and the capital work would be completed on time. The Board asked when the Orthopaedic outpatient service would be moved the Clifton Park Chapel. Mr Bertram advised that the first clinic appointments had been booked.

The Board **noted** the detail in the report and thanked Mr Cooney.

Finance Report

Mr Bertram advised that financially the Trust was back on track after the poor income position reported in August. He added that the margins remained very tight, but there has been strong in-month progress on the cost improvement programme (CIP). He added that he thought there was a key risk issue for the Board to be aware of; that being that we are currently trading ahead of the PCT plan. The PCT had resisted this forecast position for some time, expecting savings schemes to kick in later in the year to pull back demand. However, they are now beginning to acknowledge the issue and it is causing the PCT some significant concern. Mr Bertram advised that this would be picked up though the System Management Executive (SME).

Ms Raper advised that the HT had considered the finance report in detail and would ask Mr Bertram to comment on the two aspects of the report that made reference to earnings before interest, tax, depreciation and amortization (EBITDA). Mr Bertram explained the calculations performed by Monitor in relation to the Underlying Performance FRR and the Achievement of Plan FRR. Specifically that the lower weighted Achievement of Plan FRR sets a baseline using the EBITDA position for the previous year whereas the Underlying Performance FRR uses our planned (expected) EBITDA margin.

Ms Raper referred to the out patients attendance and follow up and asked Mr Bertram to comment. He explained as had been discussed earlier in the meeting that the now contractually agreed Q1 position included a £28k reduction to follow up income due to the contractual capped ratio level being exceeded. Dr Turnbull added that the follow-up ratio to new appointments is not necessarily an indicator of quality; there are occasions when patients prefer to have a follow-up in hospital rather than at the GP. Ms McManus added that, notwithstanding Dr Turnbull's comments, it is still possible to use follow-up appointments more efficiently and effectively. There is an opportunity to improve practice because historically there have been some additional challenges around a lack of facilities. The Board discussed the points being made and noted this was an area where more work would be

undertaken. Mr Bertram confirmed that this was underway through the Corporate Efficiency Team working with Directorate teams, using benchmarking information provided under the Better Care Better Value initiative.

Ms Raper referred to the CIP paper, she commented that it was a stronger position and asked how quality and safety impacted on the decisions and how clinical colleagues reflect their level of confidence. Mr Bertram advised that there are some significant examples of where quality and safety have been a critical aspect of the savings, for example the critical care outreach where quality and safety concerns resulted in some significant changes. Mr Bertram confirmed the changes that had been made to the CIP scheme development paperwork and the work of the Efficiency Committee to constantly assess for detrimental quality and safety impacts.

Professor Willcocks commented on the recently circulated efficiency newsletter, which she believes demonstrates a whole trust ownership of the issues.

The Board thanked Mr Bertram for the report and **noted** the comments in the report.

Acquisition Assurance Board

Mr Rose welcomed Ms Fenech to the Board meeting. Mr Rose asked Mr Ashton to comment on the work of the Acquisition Assurance Board (AAB).

Mr Ashton tabled a document that summarised the AAB meeting held on Friday 21st October.

Mr Ashton outlined the work the Board had undertaken in the meeting and congratulated all those involved in the development of the documents. He added that it was recognized that there were a number of reasons why the Board was not being asked to make a formal decision at this Board, as agreed in July 2011. He explained that the reasons included that there was still a final decision to be received from the Department of Health (DoH) on the fair value of SNEY along with the need to complete the Integrated Business Plan and Integration Plan. Mr Ashton commented that there was a further complication the Board should be aware of, relating to the Co-operation and Competition Panel (CCP). He advised that the CCP had published a timeline that would mean if it was kept to that the Trust would not be able to complete the Transaction at the end of March 2012. The CCP were suggesting that their work would not be completed until 5 April 2012. The Compliance Board at Monitor is not able to make a decision about the acquisition until after the CCP's report is received.

Ms Fenech added that at present the documents were being finalized and any comments Board members would like to make should be sent to her. She also explained that the Board would receive a copy of the SNEY dissolution business case, for information. She explained that the SNEY Board would approve that business case.

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

Legal due diligence report

The Board discussed the legal due diligence and noted the comments that Mr Ashton had made about the process. It was agreed that there was some additional assurance that could be received, but it was assured that work was ongoing and the final report would be received by the Board in November.

Constitution and Standing Orders

The Board noted the report submitted by Mrs Pridmore and the comments made by Mr Rose about the discussions held at the Council of Governors meeting. Ms Hayward enquired if the staff membership would be representative and whether introducing a staff governor specifically for community was inconsistent with the aim of fully integrating community staff. The Board discussed the point and agreed that it would be representative to the extent possible in the constitution. The Board noted the comments from the Council of Governors around the pressure for addition of more local authority members and noted the vote the Council of Governors had held.

The Board approved the revised constitution.

Mr Bertram asked Mrs Pridmore what the process was for the constitution. Mr Pridmore explained the process with Monitor and outlined the potential issue that might exist around the timing of the elections.

The Board of Directors also considered the standing orders and approved the standing orders.

Working draft of the Integrated Business Plan

Following the comments made by Mr Ashton and the subsequent comments from Ms Fenech about the working draft of the Integration Business Plan, Mr Rose proposed that the Board members should review the documents and provide comment to Ms Fenech by email, Mr Crowley suggested that any email comments should be copied to Board members, to avoid duplication.

Monitor Q2 submission

The Board considered the draft submission to Monitor and approved the documents. It was noted that the accompanying letter was in the process of being prepared.

Summary of the minutes of the Board meeting held on 30th November 2011

The Board of Directors was required at the meeting to consider the documents prepared in support of the acquisition of Scarborough and North East Yorkshire Healthcare NHS Trust, as well as normal Board business. The minutes reflect the two parts to the meeting.

Acquisition Assurance Board feedback

Mr Rose asked Mr Ashton if he would take the Board through the discussions held at the Acquisition Assurance Board (AAB) and lead the Board through the acquisition pack.
Mr Ashton tabled a paper summarising the discussion held at the AAB on 28th November 2011. Mr Ashton took the Board through the key points raised.

Mr Crowley was called away from the meeting.

Fair value negotiations

Mr Ashton explained that the fair value discussions were now being held between the Finance Director, Mark Ogden of the new North of England SHA cluster, and David Flory at the Department of Health. Mr Crowley and Mr Bertram confirmed that they had received positive comments back from the SHA but that discussions were continuing.

Mr Bertram added that he had held a discussion with Monitor about the exact timing of the Trust's submission, recognising the implications of delays and processes associated with bringing all partner organisations to the same deal agreement. Monitor suggested they would be relatively flexible on the submission of the information on 12th December.

Co-operation and Competition Panel (CCP) update

Mr Ashton updated the Board on the discussions held at the AAB around the CCP requirements.

Mr Ashton advised that a number of Directors were attending a meeting with the Chairman of the CCP (Lord Carter) in London, on Monday 5th December. The purpose of the meeting is to try to address some of the outstanding issues that existed.

The Board **noted** the comments and the meeting to be held on 5th December. The Board asked to be kept informed of any developments.

Self-Certification document

Mr Ashton explained that this was a report that Monitor required the Board to submit prior to financial and legal closure. The document includes a number of key statements which the Board need to provide an assurance statement to.

The Board of Directors considered the report and approved the assurance statements proposed. The Board **agreed** that Mr Rose and Mr Crowley could sign the document.
The Board noted that a further version of the document would be presented to the Board of Directors meeting in January 2012.

It was **agreed** the document would be included in the submission to Monitor.

Legal due diligence final report

Mr Ashton reminded the Board that the AAB had received a presentation from Beachcroft on the results of the due diligence and that the Heads of Terms had been built on the basis of the outcome of the financial and legal due diligence.

The Board **noted** the risks that had been identified

Clinical due diligence final report

Mr Ashton advised that this was the last due diligence report the Board had to consider in this meeting. The AAB had considered the report for the first time and Ms McManus had attended the meeting to explain the findings and the action being taken. Mr Ashton asked Ms McManus to comment on the due diligence.

Ms McManus described the process SNEY had gone through to produce the information. She reminded the Board that the purpose of the document was to identify the risks. SNEY does have a number of action plans in place that address all the issues but Ms McManus has asked for a composite plan to be put in place to address the issues.

The report is comprehensive and the Board should be assured about the systems that are in place to pick up clinical issues such as those identified in the report.

Ms McManus explained that the clinical due diligence was the first of a suite of documents that would be reviewed by the Board of Directors over the next three Board meetings. The suite includes the Quality Governance Framework, which will be presented to the Board of Directors in December and the Medical Director's statement, a draft of which will be submitted to the Board meeting in December and the statement being submitted at the January Board meeting for approval.

Dr Turnbull added that there was nothing in the report that would prevent the transaction from progressing but there were some concerns that did need to be addressed and those concerns were being through the action plan.

The Board **noted** the comments and **agreed** the document should be submitted to Monitor in December. The Board also **noted** they would receive the Quality Governance Framework for approval at the December meeting along with the draft Medical Director Statement and the final Medical Director Statement at the January meeting.

Integrated Business Plan (IBP)

Mr Rose welcomed Ms Fenech to the Board to present the IBP. Mr Ashton reminded the Board that they had seen a copy of the document at the last meeting. The document had been significantly edited and additional information had now been included. He explained that the purpose of today was to approve the document for submission to Monitor in December.

Mr Rose invited Ms Fenech to comment on the document. Ms Fenech advised that a considerable amount of work had been undertaken on the document since the last version was presented to the Board and she considered the document to be almost complete.

Mr Ashton advised the Board that the Reporting Accountant would use the document as one of the core documents for the development of their report.

The Board **approved** the IBP subject to the minor amendments that would be made over the next few days before the documents are submitted to Monitor.

Integration Plan

Ms Fenech advised that she believed the document was complete; there was one section missing that related to the management arrangements for the Trust. Mr Rose advised that the detail of the management arrangement section was being discussed at the Remuneration Committee to be held after the Board of Directors meeting.

Ms Fenech also advised that there would be one significant change made before submission, which was in the clinical integration plan. She advised that the worked examples would be changed so they relate to SNEY and York and would link with the dissolution business case.

The Board **approved** the Integration Plan and **noted** the document would be submitted to Monitor in December.

Dissolution Business Case

The Board was presented with the dissolution business case for information. The Board does not make any decision on the document. The SNEY Board is required to approve the document.

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

Heads of Terms

The Board **noted** the negotiations currently underway. It was **agreed** that Mr Crowley and Mr Bertram would continue the discussions with the SHA and the Department of Health as appropriate.

The Board **noted** the status of the Heads of Terms.

Risk and Evaluation Investment document (REID)

Mr Ashton explained that the REID document was not a mandatory document but did provide additional assurance to the Board around the transaction. Monitor released the REID document as best practice guidance. The Board is asked to note the content of the REID and note that due process has been followed.

The Board **approved** the REID subject to some minor changes proposed by the AAB. The Board **agreed** the REID should be submitted to Monitor in December.

Chief Nurse Report

Ms McManus advised that the 'Home Team' had discussed the report in detail.

The 'Home Team' (HT) consists of three Non-executive Directors who meet with the Executive Directors prior to the Board of Directors meeting to discuss the key performance reports; Chief Nurse Report, Medical Director Report, Operational Report and Finance Report. This additional meeting has been arranged to ensure the Board continues to be fully involved in the current activities in the Trust while the acquisition transaction is continuing.

Ms McManus commented that there were no significant issues to bring to the attention of the Board.

The Board noted that the report included comment about the outpatient survey and asked if there was anything the Board should made aware of. Ms McManus advised that at this stage there was nothing to bring to the Board's attention. When the final report is received by the Trust it will be reviewed by the Corporate Directors and compared with the Picker report. At present the view from the surveys shows the Trust being average. This is not where the Trust aspires to be so work will need to be undertaken to ensure the Trust is above average. Mr Crowley supported the comments made by Ms McManus.

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

Medical Director Report

Dr Turnbull advised that, as had been discussed in the Chief Nurse report, the HT had reviewed the Medical Director's report prior to the Board meeting. Ms Raper advised that there were six issues the HT would like to explore further; the first issue she wished Dr Turnbull to comment on was the Mortality and Dr Foster issues.

Dr Turnbull tabled two documents; the first demonstrated the hierarchy of harm drawn up by Dr Foster. The document shows the Trust, in common with most Trusts across the country, has a slightly

higher rate of mortality for those patients admitted at weekends. The second paper demonstrated how CHKS interpret the mortality indicators. It shows that the Trust is an outlier in two areas.

Summary Hospital Mortality indicator (SHMI), which is the Department of Health (DoH) indicator - The Trust is shown as an outlier, because of the accidental inclusion of hospice data; this will be corrected in the next version.

Hospital Standardised Mortality Ratio (HSMR) figure has fallen. The change was largely as a result of the Trust reviewing the coding, specifically around palliative care. This made a difference to the HSMR but not the SHMI. Dr Turnbull added that whilst the coding issues identified did affect the SHMI and HSMR, they did not affect the quality of care and that these are also essential to address.

Dr Turnbull added that the Trust was continuing to improve the coding systems along with undertaking significant work around the deteriorating patient and patients being admitted out of hours.

The Board discussed the possibility of adverse publicity and Dr Turnbull advised that there had been a number of stakeholders such as Monitor, SHA, DoH and Deanery discussing the various mortality measures with him. Professor Hutton asked if there was any assistance the Board could give on supporting Dr Turnbull in his discussions. The Board discussed the suggestion and Professor Hutton suggested he could talk to the Public Health Observatory (PHO) about providing the Trust with some independent assurance.

The Board **agreed** that would be an excellent opportunity for the PHO to add some additional assurance.

Annual Infection Prevention Control Report

Mr Rose reminded the Board that they had seen quarterly Infection Prevention Control Reports during the year and that this report was the annual report that summarised all the quarterly reports.

Ms McManus added that there was nothing specific in the report she wished to draw the Board's attention to as the issues within the report had been picked-up during the year.

The Board considered the report and congratulated the Infection Prevention Control team on their work during the year. The report was **approved.**

Care Quality Commission (CQC) reports

Ms McManus referred the Board to the collection of CQC reports included in the papers. She advised that the action plan required by CQC and included in the papers had been submitted to the CQC within the prescribed timeline.

The Compliance Unit are working with the Elderly and Medicine Directorate to improve the 'Do not attempt Cardio-Pulmonary Resuscitation (DNACPR)' systems. They are making sure all the systems are consistent and working on the cultural aspects. Dr Turnbull advised that there is significant work to be completed to ensure the Trust is compliant with the requirements. The first reviews that have been undertaken by the Compliance Unit showed poor compliance with the requirements but recently the level of compliance has improved significantly. Dr Turnbull and Mr Crowley have also made some additional demands on consultants to comply through a further letter to them but it remains a risk to the Trust.

Ms McManus advised that the Quality Risk Profile (QRP) produced by CQC had not changed as a result of the reports and, when the Trust speaks to our relationship manager at the CQC, she confirms the Trust is not considered to be a poor performing Trust.

Mr Sweet added that the Compliance Group had discussed the QRP and were most impressed that the QRP had not changed following the reports.

The Board **noted** the reports and action plans and the work being undertaken. The Board discussed when the CQC would return to the Trust; Ms McManus advised that the action plans will be completed by mid January and the CQC would return after it was completed. Once they have reviewed the areas, and confirmed the Trust has complied, the Trust will be able to advise Monitor that the Trust has complied and, as the Governance rating system is a live system, the Trust's governance rating will be changed appropriately.

Communication Strategy update

Mr Rose asked Ms Raper to comment on the report presented. Ms Raper advised that she felt the Communications Department had come a long way in the last 12 months. She advised that Mrs Brown (Head of Communications), Mr Crowley and her had met and discussed the strategy and how it was being implemented. Ms Raper added that she felt that the introduction of the support for Mrs Brown had allowed her to be freed to work more on the senior leadership of the department and it was demonstrating results.

Ms Raper added that she felt the internal and external communications related better to each other, although she still felt some frustration about the lack of consistent adoption of one brand image by the whole Trust.

E-communications was also improving and the hard-to-reach groups that use e-communications were starting to be reached.

Ms Raper added that a robust plan was being put in place for the next stage of the work but the Board should be assured that the quality and responsiveness of the Trust to the media had improved significantly over the last 12 months. She congratulated Mrs Brown on her achievements.

The Board discussed the website and **agreed** there is still some significant work to be completed on the website.

Proposal on partner discussions

Mr Rose presented the report and described the proposal outlined in the paper. The Board **agreed** that it was an excellent proposal. Mr Rose suggested that the first partnership discussion should be about the relationship the Trust has with Harrogate Foundation Trust. Mr Rose asked for volunteers to undertake the work and present to the Board. It was **agreed** that a Non-executive Director would take the lead on the discussion about the Trust's relationship with Harrogate Foundation Trust. The Board discussed that the exercise could be an excellent way of introducing senior managers to the Board of Directors.

Professor Hutton offered to undertake the work around the relationship with the Trust and the University of York. Mr Rose thanked Professor Hutton and **agreed** he would undertake the work around the relationship between the Trust and the University.

Professor Willcocks suggested that there was a further organisation that should be included -Joseph Rowntree Foundation. The Board **agreed**.

It was **agreed** that there would be a presentation at the Board in March on the Harrogate relationship.

Membership Report

Mr Rose presented the report. He asked the Board to note the increase in the membership. Ms Hayward asked if there was sufficient clarity as to why we were aiming for increasing membership. She suggested that there should be two levels of membership, those that the Trust would only communicate with and those that actively want to be involved in the Trust. Mr Rose explained that the increase in membership reflected the engagement the Trust has on the east coast. He added that it is important how the Trust engages with the membership and the Council of Governors does have a responsibility to make sure the engagement with the members is appropriate. It was agreed by all that the quality of engagement was more important than the numbers but that numbers need to be credible enough for electing Governors from each constituency.

The Board **noted** the report.

Chief Executive Report

Mr Crowley presented his report. He drew attention to the following items:

- Monitor compliance framework - Mr Crowley advised that the Trust's current governance risk rating following the publication of the CQC report had moved from green to amber-red
- Musculoskeletal (MSK) service review – Mr Crowley advised that there was nothing further to report on the MSK review
- North Yorkshire Review (NYR) – Mr Crowley advised that the report outlined the arrangements that were being put in place for the NYR
- Reference costs – Mr Crowley explained that the report showed the Trust's reference costs were at the same level as they had been some years ago. He explained that the information had been provided to the Board as a way of assurance. He added that there had been some drift due to the introduction of the medical school but the costs are now back where they were

Mr Rose enquired if this was something Monitor would be interested in. Mr Bertram advised that on its own he did not believe Monitor would be interested but as part of background information it was very useful.

The Board **noted** the report.

Community Estate information

Mr Rose welcomed Mr Golding to the Board meeting and asked him to present the report. Mr Golding reminded the Board that when the Trust took on community services, the estates issues around the community services had not been agreed. This report explains that there has now been some guidance that means some of the ownership of property will be transferred to the Trust as long as a number of criteria are satisfied. The DoH has recommended to the PCT that certain sites are transferred. The Transfer will not cost the Trust any money and is valued at £27m.

Mr Golding asked the Board to note the proposed transfer and support the early indication to the SHA

of the Trust's interest. The Board **agreed** that the SHA should be advised of the Trust's interest in owning the properties.

Equality and Diversity Annual Report

Mr Golding advised that this was the first annual report. He asked the Board to note the report and that a further discussion about Equality and Diversity would be held in the afternoon session.

The Board congratulated Mr Golding on the excellent work he had undertaken during the year. Professor Willcocks commented that the report underplayed the full extent of the work undertaken during the year and the progress made by the committee.

The Board **noted** the report and the work.

Operational Performance Report

Mr Cooney advised that the HT had discussed the performance report in detail and there were no specific issues that should be brought to the attention of the Board. Mr Rose asked Mr Cooney to confirm that there was nothing in the report that must be discussed by the Board at this meeting. Mr Cooney confirmed that there was nothing in the report that could not be discussed at the Board meeting in December.

18 week report

Mr Cooney outlined the Trust's current 18 week admitted backlog position and method of management. It was agreed that this method of delivery of the admitted target was not sustainable and there was also a moral question relating to patients who had waited a very long time once they had breached the 18 week standard.

After exploring the risks involved with the proposals in the paper, the view from the HT was to support the paper and the planned Q4 failure. Mr Cooney asked the Board to confirm that they were assured by the proposal made and provide authority to Mr Cooney to proceed on that basis.

It was noted that regular feedback would be required by the HT to monitor the progress of the planned failure and how quickly the backlog was reducing. It was agreed that there was likely to be little internal clinical resistance to the proposal as it was attempting to resolve a long standing problem that clinical colleagues felt was unjust.

The Board **agreed** with the observation that there was both a moral and delivery issue that should be addressed. The Board **agreed** that Mr Cooney had authority to develop the proposal on the basis that he would bring his further findings back to the Board in due course.

It was **agreed** that an update paper would be presented to the Board of Directors when it had completed its governance route.

The Board **noted** the detail in the report and thanked Mr Cooney.

Finance Report

Mr Bertram advised that there were no significant issues he wished to draw to the attention of the Board of Directors. The report has also been noted by the Home Team.

The Board **noted** the report.

HR Quarterly Performance Report

Ms Hayward advised that there were no significant issues she wished to draw to the attention of the Board of Directors.

The Board **noted** the report.

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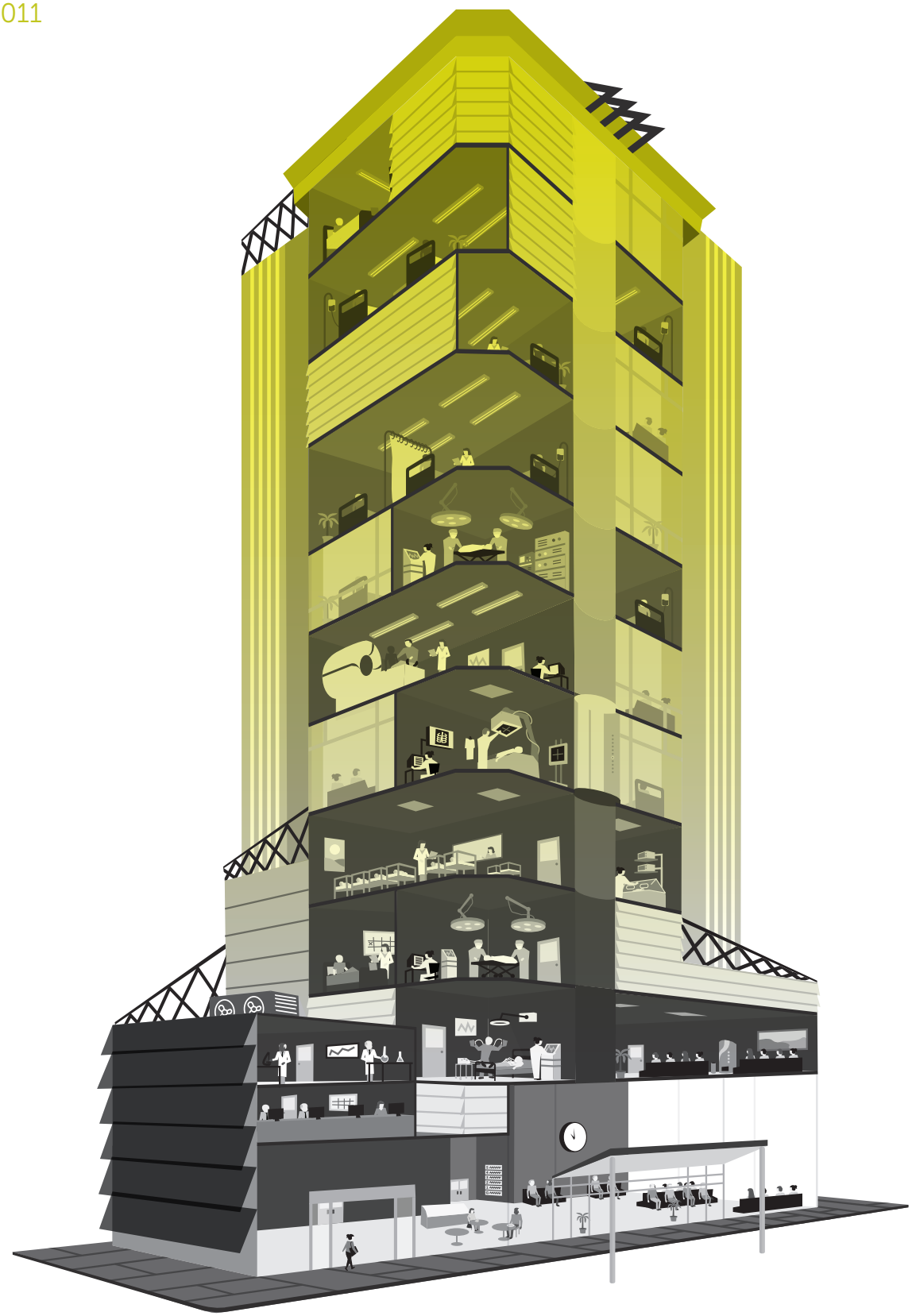
Inside your hospital

DR FOSTER HOSPITAL GUIDE
2001–2011



dr foster® intelligence

About Dr Foster

Dr Foster Intelligence aims to improve the quality and efficiency of health and social care through better use of information. We are a joint venture between the Department of Health and Dr Foster Holdings LLP, and provide a unique, innovative public service.

One of Dr Foster's key objectives is to promote the development of an information culture in the NHS by providing appropriate insight and analysis to clinicians, managers and organisations in order to help them deliver the best quality healthcare. We also provide comparative information about the performance of hospitals to consumers, to enable them to make informed decisions about their care. Our thought leadership programme seeks to share new thinking, provoke debate and stimulate action in transforming data into knowledge. We are committed to transparency and publish all our methodologies in full.

The Dr Foster Unit at Imperial College London has developed pioneering methodologies that enable fast, accurate identification of potential problems in clinical performance, as well as areas of high achievement.

Dr Foster works to a code of conduct that prohibits political bias and requires it to act in the public interest. The code is monitored by the Dr Foster Ethics Committee, an independent body chaired by Professor Alan Maynard, director of the Health Policy Group, York University.

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Contents

Introduction

Roger Taylor
Co-founder, Dr Foster

10 HOSPITAL GUIDES

This is the tenth Dr Foster Hospital Guide. It is a moment to reflect on how healthcare has changed in England over the past ten years. The timeline on page 8 summarises some of the key facts.

Improvements in patient safety, reductions in infection rates and better waiting times have all contributed to an improved NHS.

There has been a remarkable fall in mortality rates. The death rate among the population is over 20 per cent lower than it was a decade ago, helped by better hospital care.

At the same time, it is concerning that many of the issues raised in the first Hospital Guide remain problems ten years later: hospitals performing low volumes of surgery where high levels are needed to ensure good outcomes, and hospitals failing to meet the best standards of care despite many years of evidence of the impact this has on patients.

A safe NHS is an NHS that provides care 24/7. This year's guide shows that we are some way from that target, with significantly reduced services at weekends and nights. It will take hospitals, GPs and ambulance crews working together to configure services in a way that ensures safe care round the clock.

For some conditions, greater concentration of specialist services in fewer but high-performing hospitals is required. For other conditions, providing services locally at weekends and evenings is the answer. It means changing the way our hospitals work.

The examples of best practice in this guide demonstrate that it is possible.

10 THINGS WE HAVE LEARNED THIS YEAR:

1. There are many ways to measure mortality rates but, however you measure it, some hospitals appear to have consistently high and low mortality rates. **Chelsea and Westminster** stands out as a hospital with low rates on every measure. At the other extreme, **Hull and East Yorkshire Hospitals** is notable for consistently high rates. See pages 12–18
2. Being admitted to hospital at weekends is risky. Patients are less likely to get treated promptly and more likely to die. The chances of survival are better in hospitals that have more senior doctors on site. But some hospitals with A&E departments have very few senior doctors in hospital at weekends or overnight. See pages 19–21
3. Delivering safe care 24/7 does not require more resources. Local A&E departments need to identify the services they can provide safely and link with others to provide the services they can't. Examples of best practice, from London to Northumbria, demonstrate what is possible. See page 22
4. London has now achieved the lowest mortality rate following a stroke in England by cutting the number of A&E departments treating stroke from 31 to eight, but making sure those eight provide the highest standards of care. The rest of the country should follow suit. See pages 23–25
5. Do not have an abdominal aneurysm repaired in one of the 39 hospitals that perform the operation infrequently. Patients are much more likely to die. See pages 30–31
6. Private hospitals providing services to NHS patients get good outcomes and positive patient ratings. Of course they have a much easier task, dealing only with relatively fit patients. Nonetheless, if you are one of those patients, these organisations can offer a high-quality service. See pages 34–35
7. Better care saves money. Hospitals that implement best practice in helping patients recover quickly from surgery achieve better outcomes for less money. See page 36
8. Some aspects of patient safety are improving but harm to patients still happens far too often. Unfortunately, we still do not record what happens to patients with sufficient accuracy to properly gauge how best to tackle the problem. Improvements to the data are the first essential step to addressing the problem. See pages 37–39
9. Take note of what other patients say on the web about their care. It provides a valuable insight. In some cases, more than three-quarters of patients commenting say they would not recommend their hospital. In others, over 90 per cent would. See pages 40–42
10. Staff behaviour is crucial to patient experience. Our analysis of patient comments on the internet shows that disrespect and not being kept informed are the two main reasons why patients would not recommend their hospital. This matters to patients far more than single-sex wards or cleanliness. See pages 40–42

2001

10 Hospital Guides: 10 years of improvement in the NHS

> I campaigned for the publication of mortality ratios as I wanted clinicians to use these to monitor and improve care. It is very pleasing that, ten years on, these are now used widely by clinicians, managers, and regulators to check their treatment of patients.

Professor Sir Brian Jarman,
Director, Dr Foster Unit, Imperial College London

2011

2011 marks the tenth edition of the Dr Foster Hospital Guide. When we started, our mission was simple: transparency in outcomes, choice for the patient and accountability for the hospitals. It remains the same today.

Progress in some areas has been remarkable, not least the fall in hospital death rates using our key mortality measure, the Hospital Standardised Mortality Ratio (HSMR). Death rates across the UK have fallen dramatically over the past ten years. In 2009, there were under half a million deaths registered. The last time the figure fell this low was in the mid-1950s, when the population was 10 million fewer[1].

Some of the reasons for this fall are undoubtedly improvements in hospital care. The fall in the HSMR points to this fact. While some of the reasons for the decline are artefacts in the data – improvements in coding and identifying underlying health conditions (co-morbidities) – one cause is surely medical advances and better hospital care. By publishing these data, Dr Foster has helped clinicians and managers become aware that they may have a problem and start to put it right.

Our information directly led to investigations at Mid Staffordshire NHS Foundation Trust and Basildon and Thurrock University Hospitals NHS Foundation Trust. It has also led to many changes in practice across the NHS. Mortality rates, now published on the NHS digital portal NHS Choices (www.nhs.uk), are an accepted currency in measuring quality and safety in the NHS. The new Summary Hospital-level Mortality Indicator (SHMI) is a welcome contribution to this field.

HOSPITAL GUIDE KEY THEME

First publication of hospital mortality ratios
01/01

First publication of heart surgery mortality ratios
03/02

Spotlight on long waiting times
04/03

Information on elective operations to support patient choice
05/04

Hospitals rated on quality, efficiency and patient experience
12/05

Problems highlighted at Mid Staffordshire NHS Foundation Trust
04/07

Measurement of 'Darzi' outcomes
11/08

Concerns raised over patient safety failings at Basildon & Thurrock University Hospitals NHS Foundation Trust
11/09

Measuring the NHS outcomes framework
11/10

Safety and quality 24/7
11/11

STANDARDISED ALL-AGE ALL-CAUSE MORTALITY

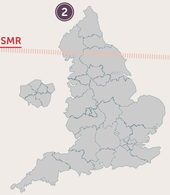
6,650 Per million people
6,631
6,617
6,265
6,131
5,914
5,791
5,746
5,478
5,378

AVERAGE INPATIENT WAITING TIMES[2]

96 Days
99
95
84
78
79
60
48
50
50

HOSPITAL STANDARDISED MORTALITY RATIO

115 HSMR
114 HSMR
110 HSMR
106 HSMR
100 HSMR
94 HSMR
88 HSMR
82 HSMR
74 HSMR
67 HSMR



3 Patient Choice introduced

4 Healthcare Commission

7 CHKS EXCELLENT

7 CareQuality Commission

2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011

REGULATION

1. Bristol Inquiry report highlights unsafe practices at Bristol Royal Infirmary and recommends greater transparency and use of data to monitor outcomes

2. NHS star ratings published

3. Monitor established to regulate the new, more independent foundation trusts

4. CHI replaced by the Healthcare Commission

5. Shipman Inquiry published, highlighting difficulties in regulation of doctors. It leads to the introduction of re-licensing for doctors

6. Healthcare Commission publishes investigation into infection control at Maidstone and Tunbridge Wells NHS Trust, highlighting failings in quality of nursing care

7. CQC replaces Healthcare Commission

8. Healthcare Commission publishes investigation into Mid Staffordshire NHS Foundation Trust

9. First Mid Staffordshire Inquiry highlights poor quality of care at the hospital following concerns raised by mortality rates published in the 2007 Dr Foster Hospital Guide

NHS REORGANISATIONS

1. NHS reform bill receives Royal assent, abolishing Community Health Councils and promoting greater competition within the NHS

2. Strategic Health Authorities and 300 Primary Care Trusts established

3. Patient Choice introduced, allowing patients referred for common elective procedures to choose between local hospitals

4. First foundation trusts established

5. Payment by Results introduced

6. Independent treatment centres begin treating NHS patients

7. PCT and SHA reconfiguration: Annual Health Check replaces star ratings

8. Patient forums replaced by LINks

9. PCTs separate into commissioning and provider arms

10. Coalition government takes office and publishes Liberating the NHS, a white paper proposing clinician-led commissioning

11. NHS reforms pause and Future Forum established

EVENTS

1. National Programme for IT (NPfIT) established, with the aim of making electronic patient records available throughout the NHS. Ten years on, the programme will be pulled without having achieved this objective

2. Dr Foster Intelligence, a joint venture between the Department of Health and Dr Foster, is established to encourage a market to develop in analysis and interpretation of healthcare data

3. Dr Foster launches the NHS Choices website to provide better information to the public about NHS services

4. Ban on smoking in public places

5. High Quality Care for All published, making safe, effective care and a good patient experience the key goals of the NHS

6. Dr Foster launches the first global hospital benchmarking project

7. NPfIT abolished after ten years without achieving objectives

SECRETARY OF STATE FOR HEALTH

ALAN MILBURN

JOHN REID

PATRICIA HEWITT

ALAN JOHNSON

ANDY BURNHAM

ANDREW LANSLEY

LABOUR GOVERNMENT

COALITION GOVERNMENT

Hospitals with the *highest and lowest* mortality rates

There are many ways to measure mortality rates. But however we do it, we find enormous differences in the outcomes for patients treated at different hospitals.

Hospital mortality measures

Hospital Standardised Mortality Ratio (HSMR)		
	A measure of deaths while in hospital care based on 56 conditions which represent 80 per cent of deaths. Deaths only take place in hospital	USES A check on the quality of care given in hospitals. High ratios can be used to identify underlying problems
Summary Hospital-level Mortality Indicator (SHMI)		
	Deaths following hospital treatment. Based on all conditions, deaths are measured which take place in or out of hospital for 30 days following discharge	USES A check on the quality of care in hospitals and immediately after discharge
Deaths after Surgery		
	Surgical patients who have died from a possible complication	USES May indicate problems with surgery, either patients developing complications during surgery or raising questions about whether some operations should have taken place
Deaths in Low-Risk Conditions		
	Deaths from conditions where patients would normally survive	USES To monitor and investigate particularly unexpected deaths

We are featuring four measures of mortality in this year's Hospital Guide. The table to the left summarises what each of these measures looks at. All these measures should be used as 'red flags' or warning signs. They indicate that there is a risk that poor quality care is leading to higher than expected mortality; they do not prove that this is happening.

Clinical leaders in each hospital should investigate incidents where their hospital is what we call an 'outlier' (this means their mortality ratio is significantly higher than the predicted value). Patients and the public should also be aware that these warning signs have been identified.

Trusts with high mortality rates

No trust is higher than expected on all four mortality measures. Two trusts – **Hull and East Yorkshire Hospitals** and **University Hospital of North Staffordshire** – are higher than expected on three of our four mortality measures. Both are high on deaths after surgery, which looks at patients who undergo surgery and have complications. **Hull and East Yorkshire Hospitals** is also high on HSMR and SHMI. Last year, Hull argued that its high in-hospital mortality rate was due to the fact that more patients remained in hospital to die than at other trusts. The SHMI provides a useful reality check by comparing all deaths within a fixed time of treatment, whether or not they occurred in the hospital. Hull appears high on this measure also. Hull has now registered high mortality rates on a number of measures for two years running.

University Hospital of North Staffordshire is one of five trusts that have high mortality rates among patients with conditions where risk of death is very low. The majority of these deaths are among older patients and none of these hospitals has outlying mortality rates if this analysis is limited to patients under 75. The deaths will often relate to pre-existing underlying conditions. Nonetheless, where rates are higher than expected, understanding the causes is important.

The table below lists the 19 hospital trusts that have high mortality rates measured both with the in-hospital measure (HSMR) and the all-deaths measure (SHMI).

Blackpool Teaching Hospitals NHS Foundation Trust
Buckinghamshire Healthcare NHS Trust
Burton Hospitals NHS Foundation Trust
Dartford and Gravesham NHS Trust
George Eliot Hospital NHS Trust
Hull and East Yorkshire Hospitals NHS Trust
Isle of Wight NHS Primary Care Trust
Medway NHS Foundation Trust
Mid Cheshire Hospitals NHS Foundation Trust
North Cumbria University Hospitals NHS Trust
Northampton General Hospital NHS Trust
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust
Shrewsbury and Telford Hospital NHS Trust
The Dudley Group of Hospitals NHS Foundation Trust
The Royal Wolverhampton Hospitals NHS Trust
United Lincolnshire Hospitals NHS Trust
University Hospitals of Morecambe Bay NHS Foundation Trust
Worcestershire Acute Hospitals NHS Trust
York Teaching Hospital NHS Foundation Trust

19

trusts are high on two key indicators. Two trusts, **Hull and East Yorkshire Hospitals NHS Trust** and **University Hospital of North Staffordshire NHS Trust**, are high on three

METHODOLOGY

Most of the indicators in this report are risk-adjusted outcomes. We compare the actual number of events (i.e. deaths) in an NHS trust against the number of events 'expected' (i.e. the predicted number of deaths). This latter value accounts for several factors outside the control of a hospital, such as the age and sex of the patient. We determine outliers using 99.8 per cent control limits. This means we are 99.8 per cent certain that the result differs from the expected range and there is a 0.2 per cent risk that it is a 'false positive'. We either calculate adjusted ratios (where performance is compared with a national average of 100) or adjusted rates (which are a percentage).

Trusts with low mortality rates

Only one hospital, **Chelsea and Westminster Hospital,** achieves low mortality rates across all four of our mortality indicators. This is an impressive achievement and warrants a special mention in our Trust of the Year awards. The **Royal Devon and Exeter** was low for SHMI and deaths after surgery. The following trusts were low on both the HSMR measure of in-hospital mortality and the SHMI measure of mortality in-hospital and after discharge. Those with an asterisk were also low for deaths after surgery. Those marked with † were also low for deaths in low-risk conditions.

Barnet and Chase Farm Hospitals NHS Trust
Barts and the London NHS Trust
Cambridge University Hospitals NHS Foundation Trust
Chelsea and Westminster Hospital NHS Foundation Trust*†
Epsom and St Helier University Hospitals NHS Trust
Frimley Park Hospital NHS Foundation Trust
Guy's and St Thomas' NHS Foundation Trust
Imperial College Healthcare NHS Trust†
King's College Hospital NHS Foundation Trust†
Kingston Hospital NHS Trust†
Newham University Hospital NHS Trust†
North West London Hospitals NHS Trust
Royal Devon and Exeter NHS Foundation Trust*
Royal Free Hampstead NHS Trust
Sheffield Teaching Hospitals NHS Foundation Trust
South London Healthcare NHS Trust†
St George's Healthcare NHS Trust
The Whittington Hospital NHS Trust†
University College London Hospitals NHS Foundation Trust†
University Hospitals Bristol NHS Foundation Trust
West Suffolk Hospitals NHS Trust

Coding of end of life care

It is important to adjust death rate measures to take into account patients who are admitted to hospital to die. Hospitals interpret the rules about how to record this in different ways. Higher rates of palliative care recording can lower a hospitals mortality ratio. For this reason, the SHMI measure makes no adjustment for palliative care. In contrast, with the HSMR, we have taken the decision to adjust for palliative care – because it is fairer to trusts that have a hospice on site – but also to publish the rates of palliative care recording by different trusts. The list below shows trusts that code over a quarter of their in-hospital deaths (HSMR) as being palliative care cases. Data for all trusts can be found at our website, www.drfosterhealth.co.uk.

Aintree University Hospitals NHS Foundation Trust
Basingstoke and North Hampshire NHS Foundation Trust
Guy's and St Thomas' NHS Foundation Trust
Heatherwood and Wexham Park Hospitals NHS Foundation Trust
Hinchingbrooke Health Care NHS Trust
Imperial College Healthcare NHS Trust
King's College Hospital NHS Foundation Trust
Newham University Hospital NHS Trust
Salford Royal NHS Foundation Trust
Western Sussex Hospitals NHS Trust

TRUSTS WITH BOTH GOOD AND BAD MORTALITY RESULTS

Because the mortality metrics are constructed differently they sometimes produce results which appear to contradict each other. Three trusts have large differences in their mortality rates depending on whether it is measured using the SHMI measure or the HSMR measure.

Aintree University Hospitals NHS Foundation Trust has an HSMR of 89, which is lower than expected, and a SHMI of 111, which is higher than expected. A possible reason is that Aintree has coded 30 per cent of its deaths in the HSMR group with a palliative care code (see section below left). The national average is 15 per cent. If palliative care was taken into account in the SHMI, Aintree's value would fall to 92.

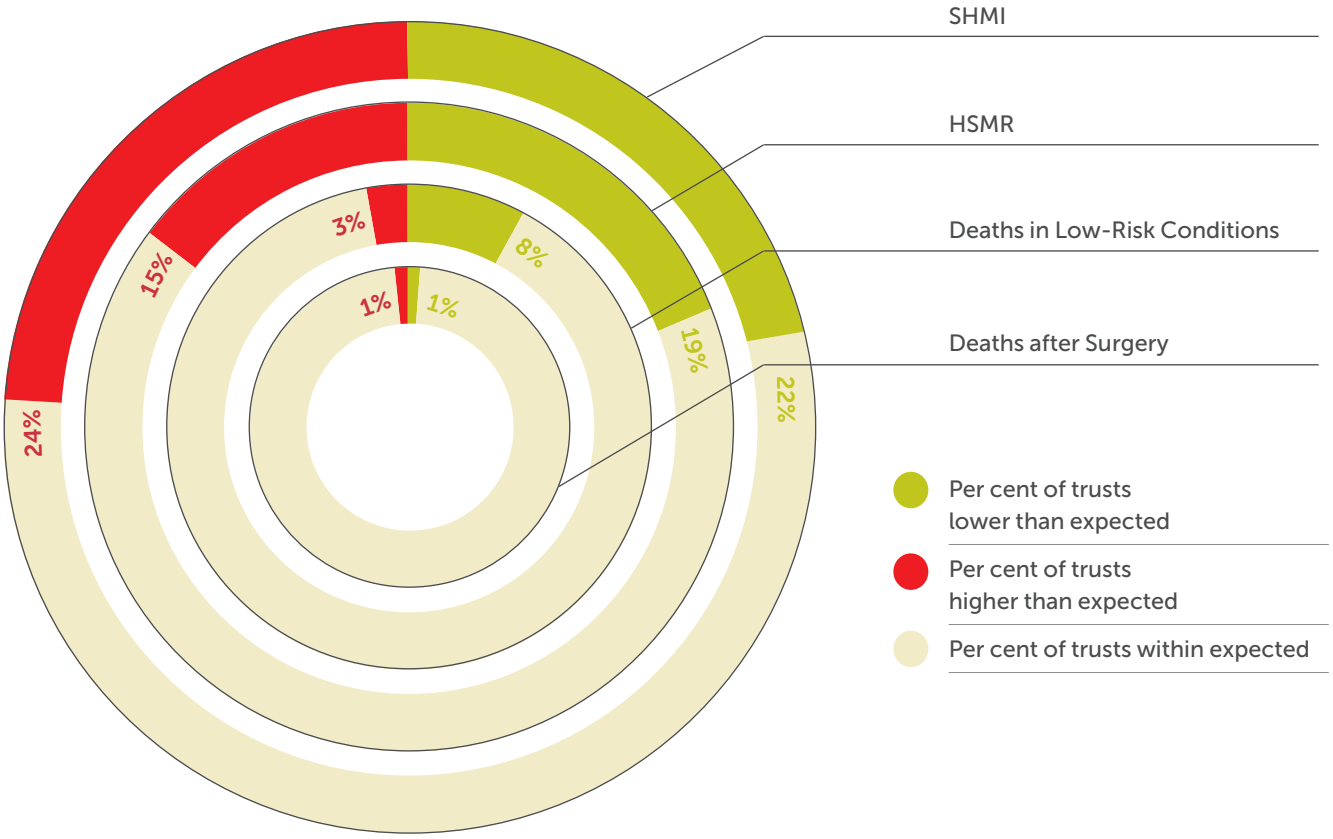
The trust's medical director, Dr Gary Francis, said: "It is important that the national guidance in relation to palliative care coding is clarified to encompass specialist palliative care support that is not wholly bed based. Aintree is justifiably proud of its specialist palliative care services, supporting our dying and chronically sick patients, and their families, in the latter stages of their illness. The current palliative care coding guidance does not effectively cover services where palliation is indicated during a patient's existing stay where cancer or chronic disease makes it appropriate."

Dr Foster is supporting calls for palliative care coding guidelines to be made clearer.

Conversely, **Royal Surrey County Hospital NHS Foundation Trust** has an HSMR of 105 ('within expected') and a significantly low SHMI of 91. Their palliative care coding rate is only four per cent.

Poole Hospital NHS Foundation Trust has an HSMR of 109 ('within expected') and a SHMI of 92, which is lower than expected. In this instance, the discrepancy may be to do with the inclusion of out-of-hospital deaths. When these are excluded from the SHMI calculation, the SHMI rises to 100.

An overview of our four measures of mortality



REDUCING MORTALITY RATIOS: EVIDENCE IN PRACTICE

North Tees and Hartlepool NHS Foundation Trust has put in a number of new measures to ensure its clinical practice and coding are as effective as possible.

Every Monday, a team of senior doctors and nurses meet to review the standards of patient safety and quality of care during the previous week. They review incidents, deaths and cardiac arrests and whether or not there is any learning from each event. This ensures that important decisions are made quickly. It has also resulted in excellent communication and co-ordination of clinical improvements.

In the past year, the clinical teams have reviewed the care of more than 650 patients post-discharge. They have scrutinised every element of patient care received by those patients, using the global trigger tool to understand whether there were any opportunities for them to have done things any better.

They have also reviewed more than 150 sets of notes of patients who had died, to establish whether there were opportunities for anything to have been done better. All documentation has been standardised, with all healthcare professionals writing contemporaneously in the same document. These have all helped the trust to reduce its HSMR from 107 in 2009/10 to 95 in 2010/11.

4

Chelsea and Westminster Hospital NHS Foundation Trust is the only trust that is low on all four mortality measures

Mortality ratios 2010/11

We are featuring four measures of mortality in this year's Hospital Guide. All these measures should be used as 'red flags' or warning signs. They indicate that there is a risk that poor-quality care is leading to higher than expected mortality; they do not prove that this is happening. We only apply these analyses to NHS acute (non-specialist) trusts.

* (per 1,000 patients)

NHS acute trust	SHMI	HSMR	Deaths in Low-Risk Conditions*	Deaths after Surgery
Aintree University Hospitals NHS Foundation Trust	111	89	1.32	130
Airedale NHS Foundation Trust	93	84	0.64	68
Ashford and St Peter's Hospitals NHS Foundation Trust	91	102	0.68	92
Barking, Havering and Redbridge University Hospitals NHS Trust	96	108	0.78	115
Barnet and Chase Farm Hospitals NHS Trust	89	88	0.45	68
Barnsley Hospital NHS Foundation Trust	106	109	0.94	134
Barts and the London NHS Trust	69	79	0.72	92
Basildon and Thurrock University Hospitals NHS Foundation Trust	115	98	0.72	86
Basingstoke and North Hampshire NHS Foundation Trust	114	99	0.25	126
Bedford Hospital NHS Trust	100	93	0.49	121
Blackpool Teaching Hospitals NHS Foundation Trust	117	112	0.96	115
Bradford Teaching Hospitals NHS Foundation Trust	94	85	0.46	76
Brighton and Sussex University Hospitals NHS Trust	101	100	0.85	106
Buckinghamshire Healthcare NHS Trust	112	112	0.64	116
Burton Hospitals NHS Foundation Trust	112	112	1.60	88
Calderdale and Huddersfield NHS Foundation Trust	103	96	0.48	107
Cambridge University Hospitals NHS Foundation Trust	78	75	0.44	91
Central Manchester University Hospitals NHS Foundation Trust	103	100	0.29	82
Chelsea and Westminster Hospital NHS Foundation Trust	78	85	0.35	29
Chesterfield Royal Hospital NHS Foundation Trust	104	105	0.78	117
City Hospitals Sunderland NHS Foundation Trust	107	105	0.54	103
Colchester Hospital University NHS Foundation Trust	113	107	0.98	90
Countess of Chester Hospital NHS Foundation Trust	111	104	1.02	95
County Durham and Darlington NHS Foundation Trust	96	97	0.88	102
Croydon Health Services NHS Trust	105	105	1.01	131
Dartford and Gravesham NHS Trust	109	117	0.93	70
Derby Hospitals NHS Foundation Trust	106	101	0.92	97
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	102	103	0.65	93
Dorset County Hospital NHS Foundation Trust	103	109	0.85	103
Ealing Hospital NHS Trust	87	90	0.88	120
East and North Hertfordshire NHS Trust	118	100	1.08	117
East Cheshire NHS Trust	96	104	0.76	98
East Kent Hospitals University NHS Foundation Trust	95	85	0.92	103
East Lancashire Hospitals NHS Trust	114	108	0.70	70
East Sussex Healthcare NHS Trust	109	106	1.40	88
Epsom and St Helier University Hospitals NHS Trust	91	87	0.99	83
Frimley Park Hospital NHS Foundation Trust	90	78	0.41	86
Gateshead Health NHS Foundation Trust	99	107	0.78	94
George Eliot Hospital NHS Trust	121	117	1.16	151
Gloucestershire Hospitals NHS Foundation Trust	98	99	1.20	72
Great Western Hospitals NHS Foundation Trust	100	98	0.51	109
Guy's and St Thomas' NHS Foundation Trust	91	78	0.49	109
Harrogate and District NHS Foundation Trust	94	101	0.56	81
Heart of England NHS Foundation Trust	104	97	0.77	122
Heatherwood and Wexham Park Hospitals NHS Foundation Trust	100	98	0.49	110
Hinchingbrooke Health Care NHS Trust	90	82	0.58	126
Homerton University Hospital NHS Foundation Trust	95	110	0.83	79
Hull and East Yorkshire Hospitals NHS Trust	115	119	0.79	160
Imperial College Healthcare NHS Trust	75	67	0.40	96
Ipswich Hospital NHS Trust	101	98	0.74	82

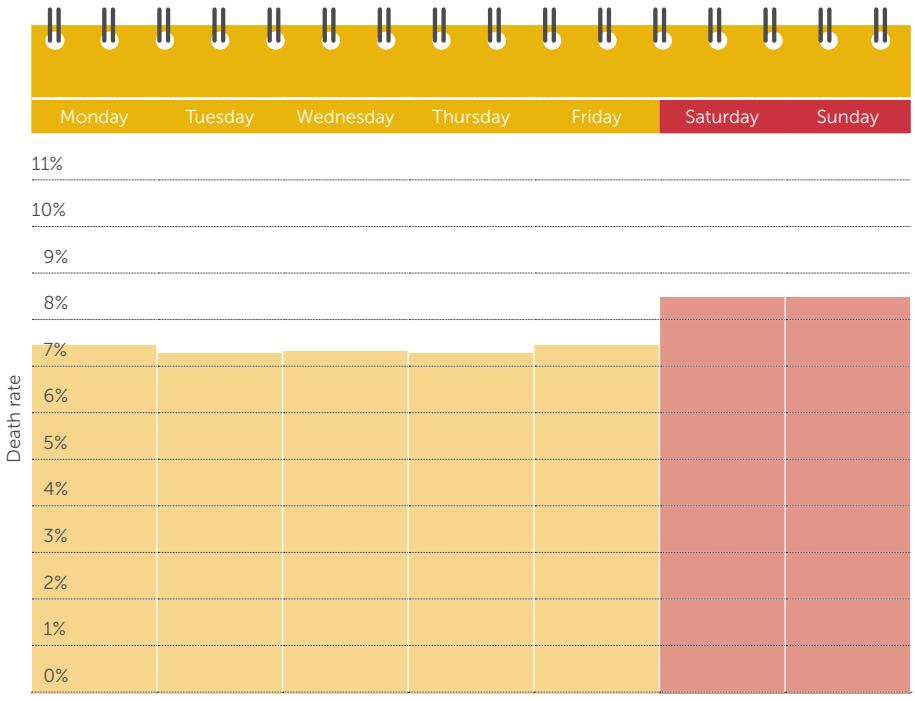
NHS acute trust	SHMI	HSMR	Deaths in Low-Risk Conditions*	Deaths after Surgery
Isle of Wight NHS PCT	119	123	1.81	119
James Paget University Hospitals NHS Foundation Trust	86	98	0.63	96
Kettering General Hospital NHS Foundation Trust	108	97	0.52	102
King's College Hospital NHS Foundation Trust	92	80	0.41	106
Kingston Hospital NHS Trust	86	73	0.22	86
Lancashire Teaching Hospitals NHS Foundation Trust	98	104	0.69	89
Leeds Teaching Hospitals NHS Trust	94	95	0.73	106
Lewisham Healthcare NHS Trust	95	95	1.18	99
Luton and Dunstable Hospital NHS Foundation Trust	108	105	0.92	76
Maidstone and Tunbridge Wells NHS Trust	104	101	0.86	92
Medway NHS Foundation Trust	116	115	1.04	127
Mid Cheshire Hospitals NHS Foundation Trust	110	114	0.49	83
Mid Essex Hospital Services NHS Trust	107	107	0.88	74
Mid Staffordshire NHS Foundation Trust	99	90	0.38	90
Mid Yorkshire Hospitals NHS Trust	106	98	0.81	79
Milton Keynes Hospital NHS Foundation Trust	103	101	0.78	107
Newham University Hospital NHS Trust	80	78	0.36	113
Norfolk and Norwich University Hospitals NHS Foundation Trust	99	102	0.71	69
North Bristol NHS Trust	98	96	1.11	101
North Cumbria University Hospitals NHS Trust	112	118	0.53	163
North Middlesex University Hospital NHS Trust	94	101	0.44	129
North Tees and Hartlepool NHS Foundation Trust	103	95	1.38	83
North West London Hospitals NHS Trust	84	86	0.45	69
Northampton General Hospital NHS Trust	114	116	0.27	146
Northern Devon Healthcare NHS Trust	93	113	0.96	48
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust	115	116	0.87	93
Northumbria Healthcare NHS Foundation Trust	100	101	0.99	80
Nottingham University Hospitals NHS Trust	97	101	1.06	105
Oxford Radcliffe Hospitals NHS Trust	102	106	0.66	114
Pennine Acute Hospitals NHS Trust	106	100	0.57	125
Peterborough and Stamford Hospitals NHS Foundation Trust	105	98	0.93	116
Plymouth Hospitals NHS Trust	94	90	0.86	79
Poole Hospital NHS Foundation Trust	92	109	0.83	73
Portsmouth Hospitals NHS Trust	99	103	0.83	76
Royal Berkshire NHS Foundation Trust	110	102	0.92	87
Royal Bolton Hospital NHS Foundation Trust	105	104	0.34	110
Royal Cornwall Hospitals NHS Trust	101	103	0.67	71
Royal Devon and Exeter NHS Foundation Trust	92	94	0.84	54
Royal Free Hampstead NHS Trust	77	70	0.55	71
Royal Liverpool and Broadgreen University Hospitals NHS Trust	100	91	1.04	85
Royal Surrey County Hospital NHS Foundation Trust	91	105	1.01	86
Royal United Hospital Bath NHS Trust	94	99	1.74	115
Salford Royal NHS Foundation Trust	95	80	0.78	69
Salisbury NHS Foundation Trust	96	95	0.97	69
Sandwell and West Birmingham Hospitals NHS Trust	101	106	0.55	78
Scarborough and North East Yorkshire Health Care NHS Trust	112	107	0.63	120
Sheffield Teaching Hospitals NHS Foundation Trust	86	92	0.88	101
Sherwood Forest Hospitals NHS Foundation Trust	103	114	0.92	120
Shrewsbury and Telford Hospital NHS Trust	112	115	0.88	129
South Devon Healthcare NHS Foundation Trust	97	96	1.43	81

NHS acute trust	SHMI	HSMR	Deaths in Low-Risk Conditions*	Deaths after Surgery
South London Healthcare NHS Trust	90	90	0.42	96
South Tees Hospitals NHS Foundation Trust	98	98	0.66	101
South Tyneside NHS Foundation Trust	100	111	1.62	99
South Warwickshire NHS Foundation Trust	108	100	1.12	133
Southampton University Hospitals NHS Trust	96	105	0.58	74
Southend University Hospital NHS Foundation Trust	106	100	0.87	81
Southport and Ormskirk Hospital NHS Trust	110	107	0.89	60
St George's Healthcare NHS Trust	78	73	0.41	105
St Helens and Knowsley Hospitals NHS Trust	100	93	0.83	84
Stockport NHS Foundation Trust	91	102	0.74	64
Surrey and Sussex Healthcare NHS Trust	96	104	0.96	86
Tameside Hospital NHS Foundation Trust	117	101	1.14	136
Taunton and Somerset NHS Foundation Trust	94	98	0.63	93
The Dudley Group of Hospitals NHS Foundation Trust	109	116	0.60	130
The Hillingdon Hospitals NHS Foundation Trust	88	97	0.84	99
The Newcastle upon Tyne Hospitals NHS Foundation Trust	94	99	0.55	118
The Princess Alexandra Hospital NHS Trust	99	99	0.86	137
The Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust	97	100	0.67	54
The Rotherham NHS Foundation Trust	102	104	0.55	113
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	101	99	0.44	62
The Royal Wolverhampton Hospitals NHS Trust	111	112	0.84	146
The Whittington Hospital NHS Trust	67	78	0.22	70
Trafford Healthcare NHS Trust	106	106	1.34	93
United Lincolnshire Hospitals NHS Trust	111	113	0.89	88
University College London Hospitals NHS Foundation Trust	72	72	0.21	124
University Hospital of North Staffordshire NHS Trust	103	116	1.39	146
University Hospital of South Manchester NHS Foundation Trust	88	93	0.50	105
University Hospitals Birmingham NHS Foundation Trust	101	107	1.99	119
University Hospitals Bristol NHS Foundation Trust	92	85	0.51	113
University Hospitals Coventry and Warwickshire NHS Trust	106	98	0.85	121
University Hospitals of Leicester NHS Trust	106	103	0.84	124
University Hospitals of Morecambe Bay NHS Foundation Trust	114	124	1.01	127
Walsall Healthcare NHS Trust	106	106	0.70	132
Warrington and Halton Hospitals NHS Foundation Trust	102	100	0.72	104
West Hertfordshire Hospitals NHS Trust	107	99	0.88	129
West Middlesex University Hospital NHS Trust	88	92	0.58	129
West Suffolk Hospitals NHS Trust	91	90	0.59	73
Western Sussex Hospitals NHS Trust	113	105	1.33	98
Weston Area Health NHS Trust	112	95	1.61	109
Whipps Cross University Hospital NHS Trust	92	97	0.67	93
Winchester and Eastleigh Healthcare NHS Trust	98	101	0.81	64
Wirral University Teaching Hospital NHS Foundation Trust	103	103	0.53	119
Worcestershire Acute Hospitals NHS Trust	110	111	0.75	86
Wrightington, Wigan and Leigh NHS Foundation Trust	106	106	0.77	112
Wye Valley NHS Trust	108	102	1.63	146
Yeovil District Hospital NHS Foundation Trust	108	117	0.88	106
York Teaching Hospital NHS Foundation Trust	115	111	1.13	95

Reducing mortality at *nights and weekends*

Your chances of surviving hospital treatment depend not just on where you are treated but also when. Patients admitted as an emergency at weekends are significantly more likely to die. The hospitals with the fewest senior doctors available at weekends have the highest mortality rates.

Day of admission: mortality rates for non-elective admissions



DIFFERENT DAY OF ADMISSION, DIFFERENT OUTCOME

Evidence that you are more likely to die if you are admitted to hospital at the weekend was first highlighted in 2010 by the Dr Foster Unit at Imperial College London[1]. It showed a higher mortality rate for patients admitted as an emergency at the weekend for many conditions including: heart attack, heart failure, stroke, some cancers and aortic aneurysms. There was, on average, a seven per cent higher mortality rate for these patients compared with people admitted between Monday and Friday.

We look at the picture across England in 2010/11. The results here are worrying. For non-elective care, the national picture confirms the findings of the 2010 study: mortality rates rise sharply for patients admitted on a Saturday or Sunday.

DO STAFFING LEVELS AFFECT MORTALITY?

Explanations for high mortality rates outside normal working hours include:

- A lack of availability of specialist community and primary care services, resulting in more patients on an end of life care pathway dying in hospital.
- Less consistent specialist services, such as diagnostics, at weekends.
- Differing staffing levels.

Staffing levels differ on weekends and weekdays. Although junior doctors work round the clock (usually on eight-hour shifts), consultants have traditionally worked Monday to Friday on site and on-call out of hours. We surveyed all hospitals in England to find out about staffing outside normal hours.

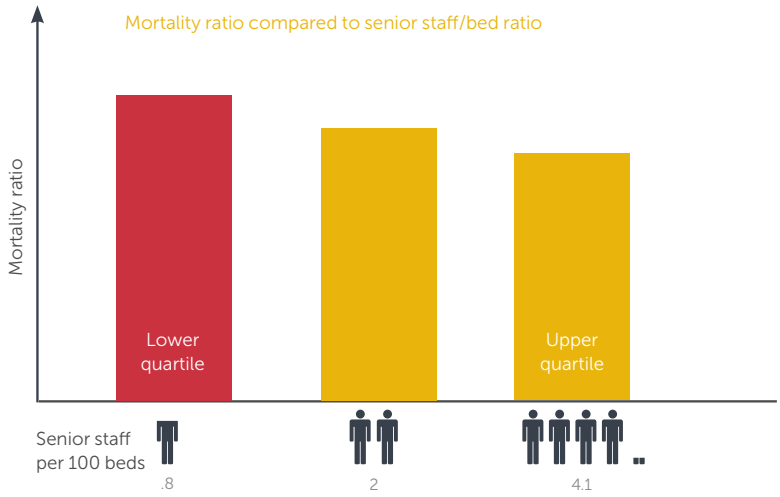
We picked two random Thursdays in March and April 2011 and asked each hospital trust how many doctors of each grade they had on site and on call. We then asked the same question for the following Sundays. We asked both about staff on site (in the hospital) and on-call (available to come into the hospital if needed).

We have mapped these data for 130 (177 hospitals) of the 147 trusts and compared the figures to NHS bed data published by the NHS Information Centre for Health and Social Care[2345] and our analysis on weekend mortality. The results are pretty stark:

- More senior staff per bed at weekends is associated with a lower weekend emergency mortality rate (HSMR).
- More senior doctors as a percentage of all doctors is associated with a lower weekend emergency mortality rate (HSMR).

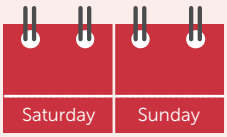
This supports the findings of Sir John Temple's review, *Time for Training*, published in May 2010. The review recommended that consultants must be more directly responsible for the delivery of 24/7 care. In many cases, trainees were responsible for treating the majority of patients out of hours, often with limited supervision.[6]

The mortality ratio for weekend admissions is significantly higher amongst trusts with the fewest doctors (see graph below).



Where HSMR is higher than expected at weekends only

Here we have attempted to identify hospitals where out-of-hours mortality may be a particular problem. The table shows trusts whose mortality ratio (as defined by the HSMR) is within the expected range for patients admitted from Monday to Friday and is higher than expected for patients admitted at the weekend.



Doncaster and Bassetlaw Hospitals NHS Foundation Trust

George Eliot Hospital NHS Trust

Mid Cheshire Hospitals NHS Foundation Trust

Northampton General Hospital NHS Trust

Nottingham University Hospitals NHS Trust

Scarborough and North East Yorkshire Health Care NHS Trust

Sherwood Forest Hospitals NHS Foundation Trust

The Royal Wolverhampton Hospitals NHS Trust

Wrightington, Wigan and Leigh NHS Foundation Trust

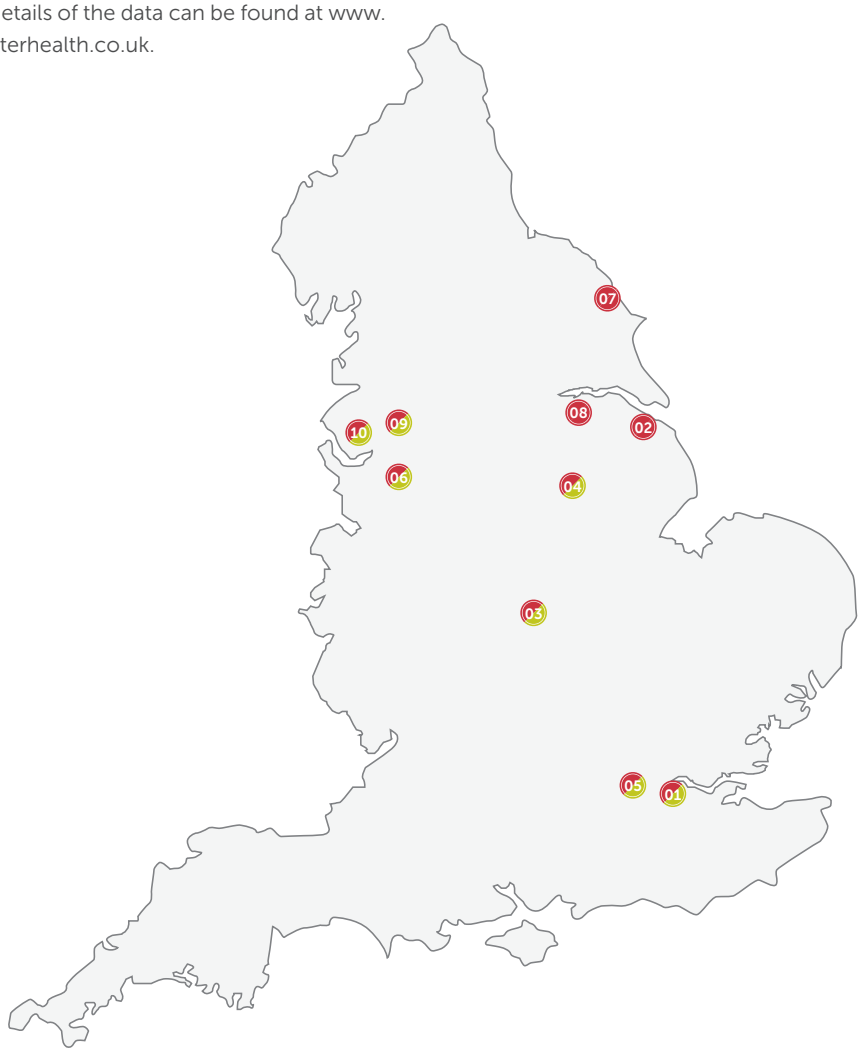
WEEKEND A&E STAFFING

Using this same staffing information we have also looked at the number of senior doctors available out of hours at each hospital with an A&E.

The range of answers was wide. Some hospitals have no consultants on site at night (over 30 per cent) while, at the other extreme, 20 hospitals had five or more consultants on site. Most medical cover out of hours is provided by doctors in training and staff-grade doctors (doctors who are no longer in training but who have not been appointed a consultant). Across all respondents, on one Thursday night at 10pm, there were 358 consultants recorded as working on site compared to over 1,000 registrars (senior trainees) and 2,000 junior doctors. Staffing at weekends is higher than at night with similar numbers of junior doctors but nearly twice as many consultants on site. Full details of the data can be found at www.drfosterhealth.co.uk.

The table to the right lists the ten hospitals with the lowest level of senior doctor staffing at weekends. We have limited it to hospitals with A&E departments (as listed on NHS Choices) where the staffing at both hospital level and trust level is relatively low and where the level of senior staff on call is also average or low. We have also identified where there are nearby A&E departments with higher levels of senior staffing.

We have included both consultants and senior registrars (now more properly known as ST3s or higher in specialist training) in our definition of senior doctors. Some hospitals, particularly those with fewer registrar training posts, make more use of staff grade doctors. Our analysis found that, like junior doctors, higher levels of staff-grade doctors were not associated with better mortality rates, so we have not included them in the analysis.



Low levels of weekend staffing

01 Darent Valley Hospital
Queen Elizabeth Hospital, Woolwich

02 Diana, Princess of Wales Hospital, Grimsby
No data on nearby A&Es

03 George Eliot Hospital, Nuneaton
University Hospital Coventry

04 King's Mill Hospital
Chesterfield Royal Hospital

05 Kingston Hospital
West Middlesex University Hospital

06 Leighton Hospital
Countess of Chester Hospital

07 Scarborough General Hospital
No A&E within 20 miles

08 Scunthorpe General Hospital
No data on nearby A&Es

09 Trafford General Hospital
Salford Royal

10 Whiston Hospital
Royal Liverpool University Hospital

A&E with low hospital staffing
Nearby A&E department with a reported higher hospital staffing level

Providing safe care round the clock

Safe care round the clock sounds like a good idea. But at a time when the NHS is struggling to maintain existing services within limited budgets, is it fair to expect hospitals to do even more? The answer lies in reorganising the resources we have, to provide care where it is needed. For many frail elderly people, not being able to see a consultant on Saturday or Sunday can be risky. Another important issue is to work as a network with other hospitals in your area. London has shown this with the reorganisation of stroke care. Instead of having all A&E departments treating strokes, with variable levels of success, a small number of hospitals now handle all stroke patients but do it to a very high standard, seven days a week, 24 hours a day (see p23). And to those who say that is all very well in London but you cannot do it in more rural areas, Northumbria shows what can be achieved.

INNOVATIVE PRACTICES IN OUT-OF-HOURS CARE

Northumbria case study

Northumbria Healthcare NHS Foundation Trust serves 500,000 people, covering the largest area of any British acute trust. It is soon to reconfigure a number of services, basing care around a new specialist emergency care hospital that will be completed in 2014. This major, whole system change is designed to give patients the best possible treatment and chance of recovery. It provides speedy access to nine clinical teams led by consultants working extended days dedicated only to acute care and a reduction in the reliance on more junior staff. The areas this focuses on include stroke care, cardiac care, respiratory care and emergency surgery. All emergency admissions will be treated at this new facility. The trust undertook an extensive public consultation exercise and 74 per cent of respondents felt this would improve the provision of emergency care.

The trust was one of the first in England to introduce a Hyper Acute Stroke Unit (HASU). See page 23 for more information on these. Northumbria has been rated as one of the best trusts for stroke care in the country in the Hospital Guide for the last two years.

Homerton case study

Homerton University Hospital NHS Foundation Trust has introduced an Acute Care Team (ACT), comprised of consultants, specialists and trainees, that delivers a consultant-led, 24/7 service. This was in response to the Temple Report (see page 20).

The ACT has no commitments other than acute care and takes a multi-disciplinary approach across emergency care, orthopaedics, urology and acute medicine. A key change introduced has been the extension of the consultants' 'normal' working day until 10pm on week days and into the weekend. This means that surgery can continue through the evening until 10pm and avoids junior doctors delivering emergency surgery without consultant supervision.

A second key change has been the establishment of distinct 'emergency' and 'elective' teams for both service delivery and training. As well as delivering a consultant-led service, the introduction of the ACT has enabled Homerton to improve training and comply with the European Working Time Directive 2009, two years earlier than required.

Poole case study

Poole Hospital serves a large, and growing, older population in east Dorset. In 2010, the geriatricians seized the opportunity to improve patient care and make efficiency savings by converting an inpatient ward into a dedicated assessment unit for older people.

The Rapid Assessment and Consultant Evaluation (RACE) unit is staffed seven days a week by senior doctors, nurses and therapy staff who are all highly skilled in the evaluation of older people.

All patients receive a comprehensive assessment and discharges are carefully planned. A daily emergency clinic is also held on the unit to facilitate admission avoidance.

The RACE unit has made an important contribution to quality, as well as efficiency by allowing the safe closure of 30 acute beds. Nearly one in three elderly patients is now assessed, treated and discharged with a comprehensive plan within 48 hours of admission, while the average length of stay has reduced from 12 days to nine without significant increases in readmissions.

Hospital networks save lives

It is not possible for every hospital to provide every service 24/7. In London, this problem was solved by strengthening stroke care networks.

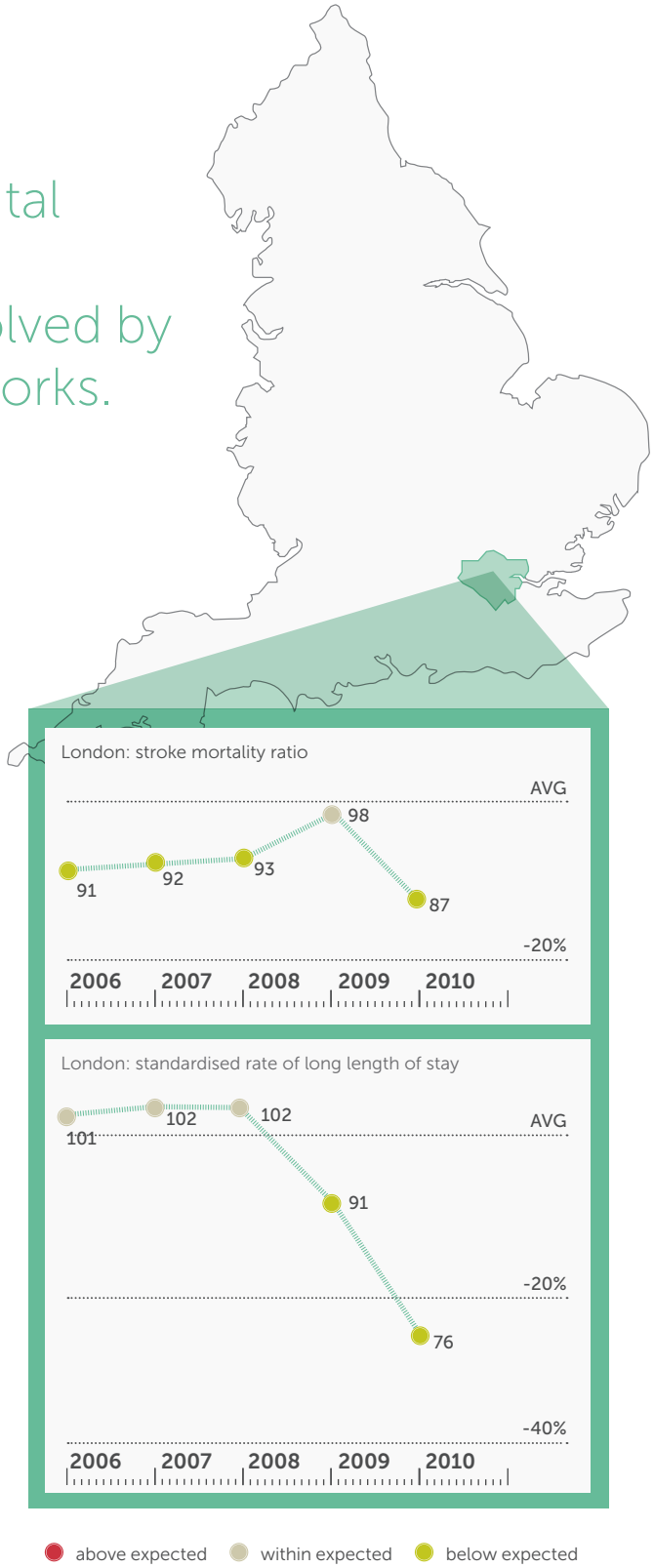
London has overhauled its stroke service. Previously, most hospitals with an A&E attempted to provide stroke care services, with varying degrees of success. Today, just eight hospitals provide consistently high-quality care in units known as Hyper Acute Stroke Units (HASUs). These are staffed 24 hours a day by stroke experts. Arrangements are in place with ambulance services to take patients with a suspected stroke straight to their nearest HASU. So does the data back up the theory that centralised care equals improved outcomes?

CARE IN THE CAPITAL IS LEADING THE WAY

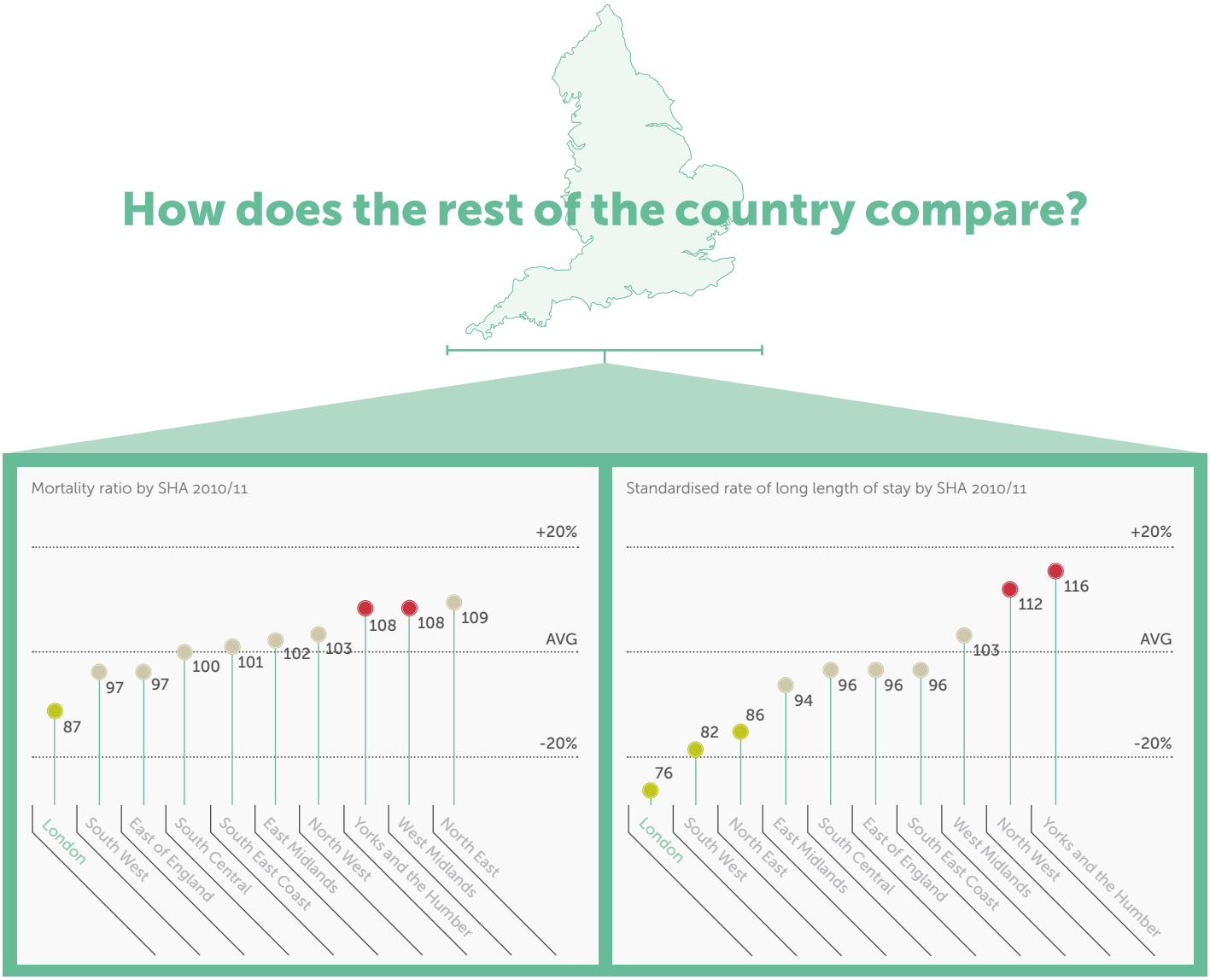
The reorganisation in London, which was as a result of the National Stroke Strategy (2007)[1] and a stroke strategy for London (2008),[2] is an exemplar of how services should be delivered within today's NHS.

The result has been a significant fall in mortality between 2009/10 and 2010/11. Part of this has been achieved by improving the standards of care out of normal hours. Prior to the reorganisation (2009/10), ten per cent of stroke patients died within seven days of admission if they came into hospital at the weekend, compared with eight per cent admitted on weekdays. After the reorganisation, the weekday mortality rate dropped to 6.4 per cent. But the weekend mortality rate fell even faster to 7.3 per cent.[3]

87
London SHA has the lowest mortality ratio in the country



How does the rest of the country compare?



There is much the rest of the country can learn from London. For weekday admissions, **London** has a mortality ratio significantly lower than expected (all the other SHAs are within the expected range). For weekend admissions, the **North West**, **Yorkshire and the Humber** and **West Midlands** SHAs have higher than expected ratios.

Reconfiguration is starting to spread across the country. Now every SHA has at least three hospitals that describe themselves as Hyper Acute Stroke Units in the Dr Foster Hospital Guide questionnaire (though definitions of what constitutes a HASU vary). But are services improving?

WHICH HOSPITALS PERFORM BEST?

Dr Foster has looked at five measures of patient care derived from routine hospital data: mortality rates, long length of stays, unexpected readmissions to hospital, patients discharged to their usual place of residence (within 56 days), and patients who developed pneumonia due to swallowing problems. Last year we also looked at rates of scanning and administering clot-busting drugs, but decided not to examine these outcomes this year while we make some refinements to the methodology.

It is reassuring that this year no trusts have an exceptionally high mortality ratio and five have lower than expected ratios. These are: **Gloucestershire Hospitals NHS Foundation Trust**, **Imperial College Healthcare NHS Trust**, **Royal Liverpool and Broadgreen University Hospitals NHS Trust**, **St George's Healthcare NHS Trust** and **University Hospitals Bristol NHS Foundation Trust**. Results for all the other individual indicators can be found on our website, www.drfosterhealth.co.uk.

While significant variations in the quality of care between hospitals and between regions remain, mortality rates have fallen year on year since 2006/7. However, the continued gap between mortality rates for patients admitted out of normal working hours and those admitted on weekdays continues to be a source of concern. The good news is that by adopting the networked approach used in London, these problems can be addressed.

No trusts have an exceptionally high mortality ratio for stroke in 2010/11

Performance

Last year we identified six trusts in our 'Best performers' category and eight trusts in our 'Worst performers' category. This year we have used the same criteria: 'Best performing' means exceeding expectations for at least two of the indicators and not being below expectations on any of the others; 'Worst performing' means below expectation for at least two of the indicators and not exceeding expectations on any of the others. This gives the conclusions shown in the table below.

EXPERT OPINION

Dr Andy Mitchell,
medical director, NHS London

The case for change in stroke services is compelling. In many parts of the country patients are not offered the evidence-based care that will improve their outcomes because of historical patterns of service delivery.

Following the recommendations of the 2007 National Stroke Strategy, **London** and **Manchester** have led the way in system redesign. Crucial to successful change was a collective determination to realise the vision of improving service quality and outcomes. Strong and inclusive clinical leadership was reinforced by a collaborative, pan-London approach to commissioning. Implementation required potential providers to compete in meeting a demanding service specification, with bids undergoing an assessment and designation process that was independent, transparent, and had guaranteed strategic coherence.

In a constrained financial climate, given the investment required, the key question is, 'Has this ambitious strategic change project been cost effective?' Preliminary data suggests that in terms of deaths averted, disability avoided and quality of life years gained, it has. Our challenge for the future will be to replicate such system-wide change, wherever necessary, in a very different commissioning environment.

	Mortality ratio	Long length of stay	Emergency readmission rate (28 days)	Pneumonia due to swallowing difficulty	Discharge home within 56 days
Best performers					
Brighton and Sussex University Hospitals NHS Trust	●	▼	●	▼	●
Guy's and St Thomas' NHS Foundation Trust	●	▼	●	●	▼
North Tees and Hartlepool NHS Foundation Trust	●	▼	●	●	▼
Northumbria Healthcare NHS Foundation Trust	●	●	●	▼	▼
Plymouth Hospitals NHS Trust	●	▼	●	▼	●
Royal Cornwall Hospitals NHS Trust	●	▼	●	●	▼
Royal United Hospital Bath NHS Trust	●	▼	●	▼	▼
South Devon Healthcare NHS Foundation Trust	●	▼	●	▼	●
South Tees Hospitals NHS Foundation Trust	●	▼	●	▼	●
St George's Healthcare NHS Trust	▼	▼	●	●	●
University Hospital of South Manchester NHS Foundation Trust	●	●	●	▼	▼
Worst performer					
Ashford and St Peter's Hospitals NHS Foundation Trust	●	●	●	▲	▲

▲ above expected ● within expected ▼ below expected

Follow *best practice and* treat patients promptly

If you break your hip you have a one in ten chance of dying. But the odds of survival are much better if you are treated quickly – ideally within two days. If you are admitted on a Friday or Saturday your chances of prompt treatment are lower.

A broken hip (also known as a fragility hip fracture or fractured neck of femur) is a condition primarily affecting the elderly: the average hip fracture patient in England in 2010/11 was 81 years old. In an ageing society, the burden of hip fracture on the health service is increasing and the 61,000 admissions for hip fracture between April 2010 and March 2011 in the NHS in England represents an increase of 17 per cent since 2001. Projections suggest that the number of hip fracture patients will reach over 100,000 by 2020.[1]

Surgery is the first-line treatment, with more than 98 per cent of patients in 2010/11 undergoing an operation.[2] Almost all hip fracture patients are admitted as an emergency and we have excluded the few elective admissions from our analyses.

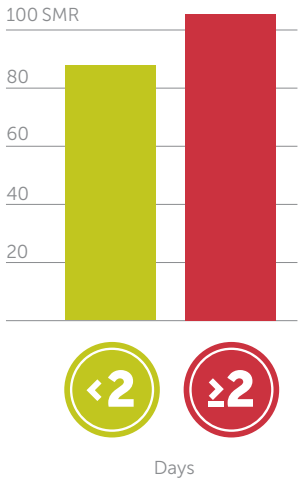
Mortality among hip fracture patients is high, with nine per cent of inpatients dying during their hospital stay in 2010/11 and one-year mortality rates at 30 per cent[1]. This represents over 5,500 in-hospital deaths and 18,000 deaths within a year in 2010/11. At current rates, this would be 9,000 in-hospital and 30,000 one-year deaths a year by 2020.

In-hospital mortality in 2010/11 varied between provider from 3.2 per cent to 16.3 per cent, suggesting there is room for improvement. Looking at casemix-adjusted mortality, two trusts have higher than expected risk of mortality: **Dartford and Gravesham NHS Trust** and **Western Sussex Hospitals NHS Trust**. Two have lower than expected mortality, **Bradford Teaching Hospitals NHS Foundation Trust** and **Mid Essex Hospital Services NHS Trust**.

Mortality following hip fracture is affected by multiple factors, not least the age and underlying co-morbidities of the patient.

It has been shown in numerous studies that organisational factors in the patient's treatment are a major determinant of patient survival.[3] A crucial factor is how long the patient has to wait for surgery, with longer wait times associated with higher death rates.[4, 5]

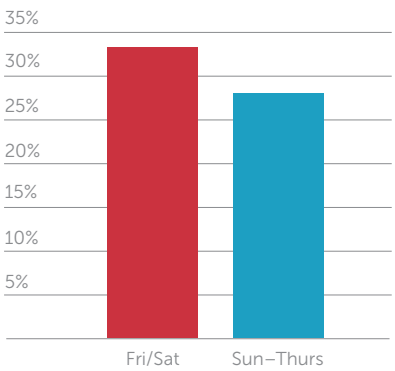
1. Mortality



2. Waiting

30%
of patients wait two days or more

3. Day of admission affects operation time



Percentage not operated on within two days

4. Operations at the weekend

11%
of trusts are significantly worse at operating promptly at the weekend

Operations not within two days

Despite the impact on outcomes of rapid surgery for hip fracture patients, 30 per cent of hip fracture admissions in 2010 were not operated on within two days. The best and worst performing hospitals for this indicator are shown in the table on page 29. In five trusts, 50 per cent or more of all hip fracture patients waited more than two days for an operation: **Doncaster and Bassetlaw Hospitals NHS Foundation Trust, Leeds Teaching Hospitals NHS Trust, Pennine Acute Hospitals NHS Trust, Royal Free Hampstead NHS Trust** and **South Tyneside NHS Foundation Trust.**

Access to treatment over a weekend is a weak link in the management of hip fracture patients

In 2007, the British Orthopaedic Association recomended that hip fracture patients are operated on within 48 hours of admission in order to reduce morbidity and mortality.[1]

Dr Foster tracks hip fracture admissions where patients do not undergo an operation within two days of admission. The all-England death rate for hip fracture patients operated on within two days of admission is substantially lower (7.4 per cent) than the rate for patients waiting longer than two days for their operation (10.1 per cent). A casemix-adjusted comparison of the risk of death in these two patient groups also indicated a higher risk of death in patients waiting longer than two days.

This past year has seen increased recognition within the NHS of the need to operate as quickly as possible on hip fracture patients. In June 2011, NICE issued its first clinical guidance for the management of hip fracture, recommending that surgery is performed on the day of or the day after admission. It recommended that correctable co-morbidities are identified and treated immediately so as not to delay surgery unnecessarily.[3]

In addition, the best practice tariff for hip fracture, which was introduced in 2010/11, has been continued in 2011/12,[6] as part of the system by which NHS trusts are paid for the care they provide. The tariff includes an incentive payment that depends upon the patient undergoing surgery within 36 hours of arrival in an emergency department, or, for inpatients, from the time of diagnosis.

At present, many providers have a way to go to achieve the two day target and will have to significantly rethink their hip fracture patient management pathways to reach eligibility for the best practice payment.

With these central drivers giving hospitals incentives to reduce time to surgery for hip fracture, we hope that the proportion of patients not receiving surgery within two days will decrease substantially over the coming year and that we can test this in next year's Hospital Guide.

An important aspect of minimising delay to surgery for hip fracture patients is to remove administrative and organisational barriers. One such barrier is inefficient patient pathways and unreliable access to clinicians and surgical services at weekends (see p19 for our section on weekend mortality).

We compared the rate of hip fracture patients receiving an operation within two days of admission for patients admitted on a Friday or Saturday with patients admitted on a Sunday to Thursday. Across the country, the number of patients waiting more than two days for an operation was significantly higher, an increase of 4.8 per cent, among patients admitted on a Friday or Saturday compared with patients admitted on a Sunday to Thursday.

Rate of hip fracture patients not operated on within two days of admission

Above expected	Rate %
Barking, Havering and Redbridge University Hospitals NHS Trust	37.1
Bedford Hospital NHS Trust	40.4
Blackpool Teaching Hospitals NHS Foundation Trust	47.3
Brighton and Sussex University Hospitals NHS Trust	39.8
Central Manchester University Hospitals NHS Foundation Trust	49.2
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	50.5
Heart of England NHS Foundation Trust	44.4
Hinchingbrooke Health Care NHS Trust	42.2
Imperial College Healthcare NHS Trust	44.5
Leeds Teaching Hospitals NHS Trust	50.2
Mid Yorkshire Hospitals NHS Trust	47.4
Newham University Hospital NHS Trust	49.1
North West London Hospitals NHS Trust	44.9
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust	41.0
Pennine Acute Hospitals NHS Trust	53.9
Plymouth Hospitals NHS Trust	40.7
Royal Bolton Hospital NHS Foundation Trust	42.6
Royal Free Hampstead NHS Trust	50.0
Royal Liverpool and Broadgreen University Hospitals NHS Trust	38.3
Royal United Hospital Bath NHS Trust	40.1
Shrewsbury and Telford Hospital NHS Trust	43.3
South Devon Healthcare NHS Foundation Trust	46.1
South Tees Hospitals NHS Foundation Trust	43.8
South Tyneside NHS Foundation Trust	50.9
Southampton University Hospitals NHS Trust	36.5
Tameside Hospital NHS Foundation Trust	40.9
United Lincolnshire Hospitals NHS Trust	37.1
University Hospitals Birmingham NHS Foundation Trust	40.6
West Middlesex University Hospital NHS Trust	40.4
Western Sussex Hospitals NHS Trust	42.0
Worcestershire Acute Hospitals NHS Trust	42.2

Below expected	Rate %
Aintree University Hospitals NHS Foundation Trust	13.6
Basingstoke and North Hampshire NHS Foundation Trust	19.9
Burton Hospitals NHS Foundation Trust	20.8
Calderdale and Huddersfield NHS Foundation Trust	16.8
County Durham and Darlington NHS Foundation Trust	2.0
Dorset County Hospital NHS Foundation Trust	14.9
East Kent Hospitals University NHS Foundation Trust	20.3
East Sussex Healthcare NHS Trust	20.4
Great Western Hospitals NHS Foundation Trust	20.0
Guy's and St Thomas' NHS Foundation Trust	16.3
Ipswich Hospital NHS Trust	17.2
Kettering General Hospital NHS Foundation Trust	18.5
Kingston Hospital NHS Trust	15.4
Medway NHS Foundation Trust	21.7
Mid Essex Hospital Services NHS Trust	22.4
Milton Keynes Hospital NHS Foundation Trust	21.0
Norfolk and Norwich University Hospitals NHS Foundation Trust	18.2
North Bristol NHS Trust	15.6
Northampton General Hospital NHS Trust	19.0
Northumbria Healthcare NHS Foundation Trust	12.1
Portsmouth Hospitals NHS Trust	15.2
Royal Berkshire NHS Foundation Trust	17.5
Royal Surrey County Hospital NHS Foundation Trust	0.8
Scarborough and North East Yorkshire Health Care NHS Trust	19.9
Sheffield Teaching Hospitals NHS Foundation Trust	18.4
South Warwickshire NHS Foundation Trust	16.9
St George's Healthcare NHS Trust	15.2
St Helens and Knowsley Hospitals NHS Trust	16.7
Taunton and Somerset NHS Foundation Trust	15.1
The Dudley Group of Hospitals NHS Foundation Trust	18.3
The Newcastle upon Tyne Hospitals NHS Foundation Trust	18.6
The Princess Alexandra Hospital NHS Trust	19.6
University Hospitals Bristol NHS Foundation Trust	21.6
University Hospitals Coventry and Warwickshire NHS Trust	17.9
West Suffolk Hospitals NHS Trust	13.6
Wrightington, Wigan and Leigh NHS Foundation Trust	14.6

Rate of hip fracture patients not operated on within two days of admission. Expected rates are inside 99.8 per cent control limits

Avoid hospitals that *only perform operations occasionally*

Patients treated in hospitals that perform operations rarely are more likely to die. Evidence of this has been available in many areas of surgery for more than a decade but the problem persists.

An Abdominal Aortic Aneurysm (AAA) is a weakening of a major blood vessel in your body. If it ruptures it is often fatal. Surgery is used to treat the condition by repairing the section of artery to prevent the risk of rupture. The severity of rupturing AAAs (and the life-saving potential of AAA surgery) requires surgery to be implemented in the highest quality controlled environments.

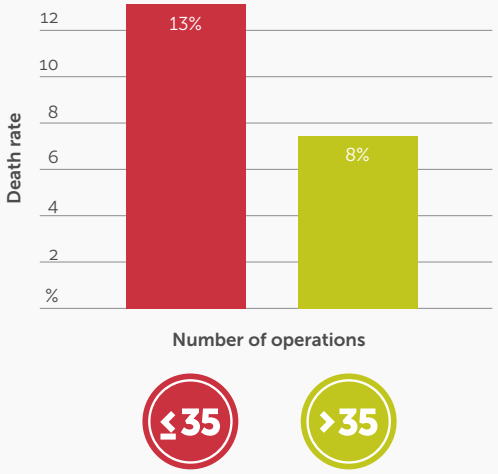
The implication of this is that smaller hospitals, or ones with non-specialised units and with fewer specialised surgeons for AAA, should not operate electively on patients at all. Instead, the bigger and busier hospitals should provide centralised care for AAA patients.

A recent review by the Vascular Society, the organisation that represents surgeons who treat aneurysms in the UK, found that: "Mortality rates after elective AAA repair are higher than in the rest of Europe"[1].

Our data here compares the death rate for AAA in low-volume NHS trusts (35 or fewer procedures a year) and high-volume NHS trusts (more than 35 procedures a year), measured in 2010/11. The 35 threshold is based on evidence cited by the Vascular Society which recommends that hospitals perform at least 100 elective operations over three years[1 2]. Our guide defines low-volume hospitals as those doing more than ten operations and 35 or fewer operations a year.

70%

higher death rates following AAA operations in low volume hospitals



The death rate is reduced from 13 per cent to eight per cent when hospitals are doing more than 35 AAA procedures a year. A re-structuring of vascular surgery services could improve the situation. Many hospitals have entered into 'vascular networks', under which some or all of their AAA patients are transferred to larger centres. Better informed patients and GPs seeking treatment at more expert centres could also improve outcomes.

The Ipswich Hospital NHS Trust has acknowledged its low volumes and from April 2012 aneurysm repair will be performed at Colchester Hospital as part of a service integrated between the two hospitals. The main reason for this choice was the small number performed at Ipswich compared with Colchester. The reconfiguration was a clinician-led initiative, supported by management.

EXPERT OPINION

Mr Toby Richards FRCS MD,
consultant vascular and endovascular surgeon,
University College London Hospitals NHS Foundation Trust

The provision of AAA surgery is under close scrutiny. In 2008, a European report suggested a higher overall mortality in the UK for elective surgical repair of AAA of 7.9 per cent compared to a European average of 3.5 per cent. The data in the Hospital Guide is compelling and aligned to previous volume-outcome analysis, which also suggested that low volume institutions generally had higher mortality.

These differences could be confounded by the more rapid adoption in larger centres of less invasive techniques (known as endovascular), which have lower complication and mortality rates. Other factors that may contribute to variation in results between units include experience and workload of individual surgeons, organisational structure and potentially the development of vascular surgeons in a dedicated specialty. Nevertheless, there is increasing data showing association between better outcomes in high volume units where experience, infrastructure and staff support combine to improve patient care. These data should enable individual surgeons, centres and regions to focus on quality care improvement to achieve optimal results in the management of patients with AAA.

Trusts that performed 35 or fewer AAA procedures in 2010/11

These trusts, along with their commissioners, should think about either increasing their volumes or ceasing to carry out these operations. If the hospitals performing low volumes had achieved the same survival rates overall as the larger units, it would have meant 52 fewer people dying, although without knowing the details of each case it is impossible to say how many of those lives might have been saved.

Aintree University Hospitals NHS Foundation Trust

Ashford and St Peter's Hospitals NHS Foundation Trust

Basildon and Thurrock University Hospitals NHS Foundation Trust

Blackpool Teaching Hospitals NHS Foundation Trust

Bradford Teaching Hospitals NHS Foundation Trust*[3]

Buckinghamshire Healthcare NHS Trust

Calderdale and Huddersfield NHS Foundation Trust*[4]

Chesterfield Royal Hospital NHS Foundation Trust

Countess of Chester Hospital NHS Foundation Trust

Dorset County Hospital NHS Foundation Trust

East and North Hertfordshire NHS Trust

Epsom and St Helier University Hospitals NHS Trust

Gateshead Health NHS Foundation Trust

Heatherwood and Wexham Park Hospitals NHS Foundation Trust

Ipswich Hospital NHS Trust*[5]

Kettering General Hospital NHS Foundation Trust

Mid Staffordshire NHS Foundation Trust

Mid Yorkshire Hospitals NHS Trust

Milton Keynes Hospital NHS Foundation Trust

Northampton General Hospital NHS Trust

Northern Devon Healthcare NHS Trust

Northern Lincolnshire and Goole Hospitals NHS Foundation Trust*[6]

Peterborough and Stamford Hospitals NHS Foundation Trust

Royal Berkshire NHS Foundation Trust

Royal Bolton Hospital NHS Foundation Trust

Salisbury NHS Foundation Trust

Sandwell and West Birmingham Hospitals NHS Trust

Sherwood Forest Hospitals NHS Foundation Trust

Southend University Hospital NHS Foundation Trust[7]

Southport and Ormskirk Hospital NHS Trust

Tameside Hospital NHS Foundation Trust

The Hillingdon Hospitals NHS Foundation Trust

The Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust

The Royal Wolverhampton Hospitals NHS Trust

Walsall Healthcare NHS Trust

Warrington and Halton Hospitals NHS Foundation Trust

Whipps Cross University Hospital NHS Trust*[8]

Wirral University Teaching Hospital NHS Foundation Trust

Wrightington, Wigan and Leigh NHS Foundation Trust

Those marked * have told Dr Foster they have ceased to perform AAA surgery since March 2011 or plan to do so in the near future

Introduce *new and better* treatments quickly

It is estimated that it takes 15 years from the discovery of a new treatment to its widespread adoption by doctors. The faster it happens the better. One success story has been the introduction of PCI (Percutaneous Coronary Intervention), a new way to treat heart attacks.

Since 2006, PCIs have been increasingly adopted as a way of treating heart attacks. During a PCI, a catheter is passed into an artery in either the groin or arm. This catheter is then directed to the blocked artery, where a stent is inserted to strengthen the blocked artery. PCI is an alternative to open-heart surgery (coronary artery bypass surgery). It is a less intrusive treatment and is shown to reduce the risk of patient mortality.

Our data shows how PCIs have increased over the past five years. At the same time, in-hospital mortality rates (SMRs) have fallen.

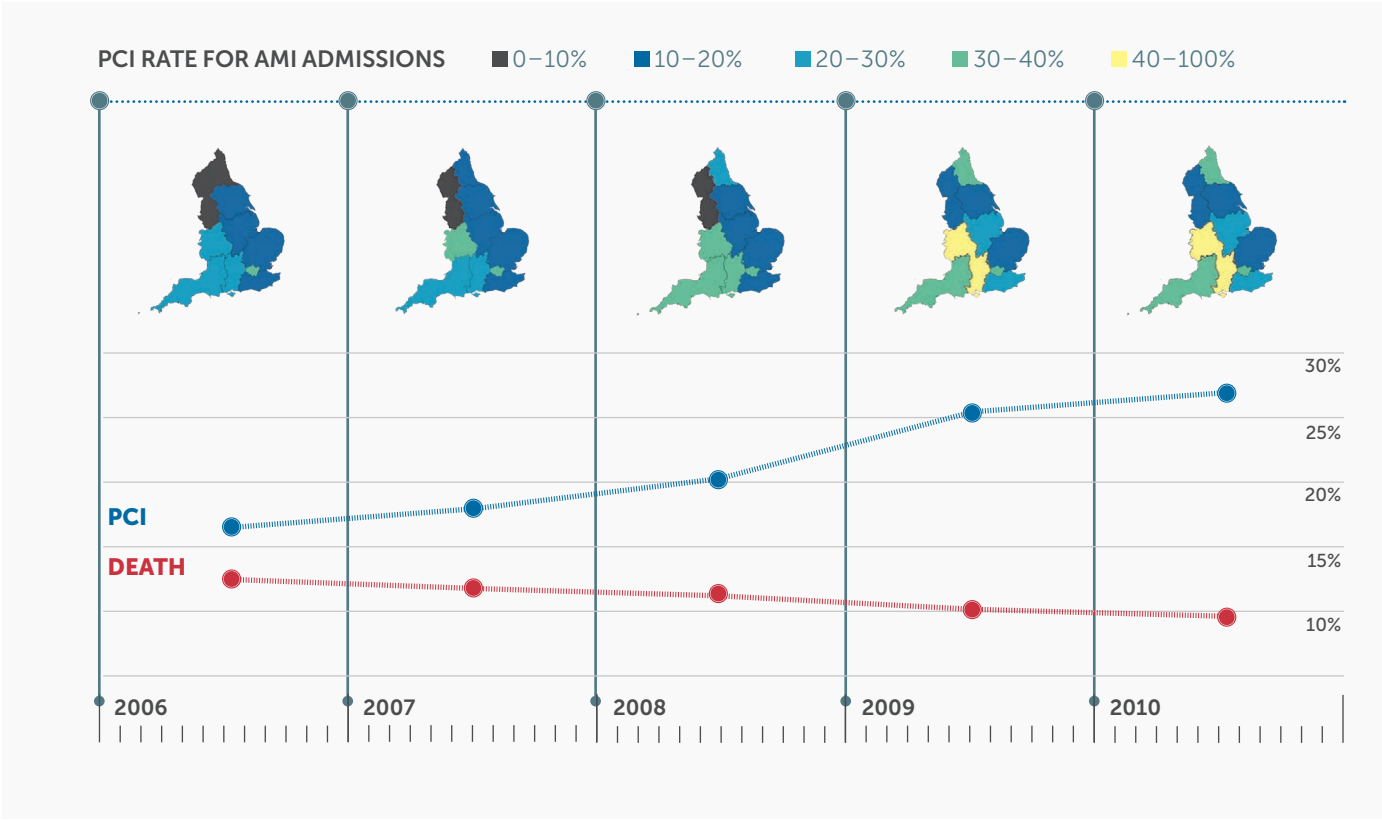
PATIENT RESPONSE

Lower mortality rates are not the whole story. The quality of long-term health of the patients who have had PCI does not always compare well with patients who have had a heart bypass operation. Part of the issue may be to do with how patients respond. Both the NHS guidelines on treating heart attacks and patient studies emphasise the importance of educating patients, increasing awareness of heart attacks as an indication of long-term heart disease.

PCI is a treatment that is relatively fast. It may be that this treatment is so quick that patients do not spend sufficient time with cardiac rehabilitation teams learning how to care for themselves. Or perhaps it is so successful that patients are left not fully appreciating the seriousness of their condition and the need to address the fact that they have a life-threatening condition.

2.5%

the rate heart attack deaths have declined by since 2006



Treatment for *hip and knee* replacement

Better treatment does not have to cost more. Often, the best way to care for patients is also the most cost effective. This is important at a time when the NHS has to save about £20billion over the next three years.

Our ageing population is putting severe pressures on the NHS. The number of people having hip and knee replacements is rising (147,000 this year compared with 124,000 in 2006). But by providing the best care, it is possible to reduce the length of time a patient spends in hospital and reduce the risk of them being readmitted for the same problem – both factors that cut costs to the NHS.

Our survey shows that hospitals that follow best practice have significantly lower numbers of patients spending a long time in hospital. It also shows that too many hospitals are failing to follow this best practice.

Surgery to replace hip and knee joints is one of the most common and beneficial operations done in the NHS. But, as with all major surgery, the process can be risky and frightening. There is much hospitals can do to try to make the patient's experience as quick, safe and free from anxiety as possible. Our rapid recovery pathway, outlined on page 36, highlights the key things hospitals can do to achieve this.

However, as the data shows, not all trusts are signed up to all parts of it, which appears to be having detrimental effects on their lengths of stay.

TREATMENT BY PRIVATE HOSPITALS

This year, for the first time, we have included independent sector providers of NHS care in our analysis of hip and knee replacements. The independent sector began treating NHS patients in 2003 when the first of a series of purpose-built treatment centres, or ISTCs, was opened to provide treatment in high volume, elective surgery. While the independent sector accounts for just three per cent of all elective NHS surgery, it performed 15 per cent of the 147,000 NHS elective hip and knee replacements carried out in the last financial year. In fact, the three largest providers of NHS hip and knee replacements are all independent sector providers. The independent sector does not treat complex cases by design and, while our risk models use all available data to adjust for the mix of patients treated, it is possible that there are residual differences that have not been taken into account.

Nonetheless, it is notable that the independent sector hospitals achieved some of the best outcomes of all hospitals providing hip and knee replacement surgery.

OUTCOMES

We looked across three key indicators of quality for both elective hip and knee replacement operations. These are:

- The number of patients with a long length of stay.
- Emergency readmissions to hospital within 28 days of the initial operation.
- Re-do rates (a patient having to have the operation re-done within one year of the initial procedure).

The best performing trusts have fewer long stay patients, lower emergency readmissions and lower revision rates for hip and knee replacement. A well performing trust would score significantly better than average on two out of three of these measures. A poorly performing trust would score significantly worse than average on two out of three of these measures.

Provider list

The best performing providers for hip operations

- Care UK*
- Spire Healthcare*
- UK Specialist Hospitals*
- Ramsay Health Care UK*
- South Warwickshire NHS Foundation Trust
- Wye Valley NHS Trust
- There were no trusts performing poorly on this indicator

The best performing providers for knee operations

- UK Specialist Hospitals*
- Interhealth Care Services (UK)*
- Ramsay Health Care UK*
- The Horder Centre*
- Spire Healthcare*
- Claremont & St Hugh's Hospitals (HMT)*
- Care UK*
- The Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust
- The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
- City Hospitals Sunderland NHS Foundation Trust
- Sandwell and West Birmingham Hospitals NHS Trust

The poorest performing providers for knee operations

- Sheffield Teaching Hospitals NHS Foundation Trust
- Great Western Hospitals NHS Foundation Trust
- Chelsea and Westminster Hospital NHS Foundation Trust

* Independent sector provider

REDUCING LENGTH OF STAY

The rapid recovery pathway is an effective way of reducing the amount of time a patient has to spend in hospital before and after orthopaedic surgery. We used the Hospital Guide Questionnaire to understand which trusts are implementing these.

20
trusts meeting all steps of the rapid recovery pathway

EXPERT OPINION

Robert Middleton, consultant orthopaedic surgeon and Tom Wainwright, clinical researcher in orthopaedics, The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

An enhanced recovery pathway (see page 36) aims to improve patient outcomes and speed up recovery following surgery. There is now good evidence from both the academic literature and the experience of exemplar sites to support the implementation of enhanced recovery pathways. Their use is also promoted by the Department of Health and recognised through the quality and productivity challenge (QIPP).

When such a pathway is implemented, the reduced post-operative convalescence period, and early achievement of functional milestones, leads to a shorter length of stay (LOS) in hospital for patients. However, what is clear from national data is that the average LOS varies considerably across hospitals. This variation is not explained by casemix, and is therefore likely to be linked to processes. Hospitals were therefore asked questions about certain characteristics of their hip and knee pathways. While not exhaustive or absolute measures of a high quality pathway, these characteristics were chosen after reviewing the latest evidence describing enhanced recovery pathways.

The responses showed a variation in care processes across different hospitals. Though none of the questions were answered unanimously, some interesting observations can be made. LOS could be reduced in some units by admitting patients on the day of surgery and by providing seven-day-a-week specialist physiotherapy. Length of stay was also higher in units that did not provide weekend physiotherapy.

So, given the proven benefit to patients, an established clinical evidence base, and a current strong economic driver for shorter LOS, why have some hospitals been more successful at implementing enhanced recovery than others? It can be hard to think differently, but the ability for enhanced recovery pathways to improve clinical outcomes and patient experience make a compelling case for change. Often the most difficult challenge is to convince colleagues and staff to break from tradition. This is where comparative data, if used responsibly, can help to challenge the status quo.

Rapid recovery pathway

1 Pre-surgery education for patients: helps relieve anxiety and increase understanding by the patient. 14 trusts do not offer pre-surgery education.

2 Admission on day of surgery: reduces length of stay. Most trusts do admit some patients before the day of surgery for reasons of age and co-morbidities only.

3 Standardised anaesthetic protocol (SAP): helps with pain management and recovery. 54 trusts do not have an SAP. Of those, seven trusts are in the process of setting one up.

4 Multi-disciplinary recording of patient records: helps share information and reduce risk of complications. 37 trusts do not use multi-disciplinary recording. Five of these are in the process of adopting this. Three trusts did not answer.

5 Orthopaedic physiotherapy service available seven days a week: not having this can affect patients who have their operation on a Friday and increase length of stay. 30 trusts don't have a seven-day service, and seven trusts have cover seven days a week but not through specialist teams.

6 Criteria-based discharge: a checklist that helps to reduce error in discharge process, reducing risk to the patient. 12 trusts said they do not have a criteria-based checklist.

7 Phoning patients in the 48 hours following discharge: this helps to reduce risk to the patient and readmissions to hospital. Only 47 trusts said they phone within 48 hours.

	Pathways							Length of stay:	
Trusts that **do not follow** four or more steps of the pathway	1	2	3	4	5	6	7	Hips	Knees
King's College Hospital NHS Foundation Trust	✓	✓	✗	✗	✓	✗	✗	▲	▲
East and North Hertfordshire NHS Trust	✓	✓	✗	✗	✗	✓	✗	▲	▲
Ealing Hospital NHS Trust	✗	✓	✓	✗	✗	✓	✗	●	▲
East Lancashire Hospitals NHS Trust	✗	✓	✓	✓	✗	✗	✗	▲	▲
Mid Cheshire Hospitals NHS Foundation Trust	✗	✓	✗	✓	✗	✓	✗	●	●
Barts and The London NHS Trust	✗	✓	✗	✗	✓	✓	✗	●	▲
Royal Cornwall Hospitals NHS Trust	✗	✓	✗	✗	✓	✗	✗	●	▲
Royal Bolton Hospital NHS Foundation Trust	✗	✓	✗	✗	✓	✗	✗	▲	▲
South London Healthcare NHS Trust	✗	✓	✗	✗	✗	✗	✗	▲	▲
St George's Healthcare NHS Trust	✗	✓	✗	✗	✗	✗	✗	▲	▲
Trusts that **follow all sections** of the pathway	1	2	3	4	5	6	7	Hips	Knees
Basildon and Thurrock University Hospitals NHS Foundation Trust	✓	✓	✓	✓	✓	✓	✓	●	●
East Kent Hospitals University NHS Foundation Trust	✓	✓	✓	✓	✓	✓	✓	▼	▼
Epsom and St Helier University NHS Foundation Trust	✓	✓	✓	✓	✓	✓	✓	▼	●
Lancashire Teaching Hospitals NHS Foundation Trust	✓	✓	✓	✓	✓	✓	✓	●	●
Mid Staffordshire NHS Foundation Trust	✓	✓	✓	✓	✓	✓	✓	●	●
North Tees and Hartlepool NHS Foundation Trust	✓	✓	✓	✓	✓	✓	✓	●	●
North West London Hospitals NHS Trust	✓	✓	✓	✓	✓	✓	✓	●	▼
Northumbria Healthcare NHS Foundation Trust	✓	✓	✓	✓	✓	✓	✓	▼	▼
Royal Surrey County Hospital NHS Foundation Trust	✓	✓	✓	✓	✓	✓	✓	▼	●
Salisbury NHS Foundation Trust	✓	✓	✓	✓	✓	✓	✓	●	●
South Tees Hospitals NHS Foundation Trust	✓	✓	✓	✓	✓	✓	✓	▼	●
The Dudley Group of Hospitals NHS Foundation Trust	✓	✓	✓	✓	✓	✓	✓	▼	▼
The Newcastle upon Tyne Hospitals NHS Foundation Trust	✓	✓	✓	✓	✓	✓	✓	●	●
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (*Step 5 not appropriate as there is no trauma unit)	✓	✓	✓	✓	*	✓	✓	▼	▼
University Hospital of South Manchester NHS Foundation Trust	✓	✓	✓	✓	✓	✓	✓	●	▲
West Hertfordshire Hospitals NHS Trust	✓	✓	✓	✓	✓	✓	✓	●	●
West Middlesex University Hospital NHS Trust	✓	✓	✓	✓	✓	✓	✓	●	●
Winchester and Eastleigh Healthcare NHS Trust	✓	✓	✓	✓	✓	✓	✓	●	●
Wrightington, Wigan and Leigh NHS Foundation Trust	✓	✓	✓	✓	✓	✓	✓	▲	▲
York Hospitals NHS Foundation Trust	✓	✓	✓	✓	✓	✓	✓	●	●

✗ pathway not followed ✓ pathway followed ▲ above expected ● within expected ▼ below expected

Patient safety

There are some signs of improvement in patient safety but we still know far too little about how often patients are being harmed by hospital treatment.

9

trusts are not compliant with all relevant NPSA alerts issued in 2011

Patient safety is probably improving. On some key indicators we have seen falls in the number of adverse events. However, in many areas the data is too unreliable to know for sure how hospitals are performing.

We reported the same problem last year. This year's figures show a mixed bag of results. The number of occasions on which an object was left behind in the patient after an operation has dropped to 125, down from 150 last year (it is very likely this is still an under-reported rate). Fewer operations were cancelled this year because the surgeons did not have the patient notes available. Fifty-seven cases of surgery being performed on the wrong body part were reported (56 cases reported last year).

Overall, there are far too many avoidable instances of harm to patients. National hospital data (SUS) shows at least:

- 14,229 incidents of problems post-operation, such as infection, including 7,378 incidences of post-operative pulmonary embolism or deep vein thrombosis (blood clots).
- 11,207 incidences of accidental puncture or laceration.

In addition, hospitals are not always managing to respond in a timely fashion to warnings about patient safety. The National Patient Safety Agency (NPSA) publishes regular alerts warning hospitals about practices that are potentially unsafe. The warnings recommend a date by which changes to practices should be implemented.

The trusts below told us they would not be compliant with all relevant NPSA safety alerts issued in 2010/11 before 1 December 2011. Many of these trusts are keen to meet NPSA alerts but told us they are suffering from a number of problems that are holding them back. Reasons for non-compliance included: a lack of staff training or evidence of staff training, budgetary problems for the commissioning of new equipment and, particularly, sourcing the correct IT systems and devices needed.

Non-compliant trust list

- **Ashford and St Peter's** Hospitals NHS Foundation Trust
- **Cambridge University** Hospitals NHS Foundation Trust
- **Luton and Dunstable** Hospital NHS Foundation Trust
- **Maidstone and Tunbridge Wells** NHS Trust
- **Medway** NHS Foundation Trust
- **North West London** Hospitals NHS Trust
- **South London** Healthcare NHS Trust
- **United Lincolnshire** Hospitals NHS Trust
- **University Hospitals Bristol** NHS Foundation Trust

57[1]

cases of surgery performed on the wrong part of the body

Up from 56 last year but down from 82 in 2009

101 trusts recorded 0 incidents

125[1]

incidents of a foreign object left inside a patient after surgery

Down from 150 last year and 209 in 2009

Wrightington, Wigan and Leigh NHS Foundation Trust recorded seven incidents, five of these relate to drill bit shavings being left in situ because, for safety reasons, it was deemed more appropriate not to disturb them

78 trusts recorded 0 incidents

452[1]

operations cancelled due to missing notes

Down from 475 in 2010 and 478 in 2009

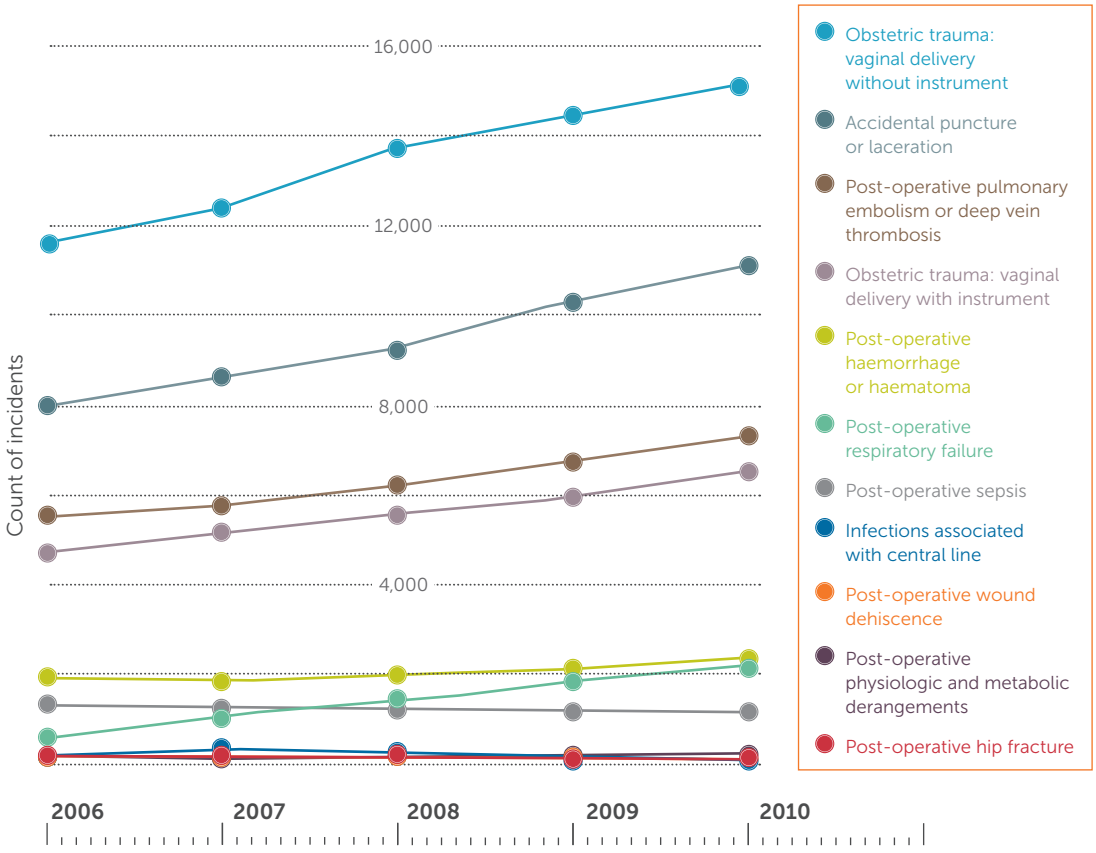
18 trusts had ten or more cancellations

Southend University Hospital NHS Foundation Trust and **University Hospital of North Staffordshire NHS Trust** recorded 19 cancellations

University Hospitals of Leicester NHS Trust, recorded 21 cancellations

65 trusts reported 0 cancellations due to missing notes

Trends in patient safety indicators 2006/07 to 2010/11



HOW BIG IS THE PROBLEM?

The truth is, we still do not properly know. Some records of patient safety problems have shown a sharp rise in recent years. But it is likely that this is happening because we are beginning to record more accurately how often things go wrong.

This is good news, as the first step towards improving patient safety is understanding where the problems are occurring. Trusts that record their data accurately are more likely to be able to identify where incidents are happening, learn from them and prevent them in the future.

SUS data is an extremely valuable source of intelligence about patient safety. However, trusts are still far too haphazard in the way they record this data, with great variability between trusts in the standard of records. Some trusts have remarkably few patient safety incidents recorded. The trouble is, there is a high likelihood that this purely reflects their failure to record the occurrence of misadventure.

One problem with the way patient safety data is recorded at the moment is that too often it is impossible to tell where the incident occurred. When Dr Foster first looked into the data around pressure sores, many trusts said they could not distinguish between those that developed while in hospital care and those that were present when the patient was admitted.

The use of a Present on Admission (POA) flag in the data would give a clear picture, not only of hospital care but of the wider care sector, including care homes. POA flags are routinely used in Australia, Canada and by the Medicare and Medicaid Services in the USA. Knowing where these pressure sores are occurring will help the NHS address what are costly, painful and sometimes fatal problems. The same applies to a range of other conditions such as falls and infections. So far a number of hospital trusts, the Care Quality Commission and a range of other bodies have signed up to support the campaign. View the campaign at www.drfoster.co.uk.

EXPERT OPINION

Charles Vincent, professor of clinical safety research, Imperial College, London

In the past decade, considerable efforts have been made to improve the safety of healthcare. Are patients any safer than they were ten years ago? The answer to this simple question is curiously elusive. While some aspects of safety are difficult to measure for technical reasons (defining preventability, say), the more substantive problem is that, for all the energy and activity, measurement and evaluation have not been high on the agenda.

This is a curious state of affairs. If you were engaged in trying to reduce heart disease, cancer or road accidents, your first question would be 'How many people have heart disease?' or `How many road accidents are there each year?' and then you would want to know if the numbers were reducing year on year.

Incident reporting

Incident reporting was originally seen as the foundation of patient safety and such systems continue to play a central role in many trusts. However, the results of reporting are often misunderstood in that they are mistakenly held to be a true reflection of the underlying rate of errors and adverse events. In fact, voluntary incident reporting systems are very poor at detecting adverse events, identifying only one in 20 of detected events in record reviews[2,3]. Most studies have found that reporting systems only detect seven to 15 per cent of adverse events. Incident reporting cannot therefore be considered as a measure of adverse events, so we need to find other approaches[4].

Measuring safety

Measuring safety encompasses both measures of failures and harm and, ideally, assessing how safe the healthcare system is at any one time. A particular challenge is to identify and capture indicators that can be validly measured as rates, in the same way as road accidents or signals passed at danger on the railways.

Common problems are that events are uncommon (such as serious medication errors) or rare (wrong site surgery), definitions are often inadequate, and the denominators are hard to define. For example, when a patient who is hospitalised experiences a narcotic overdose, is the appropriate denominator the patient or patient day, the prescribed or dispensed doses, all administered medication doses, or all administered narcotic doses[5]?

Patient Safety Indicators

The Patient Safety Indicators (PSIs) were originally developed by the US Agency for Healthcare Research and Quality (AHRQ). It is critical to appreciate that the indicators do not necessarily demonstrate unsafe care, in that some of the events identified may be unavoidable. While this is important for individual cases, however, it is less critical when aggregating data over time. Any organisation would like to reduce these events and once they are monitored programmes can be put in place to reduce them and the programmes themselves can be evaluated.

Groups around the world have adapted the AHRQ PSIs for use in their own systems. Most indicators appear to be increasing, suggesting that care may be getting steadily less safe[6]. See graph on page 38. However, at this stage of development the most likely explanation for the observed trends is improved coding. This means one should, at least for the time being, be cautious about comparing organisations or units.

The PSIs presented here represent a very important move towards the kind of safety measurement that we need in the NHS. At the moment I would personally be cautious about comparing organisations, because of uncertainty about coding and appropriate denominators. The information is nevertheless potentially very useful for any organisation seeking to improve safety over time and move beyond incident reporting to measurement and monitoring of safety.

We still do not know whether patients are safer in the NHS in 2011 than in 2001. This suggests that much more attention needs to be paid to measurement and evaluation in the next ten years than has been the case in the past.

IMPLEMENTING THE PRESENT ON ADMISSION FLAG

POAs are currently being reviewed by the NHS Information Centre, but we have developed, in consultation, a simple system that can be adopted in the interim. Code Y95 already exists to denote where a condition is 'Hospital Acquired'. We suggest NHS Connecting for Health develops a new code for 'Present on Admission' and mandates the use of either one or the other for the following 'first round' conditions:

- Acute renal failure
- AMI
- Cardiac/respiratory arrest
- Catheter-associated Urinary Tract Infection (UTI)
- Deep Vein Thrombosis (DVT)/ Pulmonary Embolism (PE)
- Falls and trauma
- GI bleeds
- Manifestations of poor glycemic control
- Stage III and IV pressure ulcers
- Stroke
- Surgical site infection
- Vascular catheter-associated infection

We would like to see coding rules improved to make routine data more reliable, to improve understanding of the harm done to patients and the outcomes of treatment.

What patients think of our hospitals

This year, for the first time, the Hospital Guide can say what patients think about individual hospitals, both NHS and private. This is because of the new opportunities on the internet for patients to record their views of hospital treatment.

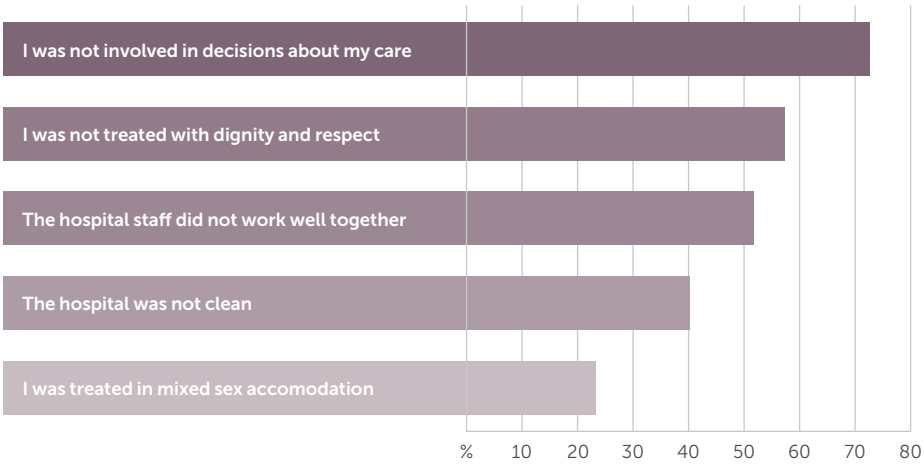
There are now a number of websites where people can comment on their local hospital. On Patient Opinion (www.patientopinion.org.uk), people can rate hospitals on a number of key questions about cleanliness, respect and decision making. The service is also used on NHS Choices (www.nhs.uk), where thousands of patients have recorded their views.

One concern about this is that you do not know whose opinions you are reading. Rather like the reviews on Amazon.com, you cannot be sure whether the people giving their opinion are biased or not. However, we have compared the results to the national patient surveys carried out by the NHS and there is a reasonable degree of agreement between them. NHS trusts that score well on these surveys also tend to score well on the data collected by Patient Opinion and NHS Choices.

On these sites, patients are asked to leave a comment about their care and to say whether or not they recommend the hospital. They are also asked to rate the hospital on five aspects (see graph on page 41).

Over half of patients say they would recommend the place they were treated in.

What causes dissatisfaction? Average negative scores for five aspects of care among patients who did not recommend hospitals



But 26 per cent would not and 16 per cent had no opinion.

We have analysed responses to understand the most common complaints among patients who would not recommend a hospital (see graph above). The issues that have most impact are lack of involvement in decisions and not being treated with respect.

A textual analysis of the comments supports these findings. The single word mentioned most often – in both positive and negative comments – is staff. Our word cloud on page 40 graphically represents the most frequent positive comments. It is the quality of the interaction with staff which overwhelmingly makes the difference between a pleasant hospital experience and a dreadful one.

There are some interesting conclusions to be drawn from comparison of hospital results. Firstly, private hospitals score well. It should be noted, though we cannot be sure, that most of these comments were registered on NHS Choices and are likely to relate to treatment of NHS patients by the private units.

It might be argued that the comparison is unfair as the private hospitals do not deal with more complex patients. On the other hand, there is no reason why we should expect more complex patients to be less happy with their treatment. Another reason may be that private hospitals are smaller. In general, smaller hospitals appear disproportionately in the more highly rated places.

Another important lesson from the data is that different hospitals within the same NHS trust often have very different results. For example, the **Royal Hallamshire Hospital** in Sheffield has one of the highest positive ratings in the country for a large hospital, with 65 per cent of patients saying they would recommend it. The nearby **Northern General**, part of the same trust (Sheffield Teaching Hospitals NHS Foundation Trust), does not do badly but is less well appreciated, with 42 per cent of patients recommending it.

One thing is certain: the information generated by these systems is enormously powerful in understanding patients' experiences and their needs. It is interesting to note the turnaround at **Stafford Hospital**, that became the subject of an inquiry into poor quality care. Prior to March 2010, two-thirds of patients treated there said they would not recommend it. Since March 2010, the majority of patients now say they would recommend it.

Hospital recommendation[1]

Hospitals most often recommended*

% recommending the hospital

- The Cheshire and Merseyside NHS Treatment Centre Private 97%
- North Downs Hospital Private 96%
- Queen Victoria Hospital (East Grinstead) NHS 96%
- Euxton Hall Hospital Private 95%
- Fulwood Hall Hospital Private 93%
- The Royal London Hospital For Integrated Medicine NHS 92%
- Boston NHS Treatment Centre Private 91%
- Emersons Green NHS Treatment Centre Private 86%
- The Heart Hospital NHS 84%
- Airedale General Hospital NHS 82%
- Frimley Park Hospital NHS 82%
- St Richard's Hospital NHS 81%
- Warwick Hospital NHS 80%
- Princess Anne Hospital, Southampton NHS 79%
- Royal Hampshire County Hospital NHS 77%

Hospitals least often recommended*

- Medway Maritime Hospital 35%
- The Royal London Hospital 35%
- Whipps Cross University Hospital 35%
- Hull Royal Infirmary 32%
- Royal Bolton Hospital 29%
- Pinderfields General Hospital 27%
- Croydon University Hospital 26%
- Queen's Hospital, Romford 26%
- Newham General Hospital 21%
- Queen's Medical Centre, Nottingham 20%

*of those with at least 20 opinions recorded

Over half of patients say they would recommend the place they were treated in

Hospital response rate

One thing that makes online patient feedback interesting is that we can see whether or not the hospital has responded to patients' comments. Data supplied by Patient Opinion shows us that some manage to respond to all comments. Others have responded to none at all. Worryingly, this includes some of those with the worst rates of recommendation, such as **Whipps Cross Hospital, Queen's Hospital, Romford and Newham Hospital. North West London Hospitals NHS Trust, Northumbria Healthcare NHS Foundation Trust** and **Tameside Hospital NHS Foundation Trust** have over 50 postings and have responded to almost all of them.

Changes have been made across a broad range of services as a direct result of patient feedback. Some changes relate to small things, such as less plastic wrapping on sandwiches so that older patients can eat lunch without help, and changing prescription timings across a location, so that vulnerable service users are not left without support over the weekend. Some changes have been more significant, such as transforming a maternity ward, including retraining staff, increasing staff numbers and a complete refocus on the needs of patients on the ward.

NHS trusts with the best record of responding to comments on the internet[2]
% of comments with a response

Burton Hospitals NHS Trust 100%

Nuffield Orthopaedic Centre NHS Trust 100%

Shrewsbury and Telford Hospital NHS Trust 100%

Trafford Healthcare NHS Trust 100%

Tameside Hospital NHS Foundation Trust 99%

Mid Staffordshire NHS Foundation Trust 98%

Northumbria Healthcare NHS Foundation Trust 97%

North West London Hospitals NHS Trust 96%

East and North Hertfordshire NHS Trust 94%

Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust 94%

EXPERT OPINION

Paul Hodgkin, founder and chief executive, Patient Opinion

The web has given people new ways to organise, connect and communicate. People are using social media to shape the world, from the demise of the News of the World to the Occupy protests. Patients talk about, and engage with, health services like never before. But what does this mean for the health service? How good is the NHS at really listening to what patients and families are saying?

For the first time, this year's Hospital Guide shows how responsive hospital trusts are to public feedback. It's a very variable picture. Some respond to everything; others don't respond at all, regardless of how much feedback they're getting. But getting a response is only the beginning. People really want to know that their feedback has had an impact, and whether the service has changed. The data from Patient Opinion begins to tell us which providers are the best at learning, changing and improving.

Busy staff often find Twitter or Facebook very difficult to interact with. Patient Opinion is designed with these staff in mind, to make feedback a powerful transformative tool for the NHS. In the coming years, the way that health services engage with the stories people tell about them will be the mark of a 'good' hospital.

WHAT IS THE LEVEL OF NURSING CARE ON WARDS FOR ELDERLY PEOPLE?

It is important to have appropriate numbers of nurses on hospital wards. Research previously undertaken by Dr Foster and published in the Nursing Times has shown the number of nurses per beds has a direct relationship with hospital mortality rates.[3]

This is especially true of elderly wards, where patients often need greater care and attention. Research by the Alzheimer's Society found that 25 per cent of all inpatients have a diagnosis of dementia.[4] We used the Hospital Guide Questionnaire to examine nursing levels on elderly care wards in our hospitals. We asked every trust to confirm whether they had elderly care wards and the total number of beds on these wards. We then asked how many nurses and healthcare assistants were scheduled to be on duty at 10pm on two Thursdays in March and April 2011 and at 11am on two Sundays in March and April 2011. 137 NHS trusts who have designated geriatric units were able to respond to this request, giving us data for 142 hospitals.[5] The results show wide variation in staffing levels.

The minimum number of nurses who should be covering a ward is two. Of the 142 hospitals who provided data, 37 had just two nurses on duty at night. Of these, 11 had just one nursing assistant – the minimum number of staff found on any wards at night. However, the right level of staffing depends on the number of patients being cared for. Wards with three members of staff varied in size from 13 beds to 28. For this reason we looked at the ratio of nurses and nursing assistants to beds in each hospital.

The lowest level of staffing per bed was found on larger wards where the staffing nonetheless remained low. For example, at **South Tyneside District Hospital**, which has the highest number of beds per nurse at night, the 59 elderly care beds are looked after at night by two nurses and four healthcare assistants. That is ten beds for each member of staff and 30 beds per nurse. Across all hospitals the average staffing ratio at night is for there to be six beds per member of staff and 12 beds per nurse. The highest level of nurse staffing was at the **Hammersmith Hospital** in London, where the ten elderly care beds are looked after by three nurses on duty at night.

We also looked at weekend staffing. Staffing levels at weekends are higher than on week-days. Weekend staffing levels are not as low as night time staffing levels. **Kettering General**, which has the lowest levels, has 75 beds that are looked after by four nurses and five assistants. That is equivalent to 19 beds per nurse or eight beds per member of staff. The national average figures are four beds per member of staff and eight beds per nurse. The highest level of staffing at weekends was at the **Northwick Park Hospital** where 50 beds were looked after by 25 nurses and 11 nursing assistants.

Dewsbury and District Hospital has the lowest overall staffing levels averaged across all measures of elderly care ward staff, with 8.8 beds per member of staff, compared with the average of 5.3.

One other aspect of staffing that varied widely was the ratio of nurses to nursing assistants. On average there is one nurse per nursing assistant. But many hospitals have more nursing assistants than nurses on duty at nights and weekends. Some, however, go the other way. For example, at **North Middlesex University Hospital**, which had one of the highest levels of nurse staffing, the geriatric wards are looked after at night by eight nurses and two nursing assistants.

EXPERT OPINION

Professor Peter Griffiths, chair of health services research, University of Southampton

Caring for older people in hospital is often seen as a low-skill activity with wards given a lower level of staffing and fewer qualified nurses. Yet many older people in hospital have substantial needs for care, supervision and support. Most have significant medical needs. Even those whose stay is extended while awaiting a social care package are likely to have a high level of need.

Enquiries into deficits of NHS care over recent years have highlighted the potential consequences of insufficient nursing staff to provide support and ensure that safety is maintained (for example, falls, which can lead to serious injuries). Confused older people can become particularly agitated at night, when there are less staff. The demands make this a challenging environment in which to deliver safe and effective care.

These figures show a huge variation in how trusts staff these types of wards at night. Some use only registered nurses; others rely on healthcare assistants. Given the likely needs of these patients and the unfamiliar environment, the staffing levels reported by some trusts seem low. It seems reasonable to ask whether they have clearly assessed the needs of patients and if they are sure that these needs can be safely met with such staffing levels.

Who are our *trusts of the year?*

Each year we highlight NHS trusts that have performed consistently well over the metrics highlighted in the guide, naming them our trusts of the year.

4

Chelsea and Westminster Hospital NHS Foundation Trust is the only trust that is low on all four mortality measures

This year we have made a change to our approach. We are giving awards to four excellent hospitals, one in each of the new NHS regions. To identify these trusts we have looked at two measures of hospital quality: mortality and patient experience.

Firstly, we looked across our four measures of mortality (see page 12) and identified hospitals that were not 'above expected' for any of the metrics. We then considered responses from three questions in the national patient survey and calculated an average score. The questions were:

- Overall, how would you rate the care you received?
- Were you involved as much as you would like in decisions about your care and treatment?
- Did you feel you were treated with respect and dignity while you were in the hospital?

Trust	Region	SHMI	HSMR	Deaths after Surgery	Deaths in Low-Risk Conditions	How would you rate the care you received?[1]	Did you feel you were treated with respect? [1]	Were you involved as much as you wanted to be?[1]
Royal Devon and Exeter NHS Foundation Trust	South	↓	●	↓	●	82	92	75
University College London Hospitals NHS Foundation Trust	London	↓	↓	●	↓	83	91	75
Cambridge University Hospitals NHS Foundation Trust	Midlands	↓	↓	●	●	81	90	75
Sheffield Teaching Hospitals NHS Foundation Trust	North	↓	↓	●	●	82	89	76

↑ above expected ● within expected ↓ below expected

ROYAL DEVON AND EXETER NHS FOUNDATION TRUST

Our patients and their families put their trust and confidence in us to provide safe quality healthcare. At the Royal Devon and Exeter NHS Foundation Trust (RD&E) we have taken this responsibility and duty of care seriously.

With this in mind, a programme of work has been undertaken to review, update and improve aspects of care in theatres, clinics and on wards. Staff awareness has been raised about the correct protocols and good practice and the trust has committed to ensuring that any surgery is performed on the right patient in the right place every time.

The RD&E has also trialled a new approach to patient care that aims to have the patient recovering sooner after major surgery. The Enhanced Recovery Programme includes pre-op assessments to identify and address risks and complications before surgery, and changes in practice to reduce the impact of the procedure on the body and post-op care to aid recovery.

Essential to the success of this approach and other service improvements has been the involvement of patients from the outset in decisions about their care. In addition to established surveys of NHS patient satisfaction, we have developed our own ways of capturing 'real time' feedback on wards from our patients. Of course, none of this progress could have been achieved without the commitment and innovation of our staff to better patient care and experience. The emphasis on teamwork cannot be overstated.

Angela Pedder OBE, chief executive

UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST

We pride ourselves on offering the best possible care to all our patients and this is a fantastic achievement for everybody connected with University College London Hospitals NHS Foundation Trust (UCLH). You can have new hospital facilities and all the modern equipment money can buy, but our greatest asset will always be our staff.

It is not surprising that the key questions that patients ask their doctor are whether it will be safe, what the outcome will be, and what the experience will be like. These are our priorities: safety, outcomes and experience.

Despite treating patients with some of the most complicated conditions due to the specialist services we provide, our mortality rates are consistently among the lowest in the country. Safety must be at the heart of everything we do.

We have put a lot of work into educating staff about the importance of treating patients with dignity and respect and involving them in decisions about their care. It is really satisfying that this is paying off and is reflected in the experience patients have when they come to UCLH.

Sir Robert Naylor, chief executive

CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

We are committed to putting patients first – and that means not only that their safety is paramount, but that we go out of our way to listen to their views both during their time at the hospital and after they go home.

Both Addenbrooke's and the Rosie Hospitals are recognised as centres of medical excellence and innovation, and our role in Cambridge University Health Partners – one of the first NHS academic health science centres – makes this one of the richest pools of clinical and scientific knowledge in Europe.

When it comes to patient safety, our strategy is to minimise all avoidable risks, but if something goes wrong then we analyse events and work out what needs to change. We've cut our infection rates for MRSA and C. difficile further than anyone thought possible a few years ago, and our standardised mortality rates are among the best in the NHS.

Our specialist services deal with rare and complex conditions that need the most modern facilities, the most up-to-date treatment, and the best doctors and nurses. But ultimately, we are here to care for everyone who needs our help, and our values – to be kind, safe, and excellent – define the way we work and behave towards our patients, partners and each other.

Dr Gareth Goodier, chief executive

SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

The 15,000 people who work for Sheffield Teaching Hospitals are the key to our ability to provide the highest quality of care to patients year after year both in hospital and in the community.

An unrelenting focus on clinical outcomes, patient satisfaction and ensuring we have engaged and committed staff is how we have continued to achieve high standards at the same time as developing innovative, integrated new ways of delivering services in response to the challenging financial climate.

In the last 18 months we have introduced a new 'gold standard' stroke service, seven-day therapy services and implemented a roll-out of a primary angioplasty service for patients across South Yorkshire and North Derbyshire who have suffered a heart attack.

A commitment to patient safety has resulted in significantly lower than average mortality rates, reflected in both HSMR and the new SHMI indicators.

Sir Andrew Cash, chief executive

We are making a special award to **Chelsea and Westminster Hospital NHS Foundation Trust** for **BEST OUTCOMES**. This is the only hospital to achieve below expected rates on all four of our measures of mortality.

Appendix

REFERENCES

Timeline

1 Births and Deaths in England and Wales ONS Statistical Bulltein 13 July 2011.
2 Mean waiting time for inpatient and day case admissions between decision to admit and admission calculated using SUS data.

More doctors at nights and weekends

1 Aylin P; Yunus A; Bottle A; Majeed A; Bell D. Weekend mortality for emergency admissions. A large, multicentre study. Qual Saf Health Care. 2010.
2 Bed information published at http://www.ic.nhs.uk/statistics-and-data-collections/data-collections/information-about-the-nhs-workforce-estates-and-facilities-management-collections/direct-collections/estates-and-facilities-management.
3 We could not obtain bed data for the following trusts: Chesterfield Royal Hospital NHS Foundation Trust, King's College Hospital NHS Foundation Trust, Sheffield Teaching Hospitals NHS Foundation Trust, The Rotherham NHS Foundation Trust.
4 The following trusts did not supply staffing information: Aintree University Hospitals NHS Foundation Trust, Barts and The London NHS Trust, Bradford Teaching Hospitals NHS Foundation Trust, Doncaster and Bassetlaw Hospitals NHS Foundation Trust, Great Western Hospitals NHS Foundation Trust, Guy's and St Thomas' NHS Foundation Trust, Hull and East Yorkshire Hospitals NHS Trust, Leeds Teaching Hospitals NHS Trust, Newham University Hospital NHS Trust, Southampton University Hospitals NHS Trust, Winchester and Eastleigh Healthcare NHS Trust.
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Network with other hospitals

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3 W L Palmer (2011) Unpublished analysis on weekend stroke care produced for NHS London.

Follow best practice and treat patients promptly

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Avoid hospitals that only perform operations occasionally

1 Vascular MDT bulletin http://www.aaaqip.com/aaaqip/evidence-base.html.
2 The Provision of Services for Patients with Vascular Disease 2012. http://www.vascularsociety.org.uk/news-and-press/2011/71-provision-of-services-for-patients-with-vascular-disease.html.
3 Since 2011, Bradford Teaching Hospitals NHS Foundation Trust, Calderdale and Huddersfield NHS Foundation Trust and Airedale NHS Foundation Trust have formed a vascular network to provide vascular services across West Yorkshire. AAA surgery will take place on two sites (Bradford and Huddersfield). Together the centre will undertake 50-60 AAA procedures a year.
4 Calderdale and Huddersfield NHS Foundation Trust: since March 2011 the service has been reviewed and a cooperative collaboration implemented with an adjacent provider. The model is supported by local commissioners and the SHA. 21 abdominal aortic aneurysms have been treated in this trust in the first six months of this year (April to September 2011).
5 The Ipswich Hospital NHS Trust: from April 2012, aneurysm repair will be performed at Colchester Hospital as part of a service integrated between the two hospitals. The main reason for this choice was the small number performed at Ipswich relative to Colchester. The reconfiguration was a clinician-led initiative, supported by management.
6 Northern Lincolnshire and Goole Hospitals NHS Foundation Trust: a review has been carried out into vascular services and it has been recognised as part of the review that the trust does not undertake the minimum number of AAA repairs recommended annually. It is planned that from April 2012 such procedures will be undertaken at Hull and East Yorkshire Hospitals NHS Trust.
7 Southend University Hospital NHS Foundation Trust completed an additional ten operations in 2010/11 but these were incorrectly coded and so did not appear in the SUS data.
8 Whipps Cross University Hospital NHS Trust: following a review of vascular services across North East London in 2010, the trust no longer performs complex vascular surgery, with effect from April 2011.

Patient safety

1 Information collected through the Hospital Guide questionnaire.
2 Sari AB-A, Sheldon TA, Cracknell A, Turnbull A. Sensitivity of routine system for reporting patient safety incidents in an NHS hospital: retrospective patient case note review. BMJ. 2007;334(7584):79
3 Vincent C. Incident reporting and patient safety. BMJ. 2007;334(7584):51.
4 Vincent C. Patient safety. 2nd ed. Oxford: Wiley Blackwell; 2010.
5 Pronovost P, Holzmueller CG, Needham DM, Sexton JB, Miller M, Berenholtz S, et al. How will we know patients are safer? An organization-wide approach to measuring and improving safety. Critical care medicine. 2006;34(7):1988-95.
6 Vincent C, Aylin P, Franklin BD, Holmes A, Iskander S, Jacklin A, *et al*. Is healthcare getting safer? BMJ. 2008;337(nov13_1):a2426.

Patient experience

1 Data supplied by NHS Choices (www.nhs.uk).
2 Data supplied by Patient Opinion (www.patientopinion.org.uk).
3 http://www.nursingtimes.net/whats-new-in-nursing/management/more-nurses-equals-better-care/2007478.article
4 Counting the cost: caring for people with dementia on hospital wards (2009) www.alzheimers.org.uk
5 The following trusts were unable to supply data: Aintree University Hospitals NHS Foundation Trust, Bradford Teaching Hospitals NHS Foundation Trust, Croydon Health Services NHS Trust, Doncaster and Bassetlaw Hospitals NHS Foundation Trust, Hull and East Yorkshire Hospitals NHS Trust, Leeds Teaching Hospitals NHS Trust, Newham University Hospital NHS Trust, Poole Hospital NHS Foundation Trust, Royal Berkshire NHS Foundation Trust, Southampton University Hospital NHS Foundation Trust, St Helens and Knowsley Hospitals NHS Trust, Whittington Hospital NHS Trust, Yeovil District Hospital NHS Foundation Trust. Two trusts did not respond to the questionnaire: Central Manchester University Hospitals NHS Foundation Trust and University Hospitals Birmingham NHS Foundation Trust

Trusts of the year

1 These are standardised scores produced by the Care Quality Commission. See http://www.cqc.org.uk/node/1667 for more information

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THE DR FOSTER TEAM

Editorial
Alex Kafetz
Andrew Kliman
Tara Athanasiou
Coco Bayley

Data and analysis
Dr Jenny Houghton
Professor Simon Jones
David Mullett
Dr Jamie Tratalos
Kim Vuong

Engagement, data collection and online
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Robert Douce
David Woosnam
Gareth Jones
David Anderson

Project management
Conor Campion
Diane Gould
Emma Whittaker

Sub-editing
Jacqui Gibbons

Design
design to communicate

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E

Council of Governors – Meeting Schedule 2011

Date	Location	Type of meeting	Time
Wednesday 12 January 2011	White Cross Social Club	NED	3.15pm-5.15pm
Wednesday 23 March 2011	White Cross Social Club	Pre meeting Private Public	3.15pm-3.45pm 3.45pm-4.15pm 4.15pm-6.00pm
Wednesday 13 April 2011	White Cross Social Club	Board to Board	4.00pm-6.00pm
Wednesday 15 June 2011	White Cross Social Club	Pre meeting Private Public	3.15pm-3.45pm 3.45pm-4.15pm 4.15pm-6.00pm
Wednesday 13 July 2011	White Cross Social Club	NED	3.15pm-5.15pm
Wednesday 14 September 2011	White Cross Social Club	Board to Board	4.00pm-6.00pm
Wednesday 12 October 2011	White Cross Social Club	Pre meeting Private Public	3.15pm-3.45pm 3.45pm-4.15pm 4.15pm-6.00pm
Wednesday 21 December 2011	White Cross Social Club	Pre meeting Private Public	3.15pm-3.45pm 3.45pm-4.15pm 4.15pm-6.00pm

Attendee by type of meeting

Pre meeting (un-minuted)	Council of Governors and Chairman of the Trust
Private (minuted)	Council of Governors and Chairman of the Trust
Public	Council of Governors, Chairman of the Trust, Directors as required, public
Board to Board	Council of Governors and Board of Directors (private meeting)
NEDs	Council of Governors, Non-executive Directors (private meeting)
AGM	Public meeting

F

York Teaching Hospital NHS
NHS Foundation Trust

Council of Governors – 21 December 2011

Membership Report 1 April to 31 October 2011

Action requested/recommendation

The Board of Directors is requested to consider this report and note its contents.

Summary

The attached report provides details on the membership numbers for the period April 2011 to the end of October 2011 and a brief summary of membership recruitment and engagement activities undertaken during the year to date.

Strategic Aims	**Please cross as appropriate**
1. Improve Quality	☐
2. Improve our 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

The more members we get, the more chance we have of reaching a diverse public.

Reference to CQC outcomes

No reference to CQC outcomes.

Progress of report	This report written for the Board of Directors and Council of Governors
Risk	No risk
Resource implications	No resources implications
Owner	Patrick Crowley, Chief Executive
Author	Penny Goff, Membership Development Manager
Date of paper	November 2011

Version number	Version 1

Council of Governors – 21 December 2011

Membership Report - 1 April to 31 October 2011

1. Introduction and background

The Board of Directors should monitor the NHS Foundation Trust membership and the level and effectiveness of membership engagement. This report provides the Board with the information to allow them to fulfil this responsibility.

2. Membership profile

The table below shows the membership movement by each current type of constituent (excluding staff):

Public Constituency:		**Nett**
At 1 April	9,610	
New members	221	
Members leaving	106	
At 31 October	**9,721**	**+111**
Patient Constituency:		
At 1 April	2,388	
New members	21	
Members leaving	30	
At 31 October	**2,379**	**-9**
Affiliate members:		
At 1April	447	
At 31 October	**961**	**+514**
Totals: **At 1 April** **At 31 October**	 **12,445** **13,061**	 **+616**

Using the proposed revised constituencies following the planned integration in 2012, the membership figures would be as follows:

Public members: York	7,246
Selby	1,995
Hambleton	730
Ryedale & E Yorks.	1,868
Bridlington	145
Scarborough	213
Whitby	43
Affiliate members: (members living outside the above constituencies)	821
Total:	**13,061**

The staff membership figure has also increased since 1 April, due to the transfer of the community staff:

Staff Constituency		nett
At 1 April	4,831	
New members (TCS staff)	1,844	
Members leaving	479	
Opt outs	20	
At 31 October	**6,176**	**+1,345**

Therefore, total membership at 31/10/11 is 19,237.

The staff membership will increase by approximately 2,600 following planned integration with Scarborough Trust.

3. Recruitment activity in 2010/11

The Membership Development Manager has planned and attended a total of 33 different events since April, in order to raise awareness of the Trust, to recruit new members and to engage with existing members. The specific activities carried out are detailed in Appendix 1 of this document. These events have resulted in over 750 new members.

Membership stands have been purchased and set up in each of the seven main hospital locations, for the display of information and application forms. Local arrangements are in place for them to be maintained with leaflets. During the month of November, the Membership Manager has been visiting each site regularly to promote the benefits of membership to patients, visitors and staff.

We have also promoted these stands to the public using the local press and to date the Whitby Gazette, Scarborough Evening News, Bridlington Free Press, Selby Times, Selby Post and Easingwold Advertiser have published the press release and photographs. Additionally we are taking out a paid “advertorial” in the Whitby Gazette with a tear-out application form. We will monitor the effectiveness of this latter approach before considering further use with publications in other new communities.

In addition, some Governors continue to target their local communities for additional members by poster displays and use of community newsletters & publications.

4. Engaging with our members

On 14 September, the Trust once again threw open its doors to welcome visitors at the annual open event at York. Around 1,500 people attended, to take part in behind-the-scenes tours, presentations and displays on a range of topics. Members of the public were able to meet managers, Governors and front-line staff, as well as attend the Annual General Meeting of the Trust.

The YorkTalk presentations are also an important way for the Trust to engage with members, by offering a range of short information sessions delivered by our staff. During the summer we decided to hold these at 5.30 pm rather than at 12.30 to try to boost attendance. Despite more initial interest and pre-bookings from members, the actual attendances did not increase significantly, so we will revert back to lunchtime sessions for the winter months. The topics have included ophthalmology, retinal screening, Age Concern services and the final session for the year in November is stroke services.

In April this year, it was decided to change the YorkTalk newsletter to a Chairman's letter, in order to release funds to develop a staff magazine. The Chairman's letter has been mailed (post/email) to each member household on two occasions since April with a third planned in December.

Phil Chapman, one of our Ryedale Governors, is working in that constituency to develop a cross-system group of stakeholders across the health and social care field, to potentially begin to share more information (electronically) with each other and their respective "memberships" (e.g. NYCC/Ryedale District Council, LINk, Ryedale Voluntary Action, YTHFT). This pilot may offer lessons of how to stimulate improved member and public engagement in each of our seven local communities. It also carries risks, of course.

For those of you who are interested to see the overall Membership Strategy statement, this is included as an Appendix to the Integrated Business Plan.

5. Recommendation

The Board of Directors is requested to consider this report and note its contents.

Author	**Penny Goff, Membership Development Manager**
Owner	**Patrick Crowley, Chief Executive**
Date	**November 2011**

Appendix 1

Membership Recruitment Events
1 April 2011 - 31 March 2012

Date	Event/venue	Constituency	Members recruited on the day	Comments
Tuesday 19 April 2011	Age Concern Over 50s Market Weighton Community Centre	Ryedale & East Yorks	0	
Wednesday 20 April 2011	Bridlington LINks meeting	Bridlington	1	
	Talk by Chairman to Parkinson Society	York	4	
Thurs 19 May 2011	Southern CEF Selby	Selby	0	
Thursday 26 May 2011	Joint recruiting with Hull & Humber Trusts at Tesco, Bridlington	Bridlington	105	
Friday 27 May	Bridlington Health Forum Meeting	Bridlington	2	
Saturday 4 June 2011	St Monica's Garden Fete, Galtres centre, Easingwold	Hambleton	18	With Jane Dalton, Helen & Alan
Monday 20 June	Ryedale LINK meeting	Ryedale & East Yorks	3	Alan & Pat
Wednesday 5 July	East Yorkshire LINk Community Involvement bus to outlying villages	Ryedale & East Yorks	3	
4, 6,7,19,20,21 July	City of York Ward Committees	York	33	With York public Governors
Wed 13 July 6.30 pm	Central CEF Selby	Selby	7	With Patrick & Bob Thomas
Sunday 17 July 2011 7am to 5pm	Malton Show	Ryedale & East Yorks	70	£83 cost
Wednesday 20 July 8 – 6.30 pm	Driffield Show	Bridlington	170	£120 cost. Joint stand with Hull/EY and Humber FT
Sunday 31 July 11– 4pm	Tesco Community Fair	York	20	Shared stand with Lucy Watson
Wed 10 August	Scarboro' & Filey Older People Forum	Scarborough	42	With Mike Proctor
Saturday 13 August 12 – 4pm	Malton & Norton Community Hospital League of Friends Summer fete	Ryedale & East Yorks	7	
Saturday 3 September 9 – 3pm	Hovingham Village market	Ryedale & East Yorks	12	With Phil Chapman & Jenny Moreton. £10 cost
Thursday 8 September 10 – 4pm	50 + Festival Information fair Guildhall.	York	26	£20 cost

Date	Event/venue	Constituency	Members recruited on the day	Comments
Monday 12 September 6.30 to 8.30 pm	East Riding LINk mtg, Spa at Bridlington	Bridlington	12	With Mike Proctor & Pat Crowley
Wednesday 14 September 2.30 – 7pm	York Teaching Hospital Open Event/AGM	York	2	
Saturday 17 September 12 – 4 pm	Tadcaster Grammar School and Sainsburys Community Family Fun Day	Selby/York	26	
Wednesday 21 September 7.30 pm	Malton Hospital League of Friends AGM	Ryedale & East Yorkshire	15	With Mike Proctor
Monday 26 September 10 to 4pm	Falls prevention service public event	York	7	
Tuesday 27 September 6.30 pm	Western CEF, Selby District Council	Selby	6	With Andy Bertram & Bob Thomas
Saturday 1 October 6.30 to 10pm	Freshers' fair at HYMS, Hull University	York	61	
Monday 3 October 10 to 4pm	Age Concern Scarborough & District Xtra life 50+	Scarborough	73	£30 cost
Friday 7 October 11 to 1pm	Scarborough Link Meeting	Scarborough	4	
Thursday 13 October 9 - 3pm	East Riding Links event at Market Weighton	Ryedale & East Yorkshire	2	
Friday 14 October 9 - 1pm	York University Freshers Fair	York	38	
Wednesday 16 November 10 – 3pm	NY LINks Selby event	Selby	21	
Monday 28 November 6.30pm	Tadcaster CEF Selby District Council	Selby		With Pat
Wednesday 7 December 6.30 pm	Eastern CEF Selby District Council	Selby		With Andy
Thursday 8 December – all day event	Whitby Over 50s Information day	Whitby		

Last updated: Thursday 9 November 2011