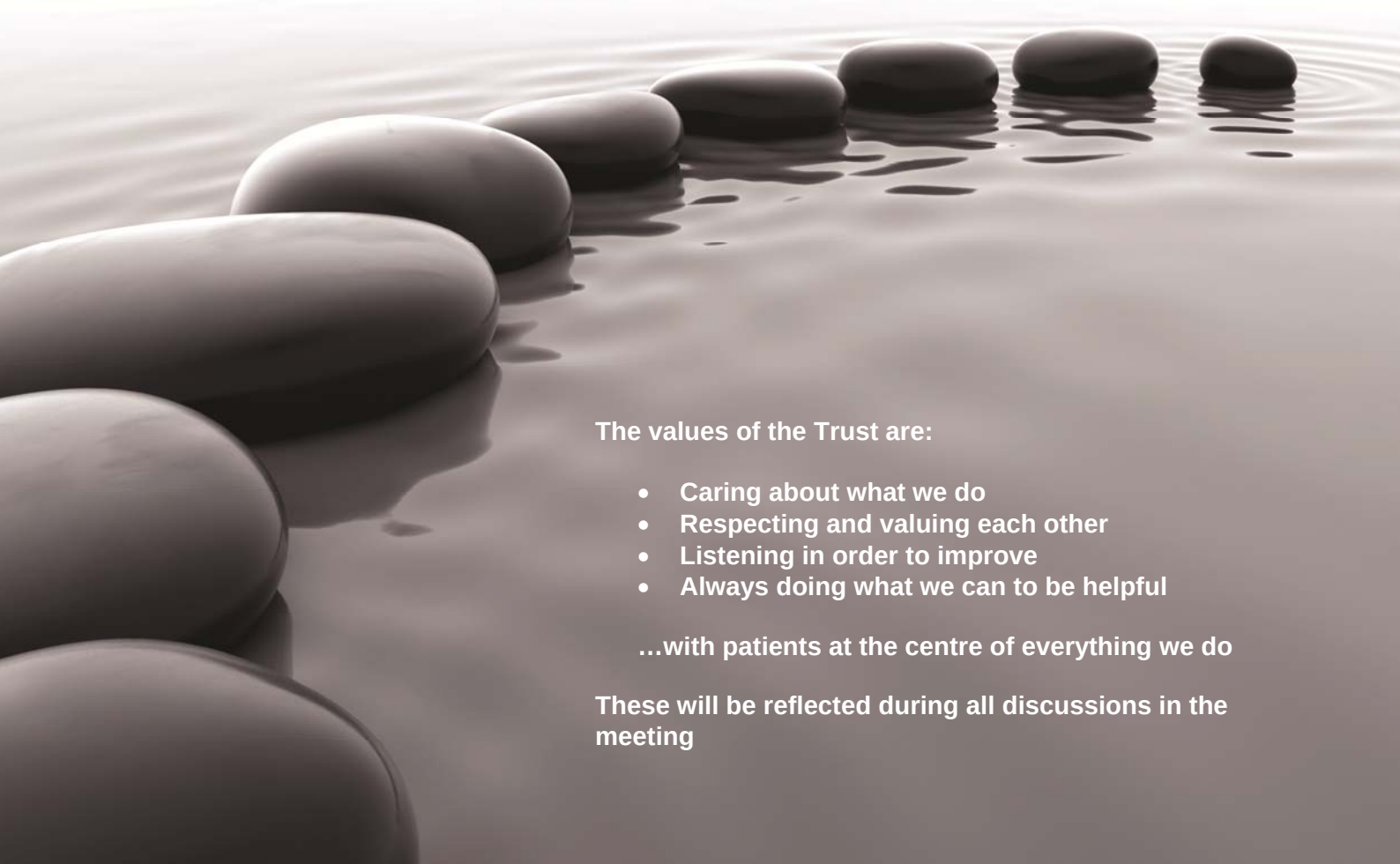
York Teaching Hospital NHS
NHS Foundation Trust

The programme for the next meeting of the Board of Directors will take place:

on: **Wednesday 30 November 2016**

in: **Health Education Room, Selby War Memorial Hospital, Doncaster Road, Selby, YO8 9BX**

Time	Meeting	Location	Attendees
9.00am to 9.30am	Remuneration Committee	Health Education Room, Selby WM Hospital	Remuneration Committee Members
9.45am to 12.15pm	**Board of Directors meeting held in public**	**Health Education Room, Selby WM Hospital**	**Board of Directors and members of the public**
12.15pm to 1.15pm	Lunch	Health Education Room, Selby WM Hospital	Board of Directors
1.15pm to 2.30pm	Board of Directors meeting held in private	Health Education Room, Selby WM Hospital	Board of Directors



The values of the Trust are:

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

…with patients at the centre of everything we do

These will be reflected during all discussions in the meeting

York Teaching Hospital NHS
NHS Foundation Trust

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On: **Wednesday 30 November 2016**

At: **9.45am to 12.15pm**

In: **Health Education Room, Selby War Memorial Hospital, Doncaster Road, Selby, YO8 9BX**

A G E N D A					
No	***Time***	***Item***	***Lead***	***Paper***	***Page***
General					
1.	9.45 – 9.55	**Welcome from the Chairman** The Chair will welcome observers to the Board meeting.	Chair		
2.		**Apologies for Absence and Quorum** • No apologies received.	Chair		
3.		**Declaration of Interests** To receive any changes to the register of Directors' declarations of interest, pursuant to section 6 of Standing Orders.	Chair	A	5
4.		**Minutes of the Board of Directors meeting held on 26 October 2016** To review and approve the minutes of the meeting held on 26 October 2016.	Chair	B	9
5.		**Matters arising from the minutes** To discuss any matters arising from the minutes.	Chair		
6.	9.55 – 10.10	**Patient Story** To receive a presentation on the Clinical Navigator Role.		Verbal	

No	Time	Item	Lead	Paper	Page
Our Quality and Safety Ambition: Out patients must trust us to deliver safe and effective healthcare					
7.	10.10 – 10.25	**Chief Executive Report** To receive an update on matters relating to general management in the Trust including an STP update.	Chief Executive	C	21
8.	10.25 – 10.45	**Quality and Safety Performance issues** To be advised by the Chair of the Committee of any specific issues to be discussed. • Patient and Quality Safety Report • Medical Director Report • Chief Nurse Report • Safer Staffing	Chair of the Committee	D D1 D2 D3 D4	27 41 73 83 99
Our People and Capability Ambition: The quality of our services is wholly dependent on our teams of staff					
9.	10.45 – 11.05	**Workforce and Organisational Development Committee Issues** To be advised by the Chair of the Committee of any specific issues to be discussed. • Workforce Metrics and Update Report	Chair of the Committee	E	109
11.05 – 11.15		**Tea break**			
Our Finance and Performance ambitions: Our Sustainable future depends on providing the highest standards of care within our resources					
10.	11.15 – 11.35	**Finance and Performance issues** To receive the minutes from the meeting and associated key papers: • Finance Report • Efficiency Report • Performance Report	Chair of the Committee	F F1 F2 F3	123 135 153 159

No	Time	Item	Lead	Paper	Page
11.	11.35 – 11.45	**2016/17-21 Business Case - Laboratory Medical Capital Scheme** To receive and approve the business case.	Director of Finance	G	167
12.	11.45 – 12.05	**Acute Medical Model** To receive a 6 month update on the Acute Medical Model at Scarborough.	Chief Operating Officer	Presentation	
13.	12.05 – 12.15	**Emergency Planning Report and Annual self-assessment against core standards** To receive and approve the self-assessment.	Chief Operating Officer	H	193
Any Other Business					
14.	12.15	**Next meeting of the Board of Directors** The next Board of Directors meeting held in public will be on 25 January 2017 in the Boardroom at York Hospital.			
15.		**Any Other Business** To consider any other matters of business. a) Cyber Ransom			

Items for decision in the private meeting:

NHSI Agency Spend Pro-forma
Outline Business Case for Elective Surgery on the East Coast update

The meeting may need to move into private session to discuss issues which are considered to be 'commercial in confidence' or business relating to issues concerning individual people (staff or patients). On this occasion the Chair will ask the Board to resolve: *'That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1(2), Public Bodies (Admission to Meetings) Act l960.*

Register of directors' interests
November 2016

York Teaching Hospital NHS
NHS Foundation Trust

Additions: No changes

Changes: No changes

Deletions: No changes

A

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

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	Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation trust including but not limited to, lenders or banks
Mr Michael Sweet (Non-Executive Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Professor Dianne Willcocks (Non-Executive Director)	**Member—**Great Exhibition of the North (2018) Board	Nil	Nil	**Chair—Charitable Trustee** **Act as Trustee** –on behalf of the York Teaching Hospital Charity **Trustee and Vice Chair—**of the Joseph Rowntree Foundation and Joseph Rowntree Housing Trust **Chair—**Advisory Board, Centre for Lifelong Learning University of York **Member—**Executive Committee YOPA **Patron—**OCAY **Chairman** - City of York Fairness and Equalities Board **Member –**Without Walls Board	**Director—**London Metropolitan University **Vice Chairman—**Rose Bruford College of HE	Nil
Mr Patrick Crowley (Chief Executive)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil

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

York Teaching Hospital NHS
NHS Foundation Trust

Minutes of the meeting of the Board of Directors of York Teaching Hospital Foundation Trust, held in public at St Catherine's Hospice, Throxenby Lane, Scarborough on 26 October 2016

Present:

Non-executive Directors:

Ms S Symington	Chair
Mrs J Adams	Non-executive Director
Mr P Ashton	Non-executive Director
Mr M Keaney	Non-executive Director
Ms L Raper	Non-executive Director
Mr M Sweet	Non-executive Director
Professor D Willcocks	Non-executive Director

Executive Directors:

Mr P Crowley	Chief Executive
Mr A Bertram	Director of Finance
Mr M Proctor	Deputy Chief Executive
Mr J Taylor	Medical Director
Mrs J Walters	Chief Operating Officer

Corporate Directors:

Mrs S Rushbrook	Director of Systems and Networks
Mrs W Scott	Director of Out of Hospital Care

In Attendance:

Mrs L Provins	Foundation Trust Secretary
Mrs H Hey	Deputy Chief Nurse
Mrs A McGale	Deputy Operating Officer (item 16/145)

Observers:

Mrs J Anness	Public Governor – Ryedale
Mrs M Jackson	Public Governor – York
Mr M Reakes	Public Governor – York
Mrs D Rose	Public Governor - Scarborough

The Chair welcomed the Governors and Helen Hey to the meeting.

16/134 Apologies for absence

Apologies were received from Beverley Geary, Chief Nurse and Brian Golding, Director of Estates and Facilities.

16/135 Declarations of interest

The Board noted the declarations of interest.

16/136 Minutes of the meeting held on the 28 September 2016

The minutes of the meeting held on the 28 September 2016 were approved as a true record of the meeting.

16/137 Matters arising from the minutes

Action Log – Ms Raper raised that the dates were very non-specific on the action log. It was agreed to make dates more specific.

Action: Mrs Provins to ensure action dates are specific.

16/138 Patient Story

Mr Crowley introduced the short film, which detailed the concerns of the spouse of a patient regarding communication of his death. Mr Crowley stated that this was about ensuring Trust values are practiced throughout the Trust and patient care is the core purpose of the Trust. Mrs Hey stated that work is being done to respond to the concerns and that nurses are now given a day with the Lead for End of Life Care as part of their preceptorship.

16/139 Report from the Chief Executive

Single Oversight Framework & System Wide Planning - Mr Crowley stated that his report had been late due to the wait for the formal announcement of the Single Oversight Framework segmentation. Mr Crowley was pleased to confirm that the Trust had been given a 2 which reflected a position as an organisation that was receiving support, but was overall trusted within the system, This segmentation placed the Trust in the top half of organisations at a difficult time for the NHS and especially in light of the merger had taken place 4 years previously.

Mr Crowley highlighted that he had had two conversations the previous day, one with a journalist who remembered the merger and one with a Director from Birmingham who was planning a merger with the Good Hope Hospital. This had reminded him of the significant journey the Trust had come on and that it takes approximately 7 or 8 years to sustain a merger and that about 50% of private organisations fail as a result of mergers. The recent strategy poster day across the organisation had shown it had been a difficult journey, but had also been worthwhile. He stressed again, that the “downside” case presented at the time of the merger was not anywhere near the challenges being currently experienced and that the whole system was under pressure and deteriorating against previously set standards.

Mr Crowley also stated that the segmentation puts the CQC inspection behind the Trust and gives the Trust something to build on. He noted that the Governors and Board had received a briefing the previous week around the system wide planning and that the ongoing conversations between organisations were helping to change attitudes and allow collaboration. Mr Crowley highlighted the current HSJ headlines illustrating that another Council had published the Sustainability and Transformation Plan for their area despite being requested not to by the NHS and this was a sign of difficulties at a national level. He stressed the need for the Trust to continue to focus on the work around Healthy Ambitions for Scarborough and use the strength of the Trust to be a force for change in Yorkshire, which will help to develop and embed a positive reputation.

Mr Crowley stated that the Trust has been provided with Sustainability and Transformation funding control totals for the years 2017/18 and 2018/19 and Mr Bertram is assessing the impact of these. Mr Bertram stated that unfortunately, the control totals do not take into account the loss of the transitional funding for Scarborough, which will leave the Trust £10m adrift. Mr Bertram stated that the Trust is not asking for further funding, but recognition of the position by having the control total adjusted. He stated that he hoped for more clarity by the end of November. There are two likely scenarios; the first being that the total is adjusted or the second, that the Trust is faced with a difficult and very stretching target for efficiencies. Mr Bertram stated that he was of the opinion that NHSI thought the Trust had a case, but were unsure of what to do about it.

Mrs Adams asked whether there had been any news regarding the tariff variation application which would help to plug the gap. Mr Bertram stated that the Local Price Modification application had been acknowledged by NHS Improvement and the Trust has indicated that if the control total is adjusted this application will not be required. There is a question of how this will all work with the timeframe for submission of plans as it unlikely that anything will be known until about February 2017.

MK asked what would happen if the Trust planned not to achieve the control total by £10m and Mr Bertram indicated that the Trust would lose the Sustainability and Transformation funding. Mr Bertram stated that the Finance Team will be getting the first cut of the numbers in about 7 to 10 days and will look at the options at that stage. Mr Bertram stated that he will keep the Board informed of developments.

Mr Sweet stated that the Single Oversight Framework segmentation looked right, but he was concerned that winter was coming and this was the most difficult time especially in light of the current issues with the Emergency Care Standard. He asked if there is any chance the segmentation will be revised downwards. Mr Crowley stated that NHS Improvement have indicated that there will be a future review of the segmentation levels at some point.

Ms Symington stated that she recommended members had a look at the whole register of Trusts as it was interesting seeing where other Trusts had been placed.

Mr Crowley stated that the Local Price Modification was a part of the armoury for the Trust along with the context of the whole system resilience of the Sustainability and Transformation Plan which implies collective subsidy and ownership.

Mr Crowley also noted the recent visit of the East Riding Scrutiny Committee to Scarborough and Bridlington which had been organised by Mr Proctor. The feedback had been that the improvements were amazing, in relation to the changes seen at both of the sites. Mr Proctor stated that there was a broader point to make, in that these were people elected by members of the public and they had highlighted the concerns continually raised by constituents regarding Bridlington prior to the merger which had now ceased.

National Cancer Performance – Mr Crowley stated that the Vale of York CCG was in the top 10 Commissioners for cancer performance which reflected positively on the Trust. Improvements were being seen at Scarborough with good patient feedback being

received. The Trust continues to work on the joint clinical summit with the CCG and primary care and this was about building trust back into the system.

Scarborough Recruitment Day – Mr Crowley highlighted the very successful day at Scarborough and the very positive feedback received.

Celebration of Achievement Awards – Ms Symington stated that significant feedback had been received regarding the awards especially regarding the impact on those receiving awards. Mr Crowley noted the awards would be held in Scarborough or Bridlington next year. Ms Symington thanked the members of the Board and Governors who attended.

16/140 Quality Safety & Performance Issues

Ms Raper stated that she would provide the Quality and Safety Committee report as she had chaired the last meeting. She reflected that several developments have been made with the one page executive summary, the action log and the continual work to build a stronger process to identifying key risks.

Ms Raper asked Mrs Hey to brief the Board on the Infection, Prevention and Control work regarding the increased number of MRSA cases. Mrs Hey stated that the number of cases had increased to 6 with 3 at York, 2 at Scarborough and 1 in the Community. Reviews had been undertaken and no themes or single wards had been identified. Mrs Hey noted that these involved extremely high risk and vulnerable patients including some ICU patients who were very unwell. Some factors identified by the reviews included inconsistent line management and issues with documentation as well as the delay in commencing suppression therapy. An action plan had been drafted which included education, training and development work and had also been linked to the training hub. The ward accreditation tool awards are being implemented in November and Trusts who have a zero MRSA rating have been contacted to see if there is anything more the Trust should be doing.

Ms Raper stated that the Committee were very pleased to note the work to progress the implementation of electronic prescribing. Mrs Rushbrook stated that electronic prescribing in relation to EDNs and TTOs was being rolled out in Ambulatory Care today and the uptake from the Junior Doctors had been pleasantly surprising.

Ms Raper stated that there had been a robust and lengthy discussion on sepsis at the meeting and she asked Mr Taylor to brief the Board on the relationship between the CQUIN actions, which was not simple. Mr Taylor noted that whilst the sepsis CQUIN required the Trust to promote the identification of sepsis and urgent treatment with broad spectrum antibiotics, the other CQUIN required less prescribing of broad spectrum antibiotics which might appear contradictory. He stressed that sepsis carried a mortality risk which if treated correctly and promptly significantly improved. The issues with antibiotic resistance were to do with the easy availability of antibiotics and overuse in the third world, the increased use of antibiotics in farming to ensure profits and the lack of development of new antibiotics.

Mrs Adams asked if the Trust still monitored the duration of use of antibiotics by area in order to see where the biggest challenges are. Mrs Hey stated that this has previously been part of the Medical Director Report. Mr Taylor agreed to put this into the report again.

Action: Mr Taylor to include the antibiotic usage monitoring in his next Report.

Ms Raper stated the Committee were very pleased to note the Sepsis Awareness Day on the 11 November 2016.

Ms Raper asked Mr Taylor to brief the Board on the issues with regard to clinical staffing in renal dialysis and that the unit was not being fully utilised. Mr Taylor stated that there were challenges in the recruitment of nurses for the haemodialysis unit which was critical. Renal physicians were still trying to offer a choice in dialysis, but this was not always possible. Mrs Hey stated that the Chief Nurse was already aware of this issue and discussions were ongoing regarding how best to approach it. A recruitment campaign would happen again shortly and work was being done to mitigate the issue wherever possible. Some patients were being transferred to extra capacity being provided by the private provider in Scarborough and further capacity was being planned for Easingwold in the next year or two. In the short term more staff were required, but patients were being put on HDU and ITU and peritoneal dialysis being used. However, this did affect patient choice and experience so a close eye was being kept on the situation.

Mrs Rushbrook noted that the situation had been further acerbated by Leeds inability to accept acute patients due to the issues with pathology. Mr Bertram stated that this is being looked at and creative ways of managing patients being identified. The directorate was also resisting the temptation to give up the facility for acute care. Mr Taylor stated that in recent years renal transplant has been successful, but the uptake has been mainly by self-care patients. It was noted that the purchase of Tanpit Lodge at Easingwold was announced at the last Board meeting.

Ms Symington noted that the Chair of the Easingwold Charity had stated that there was a lot of money in the charity and she noted it may be worth asking for support with the development of Tanpit Lodge.

Ms Raper noted the successful recruitment marketplace at Scarborough and that good feedback had been received from the Governors regarding the recruitment of new members. Mrs Hey stated that 22 registered nurses had been interviewed on the day and appointed, of which 9 were available immediately. She also noted that there had been a real success with HCAs and that there had also been success with Porters, Domestics and other staff. Mrs Hey also noted that currently approximately 70 volunteers were being processed in Scarborough.

Ms Raper stated that the Committee were pleased to note the broader opening up of visiting hours, which was part of John's Campaign. Ms Symington stated that this would also be good for all patients.

Ms Raper asked Mr Taylor to advise the Board regarding the work on dealing with the backlog of SIs which needed to be taken to Executive Board. Mr Taylor stated that work was underway to clear the backlog and make a fresh process, which was more mindful of time. He noted that learning starts at the very beginning of the process for clinical colleagues when it is within their area and that taking it to the Executive Board was a more formal type of learning. Ms Symington stated that how the Trust communicates these lessons learnt was vitally important. Mr Taylor stated that meetings are also held with the family to communicate the lessons learnt.

Mr Crowley stated that there are other ways in which to ensure a concurrent process and the role of the Executive Board should be explored in order to keep the process moving and not create a backlog.

Mr Keaney asked whether Scarborough was now fully staffed following the recruitment day. Mrs Hey stated that there were currently about 20 nursing vacancies and the position was being continually monitored. However, other initiatives such as the advanced practitioner posts continually pulled from the senior nurse staffing which created ongoing movement. Scarborough is at about a 9% vacancy level and in good times this has been about 4 to 5%.

16/141 Director of Infection Prevention and Control Quarterly Report

Mrs Hey stated that the main issue in the report has already been discussed and that the C. Difficile and MSSA figures were both below trajectory.

Mrs Hey stated that fit testing was being carried out to ensure that around 600 front line staff were being measured for the use of special masks which could be required if there is a flu pandemic. Mr Sweet asked about the current flu vaccine uptake. Mr Taylor stated that there is a CQUIN which requires 75% of front line staff to be vaccinated. Currently about twice as many staff as last year have been vaccinated. Mrs Hey stated that nursing was amongst the lowest uptake and a big campaign will be launched shortly by the Chief Nurse and matrons to vaccinate nursing staff.

Ms Symington thanked Ms Raper for a good discussion on Quality and Safety.

16/142 Out of Hospital Care Update

Mrs Scott provided an update to the Board on the Out of Hospital Care Strategy that came to the Board earlier in the year. She noted that Healthwatch have also turned the strategy into a patient user friendly document which can be shared if requested. Mrs Scott stated that the update provided information on key developments and projects such as discharge to assess and the integrated out of hospital service. She stated that there was a revised locality model and a subgroup of the Provider Alliance Board was working through the logistics and operational elements of the model.

Mrs Scott stated that the community discharge liaison service had been successful and there was an intention to make this service permanent. There were now discussions on how to integrate the discharge liaison service and work with the Local Authority to be innovative with a new and different form of discharge model locally.

Mrs Adams stated that the update had been very interesting, but she asked about the finances and how supportive the Commissioners were especially on the East Coast. Mrs Scott stated that this was a good point and there had been a recent break through on the development of intermediate care services to cover Scarborough. She noted that there may be some potential for new investment and work was ongoing to demonstrate efficiencies within the Scarborough and Community response team. Verbal commitment had been received and a business case was currently being development which would be taken back to the Commissioners next week.

Prof. Willcocks stated that the work was fascinating, especially the range of initiatives, but she wondered if there was a workforce and organisation development strategy for community services. Mrs Scott stated that there was a dedicated project manager. Prof.

Willcocks asked whether there were any volunteers involved as there was a wealth of capability available. Mrs Scott stated that she had been part of the project group and currently this had not been explored, but there should be some external models which were available to look at.

Mrs Walters stated that is was really good to see such good progress and that she had absolute confidence that this model would support patients being looked after outside the hospital environment. She noted that it was more patients attending and together with the overall lack of investment that had led to the current issues.

Ms Raper asked if any lessons could be learnt from the digital community workforce pilot. Mrs Scott responded that the efficiencies need to be established as there were significant aspirations, but it was difficult to estimate. Mrs Rushbrook stated that she would rather not use the word pilot, as this assumes that something is going to stop and this was really phase 1 of a very long journey.

16/143 Workforce Metrics and Update Report

Mr Crowley stated that a lot of the report had already been covered in the meeting and he noted that there have been modest reductions in sickness absence and turnover. He highlighted that the Staff Survey had been issued and currently the return rate was 16% which was disappointing. Last year the Trust achieved 45% which was roughly normal at a national level, but did suggest an element of survey blight and the not insignificant burden to staff to fill it out. There has been effort to try to create time for staff to provide feedback and the Trust was continuing to promote the completion of the survey.

Ms Symington noted that this was seen as a critical measure nationally by the regulators and that the results were really important. Mr Crowley thought the change from electronic to a paper version of the survey was to do with an external requirement. Mr Crowley also highlighted that there continues to be issues with appraisal and the capability and capacity to appraise staff. The other indicator that was back to premerger levels last year was about recommending the organisation to family and friends for either treatment or employment.

Mr Crowley stated that the job planning guidance had been issued in both paper and electronic format in order to get consultants to engage and take a level of personal responsibility for their part in the process. Mr Taylor stated that a more robust process had been introduced for reviewing job plans and a job planning committee had been put into place to review the sign off of job plans rather than look at the job plans per se. Mr Taylor stated that this was the end of a long process of iteration and negotiation with the LNC.

Prof. Willcocks asked what the main benefits were and Mr Taylor responded that the process that had been gone through had proved useful together with the level of parity being established across the Trust. Mr Taylor stated that it had been a back to basics and a mutual approach that was being used to create a measure of trust and re-engagement with management. Mr Taylor also noted that there has been a debate about SPA time and it has been made clear that this time in essence belongs to the Trust.

Mrs Adams asked if this would dovetail with the new consultant contract and it was noted that it will have to, but that the contract negotiations will mainly be about pay, pensions and on-call.

16/144 Finance and Performance Issues

Mr Keaney noted the very good attendance at the last meeting and that Lucy Turner's replacement also attended and is due to start in the Trust next month. Mr Keaney stated that the Committee thanked Lucy Turner for her professional and accurate reporting and noted that she will be missed. Ms Symington stated that the Board would also like to record their thanks.

Mr Keaney was pleased to report that the emergency care standard and financial control total was met for September, although this did not appear to be the case with the emergency care standard for October. Mr Kearney asked Mr Bertram and Mrs Walters to update the Board on each of their areas.

Mr Bertram stated that the Trust had hit the quarter 2 total which meant the sustainability and transformation funding would be received for quarter 2. The Trust had achieved a £2.6m surplus in September against a planned surplus of £1.6m. He confirmed that currently the Trust were still on target to hit the £10m control total at the end of the financial year. Currently £14.9m of the £26.4m efficiency target had been achieved and importantly, £11.3m of this was recurrent, which was the highest ever and was due to the really good leadership of Steve Kitching and Wendy Pollard. He highlighted a CIP planning gap, but was confident that the total would be delivered by the end of the year.

Mr Bertram stated that there was a marked improvement on consultant agency expenditure and the current pressure was on junior doctor and nursing agency spend. The current spend on agency is significantly below last year which gives some comfort, but importantly is above the trajectory for the year. Mr Bertram stated that the Single Oversight Framework does now contain a metric in relation to agency spend, which notes a tolerance of 25% distance from plan. However, Mr Bertram advised the Board that winter pressures are knocking on the door, which could have an impact on agency expenditure. Mr Bertram stated that cash levels were on plan.

Mr Bertram informed the Board of a developing risk around income levels which were unaffordable for the two main CCGs. He referenced the earlier conversation around sepsis. The work on sepsis has driven a much heightened awareness and CPD has also been developed which has enhanced patient experience and care and will have a positive effect on mortality rates. Mr Bertram stated that he has no issues with the data and it is open to scrutiny, but it does mean that there are risks developing around payment from the CCGs.

Mrs Adams asked about agency spend as she noted that there was not much seasonality factored into the numbers and had assumed that the numbers for winter needed go up dramatically. Mr Bertram explained that the plan goes with the existing profile as there are a significant number of new nurses starting which have been factored in.

Ms Symington reminded the Board that the first cut of the financial planning will be received at the November Board with the final plan coming to the Board in December before submission.

Mrs Walters stated that in respect of the emergency care standard, the Trust did achieve the Sustainability and Transformation funding trajectory of 89.5%. She stated that great

improvements have been made, but unfortunately during the last week in September and beginning of October there has been a decline. She highlighted that the whole team are devastated, but they continue to work on making significant improvements. Mrs Walters noted that York bed occupancy has been over 91% with Scarborough significantly higher at approximately 95% due to significant increases in non-elective admissions. Mrs Walters highlighted the work that had been done on pathways to ensure patients have been seen in ambulatory care protecting the bed base and that this extra activity has also been reflected in the financial position. Unfortunately, the ED trend is continuing and capacity remains a significant issue.

Mrs Walters stated that work is continuing to ensure rigour around discharge to ensure the discharge curve is brought forward. Other areas are continuing to change and support different ways of working. An acute admissions unit with 18 trolleys for ambulatory care is being opened and a surgical assessment unit will open in December. She noted that December was not an ideal time, however ambulatory care and zero length of stay patients was currently the saving grace. She highlighted the issues due to not currently having the capacity in out of hospital services in place and welcomed the work being done by Mrs Scott. She also noted that this position reflected the national position.

Prof. Willcocks stated that she attended the recent Discharge Lounge opening and that staff were incredibly enthusiastic and energetic, however a number of the Discharge Liaison Officers appear frustrated by the differences in practice and that due to this, maximum benefit was not being provided. Mrs Walters stated that a listening event had taken place and that it was also part of the work Donald Richardson was leading on to ensure everything joined up to provide better patient flow.

Mrs Rushbrook stated that a lot of data had been shared with the wards so that they could understand how their processes impact on other places especially the impact a really well run ward has on others around it. One element was to get patients to the discharge lounge earlier. Mr Bertram stated that rates of discharge through the discharge lounge is also looked at on the performance management days as there can be a wide variation and this provides an obvious source of challenge and learning.

Mrs Rushbrook also noted that wards are looking at how best they can use the discharge lounge for dementia patients. It is recommended that dementia patients should be moved there within an hour of transport coming to pick them up.

Mrs Walters stated that the Trust is trying to manage the increased pressure, but she highlighted 4, 12 hour breaches which have occurred and are being reviewed: she noted it is symptomatic of not having the appropriate services outside the hospital.

Mrs Walters stated that in relation to cancer the Trust achieved the 62 day target in August, however, the 14 day fast track position in skin has deteriorated due to the 20% increase in referrals which is stretching the service. The Trust is working with Commissioners around the referral support system advice and guidance to GPs and there are 6 GPs in Scarborough with a special interest in skin receiving training which may help to deflect potentially unnecessary referrals.

Mrs Walters stated that there is a detailed recovery plan for 18 weeks which includes using the independent sector at no additional cost, providing additional sessions.

16/145 Winter Plan

Mrs McGale provided a presentation on the Winter Plan.

Ms Symington stated that The Winter Plan was really reassuring and again this was a text book example of a management challenge, where the position could change at any moment.

Mrs Adams highlighted Scarborough and a recent night walkround which had taken place when all the escalation beds had been populated with medical outliers leaving no additional capacity. She asked Mrs McGale for her view. Mrs McGale stated that the bed base at Scarborough had always been full and the difference between Scarborough and York, was the access to community services and historic investment in community services. She stated that there needs to be a change in culture and that some patients need to be cared for outside of the hospital setting.

Mr Proctor stated that an additional ward could not be staffed so it was absolutely about investment in the community, which was the right way forward, but that GPs needed to get used to different patterns of referring and this would take time and it would be important to keep that perspective when looking at the strategy.

Mrs Walters stated that the Trust had not chosen to be in this position, but was doing what it could with the resources available. The Trust has been clear with the CCG about the lack of capacity and the need to work together.

Mr Sweet highlighted that a primary care service is not being provided over the Christmas period as the CCG are unable to fund it.

16/146 Purchasing Transformational Plan

Mr Bertram stated that the plan was for information and endorsement by the Board. He noted that this was one of the areas always talked about in relation to the expectation and hope that significant savings could be achieved. He stated the paper written by Ian Willis was a really good read and a useful vision document for any new staff joining the team. It highlighted the linkages between the Carter work and Sustainability and Transformation Plan, covered KPIs to enable measurement of success and there was a table summarising the position to date. Mr Bertram also noted the Carter Executive Steering Group would be the group to receive primary assurance on this work. Prof. Willcocks commended the work.

Ms Raper asked about item 4 on page 181 of the pack which noted an estimated 50% spend on contract and how this aligned with current risks as there were no red risks. Mr Bertram stated that significant work is going on to move this measure forward and this is resulting in rapid corrective action. Mr Ashton noted that this percentage had gone up already very quickly from 15% to 50% due to the work being progressed. Mr Bertram noted that there is still some way to go and a further conversation about the risk rating will be had if it the percentage does not continue to rise.

The Board endorsed the Purchasing Transformational Plan.

16/147 Estates and Environment Committee

Mr Sweet stated that the Committee were conscious of issues with the risk register and work was being carried out to pull the risks together and feed those through. Three audit reports had been received, one of which had been referred to the Workforce and Organisational Development Committee and the other two were discussed and assurance received that action was taking place.

Mr Sweet stated that a lot of work was being done with the Premises Assurance Model and it was also being linked to Carter and significant improvements were being made. He noted that the Committee had also received the latest version of the Carter dashboard. In relation to Carter, he reminded the Board of the need to have a 65% to 35% split of clinical to non-clinical space use. Mr Sweet also highlighted that there had been an interesting discussion which showed that some quick wins actually had longer term unintended consequences for the sustainability and development work.

Mr Sweet stated that the quarterly Health and Safety Report had shown a noticeable increase in violence and aggression against staff from dementia patients. Mrs Hey stated that a piece of work is being done with ward 37 as there have been 2 RIDDOR reportable incidents. The work being undertaken with ward 37is delivering a real improvement. There is also training from Rotherham being rolled out.

Mr Sweet stated that the Trust's Sustainable Development Plan was seen as an exemplar of good practice and was currently being shown to other Trusts. Mr Sweet stated that over a £1m had been saved from the sustainability work on combined heat and power. However, he said that it should be recognised that sustainability does not just apply to energy, but to staff in terms of their health and wellbeing.

16/148 Next meeting of the Board of Directors

The next meeting, in public, of the Board of Directors will be held on Wednesday 30 November 2016 at Selby Hospital.

16/149 Any Other Business

Ms Symington stated that the next meeting will be held at Selby Hospital (at the request of Wendy Scott) as it is unlikely that the Boardroom will be completed at York.

Ms Symington highlighted that the Board dinner will be held on the 24 November 2016 and confirmation of this will be sent out shortly.

Ms Symington closed the Board meeting with a challenge to Board members.
She explained that in a previous employment she had been asked whether customers would be "pleased and proud" if they could see what was being done behind the scenes. She highlighted the short video the Board had watched at the start of the meeting and asked Board member to reflect on whether the carer featured in the short film would feel 'pleased and proud' of the work of our Board today. She asked members to think about how we can continue to improve the work of the Board and to contact her following the meeting with any suggestions.

Action list from the minutes of the 26 October 2016

Minute number	Action	Responsible office	Due date
16/137	Action dates need to be specific	Mrs Provins	immediate
16/140	Mr Taylor to include the antibiotic usage monitoring in his next Report.	Mr Taylor	November 2016

Outstanding actions from previous minutes

Minute number and month	Action	Responsible officer	Due date
16/112	The Board to receive the refreshed Equality and Diversity objectives	Mr Golding	April 2016
15/087 Diverse Workforce	A proposal around investment in training for specialist and middle grade doctors in the future to be presented to the Board when developed	Mr Crowley	When available
15/117 Community Care update	Provide further detail on the re-ablement discussions when available.	Mrs Scott	Covered October 2016
16/057 Communications Strategy Update	Present a further update on the Communications strategy at the November Board meeting.	Mrs Brown	November 2016
16/048 Environment and Estates Committee	Programme in a session on health and safety into the Board day	Mrs Provins	January 2017

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 November 2016

Chief Executive's Report

Action requested/recommendation

The Board is asked to note the report.

Summary

This report provides an overview from the Chief Executive.

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

Implications for equality and diversity

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

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

Reference to CQC regulations

There are no references to CQC outcomes.

Progress of report	Board of Directors
Risk	No risk.

Resource implications	No resource implications.
Owner	Patrick Crowley, Chief Executive
Author	Patrick Crowley, Chief Executive
Date of paper	November 2016
Version number	Version 1

Board of Directors – 30 November 2016

Chief Executive's Report

1. Chief Executive's Overview

System-wide strategic planning

STPs, both in terms of their process and content, have received extensive media coverage, and the general narrative has, unfortunately, been one of cuts and closures. This could be attributed to the perceived lack of consultation around the plans, and the way in which they have been produced, which has led to some plans being 'leaked'.

All STPs will be published by the end of the year, to locally-agreed timetables. The plan for our area, Humber Coast and Vale, was published on 21 November. The document along with a summary version is available on the Trust's website, and those of other partners in our footprint.

It is worth at this point reminding ourselves of where they STP process has come from and what it is for. In late 2014, the Five Year Forward View for the NHS was published, setting out a clear direction for the NHS, how it must change, and what it should look like in the future.

What the STP process does is provide the tools and mechanisms that allow health and social care organisations to make the vision outlined in the Five Year Forward View a reality.

It requires organisations to work together where they may not previous have done so across health and social care to identify the health issues of most relevance to their population and develop plans that offer long-term solutions. These solutions not only need to improve the health and wellbeing of the population, they also need to address the funding gaps that we face in the future. In our footprint, there is a projected £420m shortfall if we continue as we are, and a financial gap of this magnitude is clearly not an option.

Our plan identifies five main priorities areas based on the health and care needs of the people living in our footprint. For example, in our area, people don't generally live as long as they do elsewhere, more people smoke and drink, and many people who are in hospital beds could be treated elsewhere.
The priorities are helping people stay well, place-based care, creating the best hospital care, mental health, and strategic commissioning.

The plan is the start of the process, and as more detailed work gets underway we will be involving local people in taking this forward, consulting where that is appropriate.

I am a huge advocate of the principles of STPs, as I believe that for too long the system we work in has meant the continuing fragmentation of health and social care and the creation of artificial boundaries, resulting in some of the problems all too familiar to us regarding our A&E performance, our ability to discharge patients, and the health problems we see in our communities.

Joint clinical summit

By the time our Board meeting takes place, we will have just hosted the inaugural Vale of York Clinical Summit 2016. Around 200 doctors from primary and secondary care assembled for the event, which we planned and delivered jointly with colleagues in the Vale of York CCG. The purpose of the event was to re-establish and strengthen clinical ties between our clinicians, which in light of the principles of the STP, is of increasing importance.

We will review feedback from those attending, and I hope this will become a regular fixture in our events calendar.

In the news

As mentioned above, STPs have been widely talked about in the media, however our local plan has so far received limited interest in the York and Scarborough part of the patch.

Staff from our emergency department did an excellent job when taking part in a feature for BBC Radio York looking at how patients are assessed in ED. This helped to promote the messages that are so important in winter (and indeed all year round) regarding where to access treatment and advice.

I took part in a BBC Radio York phone in, as I do on a fairly regular basis. On this particular occasion I spoke to several callers who had not had positive experiences whilst in our care. Whilst we know that these examples are not representative of the quality of care that the vast majority of our patients will experience, it served as a sobering reminder of the importance of every single individual we deal with, and of the reason that our organisation exists. No matter how challenging the circumstances we work in, or how many patients we might have seen that day, for that individual patient or relative, their experience will be unique to them and potentially life-changing, and it does no harm to be reminded of this through hearing people's stories.

BAF at a glance

The Board Assurance Framework (BAF) summary document, which has been approved by the executive directors, is attached to this report, and can used for reference throughout the meeting to ensure that any identified risk is being addressed at the subcommittees of the Board and at the Board meeting itself.

2. Recommendation

The Board is asked to note the report.

Author	**Patrick Crowley, Chief Executive**
Owner	**Patrick Crowley, Chief Executive**
Date	**November 2016**

York Teaching Hospital NHS
NHS Foundation Trust

Board Assurance Framework – At a glance.

Our Board Assurance Framework is structured round our 4 key ambitions. The BAF identifies the strategic risks to the achievement of our ambitions.

Quality and Safety - Our patients must trust us to deliver safe and effective healthcare.		**Workforce -** The quality of our services is wholly dependant on our teams of staff	
1 We fail to improve patient safety, the quality of our patient experience and patient outcomes, all day, every day	Green	1 We fail to ensure that our organisation continues to develop and is an excellent place to work	Amber
2 We fail to listen to patients and staff, act on their feedback, and share with them the changes we make.	Amber	2 We fail to creatively attract the right people to work in our trust, in the right places, at the right time	Amber
3 We fail to innovative in our approach to providing the best possible care, sympathetic to different communities and their needs.	Amber	3 We fail to retain our staff	Amber
4 We fail to separate the acute and elective care of our patients	Amber	4 We fail to care for the wellbeing of our staff	Green
5 We fail to reform and improve emergency care	Red	5 We fail to provide first class learning and development opportunities, enabling our staff to maximise their potential	Amber
6 We fail to embrace existing and emerging technology to develop services for patients	Green	6 We fail to develop learning, creating new knowledge through research and share this widely	Amber
Environment and Estates - We must continually strive to ensure that our environment is fit for our future		**Finance and Performance -** Our sustainable future depends on providing the highest standards of care within our resources	
1 We fail to work as part of our overall community to provide the very best health outcomes, in the most appropriate setting	Amber	1 We fail to work to and maintain financial stability alongside our partners, building alliances to benefit our patients	Amber
2 We fail to respect the privacy and dignity of all of our patients	Green	2 We fail to provide the very best value for money, time and effort	Green
3 We fail to positively manage our impact on the wider environment and keep our own environment clean and tidy	Green	3 We fail to exceed all national standards of care	Red
4 We fail to develop our facilities and premises to improve our services and patient care	Green	4 We fail to plan with ambition to create a sustainable future.	Amber

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 November 2016

Quality and Safety Meeting Minutes – 22 November 2016

Action requested/recommendation

The Board is asked to note the items discussed at the Quality and Safety Committee, the assurance taken from these discussions and the key items of interest that have been highlighted for the attention of the Board.

Executive Summary

The purpose of the Committee is to receive assurance and to provide challenge and scrutiny around matters of patient safety, patient experience and clinical effectiveness within the Chief Nurse and Medical Director's areas of responsibility. Each month a small number of items will be selected for escalation to the Board of Directors for information and/or debate. The agenda follows an established structure to include:

Review of Chief Nurse and Medical Directors Risk Registers.

Patient Safety items for this month

- Nurse Staffing
- Infection Prevention
- Supervisor of Midwives, Local Supervising Authority (LSA) annual audit
- Safeguarding Children Annual Report
- Serious Incidents, incident reporting and Never Events

Clinical Effectiveness items for this month

- Nursing Dashboard
- Internal Audit overview

. Patient Experience items for this month

- Friends and Family
- Patient Advice and Liaison

This month the Committee has selected the following for the particular attention of the Board.

1. Fulfilment of Duty of Candour requirements
2. Adolescent mental health services
3. Learning from recent surgical never events
4. Progress on nursing workforce
5. Flu vaccination campaign update

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

Implications for equality and diversity

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

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

Reference to CQC regulations

References to CQC outcomes.

(Regulations can be found here: http://www.cqc.org.uk/content/regulations-service-providers-and-managers)

Progress of report	These minutes have only been submitted for the Board of Directors.
Risk	Any risks are identified in the minutes.
Resource implications	Resources implication detailed in the report.
Owner	Jennie Adams, Non-Executive Director
Author	Liz Jackson, Patient Safety Project Support Officer
Date of Paper	November 2015
Version number	Version 1

Quality & Safety Committee – 22 November 2016, Neurosciences Seminar Room, York Hospital

Attendance: Jennie Adams, Philip Ashton, Libby Raper, James Taylor, Beverley Geary, Lynda Provins, Liz Jackson
Observing: Michael Shanaghey

	Agenda Item	Comments	Assurance	Attention to Board
	Last meeting notes dated 18 October August 2016	The minutes of the meeting held on the 18 October 2016 were agreed as a true and accurate record.		
	Matters arising and action log CRR Ref: MD2 & MD8	The Committee reviewed the action log and the matters arising. Item 1 – The Committee discussed the issues in Radiology. JT advised that this is a very complicated work in progress. Recruitment campaigns with possible incentives are being looked in to with HR and advice is being sought around the agenda for change framework. Additional support staff and Consultants are being considered to improve both the out of hours and seven day services with the aim to improve the quality of service across both acute sites. JA advised the Committee that she had observed the area for the new CT scanner during a walk round at Scarborough Hospital and was pleased to note that the funding was available for these necessary changes and preparatory work is due to begin in the new year. Item 2 - The Committee queried if the Internal Audit report around compliance with the Duty of Candour has been published. JT advised that there has been a delay; however, the report has now been signed off and is ready for publication. PA added that this report will go the next Audit Committee before being submitted to the Board in January. JT explained that Internal Audit had found that the Trust is complying with the Duty of Candour in terms of verbal notification and apologies; however there is an issue with demonstration of compliance with written communication to patients. Written letters that can be filed in patient notes are being looked in to. It is clear that further education around the requirements of this legislation is needed. One factor is the subjective nature of what constitutes moderate or serious harm. Staff are being advised that if in doubt the duty of candour should be fulfilled, this should always be followed for Never		JT to update Board on Audit findings around Duty of Candour

	Agenda Item	Comments	Assurance	Attention to Board
		Events and SIs irrespective of the actual level of harm incurred. Items 3 & 5 – The Committee queried if CHKS were able to visit in January to discuss Clinical Effectiveness bench marking in more detail. The Committee also asked if the National Cardiac Arrest Audit which was published in October could be presented in January along with some analysis of any particular learning for our own Trust. **Action: LP agreed to liaise with DP re CHKS** **Action: JT to liaise with DP re National Cardiac Arrest Audit**		
	CRR Ref: MD2 & MD6	Item 8 – The Committee queried if a formal set of actions have been agreed following discussions regarding the Acute Medicine senior review at SGH. JT advised that he attended the Senior Physicians meeting at Scarborough Hospital to collaboratively discuss new sustainable ways of delivering out of hours care and, rather disappointingly, no agreement was reached. Other approaches to aiding implementation of these changes to working patterns are now being considered and a job plan review may be invoked. Feedback is yet to be received from the wider senior clinical body regarding the changes required by the Acute Medical Model, the implementation of which is being led by Ed Smith. The Committee noted the inclusion of 2 Emergency Department complaints at SGH involving inappropriate discharge from the department. The committee were assured that decisions to discharge ED patients were still the responsibility of medical staff rather than ACPs. The committee agreed to monitor the impact of the AMM from a safety perspective via patient feedback and other sources. **Action: JT to update at the January Meeting.**		
	CRR Ref: MD3	Item 17 – The Committee queried the date of the Information Governance awareness week. **Action: DP to advise the Committee.** Item 19 - The recruitment of renal dialysis staff was discussed in detail at the October Board. BG advised the Committee that Donald Richardson has confirmed that experienced dialysis nurses have now been recruited which		

	Agenda Item	Comments	Assurance	Attention to Board
	CRR Ref: MD5	provided the committee with considerable assurance around the sustainability of this vital service. Item 20 – A volunteer stand was in place at the Recruitment Marketplace held in Scarborough. Information was given out on the day however BG was unsure if any applications had been received following this. The Committee was delighted by the progress being made by Kay Gamble on the volunteer agenda. Item 21 – The Committee noted and were encouraged by the number of pledges that can now been seen on the wards in relation to the night owl initiative. Noise at night remains a feature of patient complaints and is an area of focus for ward staff. Item 22 – The Committee were assured by the staffing numbers that there were no significant issues in Stroke nursing. York is over recruited and there are just two vacancies in Scarborough. Items 24 & 25 – JT advised the Committee that the backlog of SI reports will be presented to the next Executive Board in booklet form. The focus this month is on the SIs in relation to the 12 hour trolley waits in ED this spring – largely on the Scarborough site. The Committee queried if the new SI process is ready to be launched and JT confirmed that there is still some work to do to get the process right. Fiona Jamieson has presented an overview of SIs at Patient Safety Group - with 330 recorded in the last 12 months, 30 in relation to the 12 hour trolley waits. Other frequent events are falls with severe harm and new themes developing are delays in Ophthalmology outpatients and missed diagnosis in Radiology. The Committee felt that this top down analysis was a more useful way of presenting SIs to the Board via the Committee. JT added that the CCG has confirmed that the 12 hour trolley waits are no longer to be declared as Sis, in most cases no harm was caused to patients and the recommendations are repetitive and relate to system-wide changes that are already subject to an action plan.		

	Agenda Item	Comments	Assurance	Attention to Board
	Risk Register for the Medical Director and Chief Nurse	The Committee noted that there had been no amendments to the Risk Registers for the Chief Nurse and the Medical Director and queried if the risks on the Medical Directors register could be reworded to be more explicit, with special attention to MD4. JT felt that many of the risk descriptions pre-dated his appointment as MD and that he would be happy to revisit them in order to better capture the specific issues involved. JT will review the register and update the Risk Committee of any alterations. **Action: JT to review Risk Register.**		
	CRR Ref: CN9 & CN10	CN9&10 – BG confirmed that there continues to be an on-going issue with the lack of provision of CAMHS. There has been an increase in the incidences of self-harm amongst adolescents and seasonal trends have also been identified. Two serious incidents have occurred in the last four weeks. Nursing and Medical Staff do not have the skills to psychologically care for these patients; however, the patients need to be medically fit prior to receiving a psychological review. Further work needs to be undertaken around the commissioning of the Tees Esk and Wear Valley Service and meanwhile further staff training is required in both assessment and first aid in this area in this area. Adult patients are managed in crisis in the Community and Hospitals are seen as a 'place of safety' for younger people. There is a plan that all self-harm patients receive 1:1 care; however a case by case review is necessary. Mental Health provision is massively under resourced in this region as evidenced by recent national benchmarking statistics and the subject is a matter for public consultation. The committee felt this situation was putting young patients and the Trust at considerable risk and thought that it warranted a wider Board discussion to explore options.		BG to raise at Board.
	CRR Ref: MD1	MD1 – The Committee discussed the number of medicines administration, dispensing and prescription errors that featured in the integrated dashboard, these ranged between insulin errors, missed medication and outpatient dispensing. JT agreed to look in to this further. MS added that no themes or trends have been identified through investigation of these incidents. BG explained that a Nursing Medicines Management Group has been developed alongside the MDT Medicines Committee. Incidents are	The committee were assured by the detailed level of ward by ward data available and the attention given to	

	Agenda Item	Comments	Assurance	Attention to Board
		brought for discussion so that issues can be understood. Individual interventions or ward action plans are put in place.	medication errors by the senior nurse for medicines management.	
	Patient Safety			
	Nurse Staffing CRR Ref: CN2	BG advised the Committee that the newly qualified registered nurses have now commenced in post along with some return to practice individuals. More than 70 have attended induction and the preceptorship programme is in place. The recruitment fairs have had a positive impact and the possibility of exchange nurses from India is being discussed with NHS England and Health Education England next week. The Trust has been identified as a 'fast follower' in regard to the Associate Nursing Role. The committee noted the reduction in actual vacancy levels for RNs on both acute sites following the latest round of recruitment. A response around the use of the care hours per patient day data and the regulation of the nurse associate role is awaited from the England Chief Nursing Officer. Senior nurse leaders have admitted that there is more work to be done before real value can be had from collection of this data. The Committee queried if the relaxing of visiting hours has had any impact on patients being nursed by their visitors. BG explained that Johns Campaign has come in to place as the family had wanted to nurse this patient. This needs to be reviewed on a case by case basis. The AMUs on each site have the same acuity but there are very different CHPPD levels on each. BG advised that an Acuity and Dependency audit is imminent and will be led by Becky Hoskins who has identified ED and AMU as priority areas for a deep dive review. There is an increasing focus on nursing leadership and professional	The Committee were assured by the continued focus in this area and the positive steps that have been taken.	BG to update Board

	Agenda Item	Comments	Assurance	Attention to Board
		judgment and the Committee queried if the matrons take in to account other members of the multi-disciplinary team when organising staffing. BG drew the Committees attention to the skill mix paper which gives assurance that the right staff with the right skills are in the right place at the right time. The skill mix work will continue to evolve over time, with the new roles that are coming in to place. The Committee highlighted that the level of experience of nursing staff is not captured by the staffing data and that the quality and depth of experience is important. The Committee requested an update on the e-rostering project. BG advised that this project is described in detail in the Workforce Committee papers. High risk areas have been identified and focus will initially be on them. Human Resources and Occupational Health have advised that roles need to be reviewed on a case by case basis and Becky Hoskins is working closely with Matrons.		
	Infection Prevention CRR Ref: CN7 & CN8	The Special Care baby unit in York is now open to external admissions of 30+ weeks and an action plan is in place. Refurbishment plans sit with the Directorate and are managed through PMMs. There have been two new cases of MRSA, the post infection reviews should be completed imminently. BG advised that there is some variation in the compliance with MRSA screening but there is a data quality issue and screening is not reflected accurately in the data. Patients are being screened at pre-assessment and a nil return is being recorded when they are admitted, this is being reviewed. The Committee discussed the surgical site infections in Bridlington, BG advised that the paper will be submitted to private Board. An action plan has been put in place, further actions are being considered and an external Orthopaedic Surgeon has been invited to review theatre practice. JT advised that there are legitimate reasons to exclude some of these cases, some may be secondary infections not related to infection control. BG is		BG/JT to raise at private Board.

	Agenda Item	Comments	Assurance	Attention to Board
		meeting with Matrons to discuss the productive theatre module of productive ward and an additional Infection Prevention Steering Group is being held to discuss any issues further. BG advised that there has been a reduction in the infection rate due to an identified data quality issue. **Action: BG to disseminate updated data to Committee members.** There have been two incidents of Carbapenemase-producing enterobacteriaceae (CPE). The first patient was appropriately isolated on admission and CPE was identified after the second screen. A second patient was then found to be positive. The IPC team have advised that due to the rarity of this infection, cross contamination has to have occurred. All patients on the ward have been screened, co-horted and given the appropriate information. Inappropriate taps have been identified in one of the bathroom areas and will be changed. A HPV deep clean will take place when decant facilities become available.		
	Supervisor of Midwives, Local Supervising Authority (LSA) annual audit	The Committee reviewed the Supervisor of Midwives audit report which included extremely complementary feedback from Staff and women and partners on the wards. BG advised that only two items were rated amber against NMC standards; a policy was out of date and a personal record of activity had not been fully completed. The Committee noted that the still birth rate is now below the regional average.		
	Safeguarding Children Annual Report CRR Ref: CN6	BG led the Committee through the highlights of the Safeguarding Children Annual Report which included a summary of activity and will be shared externally. There has been a significant improvement in the uptake of mandatory training and development of a new delivery model for safeguarding children reflective supervision. A sexual assault centre has now been commissioned.	The Committee were assured by the advancements that have been made in this area.	BG to take to private Board.
	Serious Incidents (SIs), incident reporting and Never	JT took the Committee through the two wrong site surgery Never Events. The first was an incorrect skin lesion being removed from a patient in Dermatology outpatients. Elements of best practice from the WHO Surgical		JT to update Board on learning and

	Agenda Item	Comments	Assurance	Attention to Board
	Events	Safety checklist are being adapted for outpatient areas and may have to be adapted further on a case by case basis. The second was a small incision made on the right side instead of the left prior to a varicose vein removal procedure. The Committee were assured that the level of harm caused to these patients was minor and that learning can be taken from both of these cases. The Committee discussed the actions for the other SIs included in the Medical Directors report and highlighted that these need to be SMART wherever possible and the relevant clinicians involved at an early stage. The revised investigation process being developed by Adrian Evans is eagerly awaited but has been delayed by queries from commissioners. The Committee asked that the high level governance overview of SI numbers given by Fiona Jamieson at the Patient Safety Group be replicated at Board on a twice yearly schedule. **Action: JT to implement twice yearly SI feedback.**		actions from recent wrong site surgery never events
	Clinical Effectiveness			
	Nursing Dashboards CRR Ref: MD4	The Committee noted the inclusion of the ward Nursing dashboards and queried the figures in relation to NEWs score compliance. BG advised that some of the Surgical wards have been having issues with equipment and also agency nurses do not always have access to the electronic system which is less than ideal. JT commented that there might be scope to review the hardware and software used in this important aspect of patient care.		
	Internal Audit Overview	The Committee noted the helpful inclusion of Internal Audit Overview and asked that an update on actions relating to Deprivation of Liberty Audit be received.		
	Patient Experience			
	Friends and Family test	The Committee were pleased to see that narrative comments are now being received through the friends and family test. BG advised that a regular feedback pack is generated for each ward for dissemination to staff. Comments around lack of availability of special dietary request would be		

	Agenda Item	Comments	Assurance	Attention to Board
		passed to the E&E committee via the Chair.		
	Patient Advise and Liaison	The Patient Advise and Liaison Service has been relocated to the main corridor. The Committee were pleased to note that they now have this dedicated space and that they are raising their profile within the patient community.		
	Additional Items			
	2016/17 Flu Campaign	JT and BG advised the Committee that the Trust has now vaccinated 55% of the front line staff and the CQUIN target is to have vaccinated 75% by the 31st November. Peer vaccinations are taking place and further initiatives are being looked in to. Regular emails are being sent to staff to encourage them to have their flu vaccination and to remind them that it is their professional duty to do so. JT is hopeful that the target can still be met ensuring payment of the CQUIN.		JT to update Board
	Patient Safety Walkrounds	The Committee noted that some of the Patient Safety Walkrounds had taken place without a Director or Non-Executive Director present which may have been due to them being arranged on days when Committees were taking place. **Action: EJ to feedback to the Patient Safety Team**		
	Risk Register round up	All Risks on the Risk Registers were discussed throughout the meeting with the exception of Information Governance.		
	Next meeting of the Quality and Safety Committee: 17 January 2017 Boardroom, York Hospital at 1.30pm.			

Quality & Safety Committee – Action Plan – November 2016

No.	Month	Action	Responsible Officer	Due date	Completed
1	Sept 2016	To provide an update on the options being looked at with regard to the new radiology risk – Discussion at Sept Board. Board walkround of Radiology being organised by LP.	Medical Director	Nov 16 – moved to Jan 17	
2	Sept 2016	The Committee Requested feedback from the internal audit of Duty of Candour. Nov 16 – The final report will be reviewed by the Dec Audit Committee and to Q & S in Jan 17.	Medical Director (Health Care Governance)	Nov 16 – moved to Jan 17	
3	Sept 2016	To invite Glenn Miller, Clinical Effectiveness Chair.	Foundation Trust Secretary	Nov 16 – moved to Jan 17	
4	Sept 2016	Committee to receive additional assurance from mortality review group.	Deputy Director of Patient Safety	Jan 14	
5	Aug 2016	To invite a representative from CHKS to talk the Committee through the system.	Deputy Director for Patient Safety	Nov 16– moved to Jan 17	
6	Aug 2016	To discuss with the Deputy Director of Healthcare Governance a simple system to flag concerns with National Audits - DP noted that the Clinical Effectiveness Committee is being reviewed which should incorporate this action.	Deputy Director for Patient Safety	Nov 16– moved to Jan 17	
8	Jun 2016	Outcome of discussions with CD for Medicine and action plan (time out 27.09.16) – The Committee to request sight of the action plan.	Foundation Trust Secretary	Nov 16– moved to Jan 17	
14	Jul 2016	Review the Critical Care Action Plan at the end of the year	Medical Director	Dec 2016 – moved to Jan 17	
16	Jul 2016	Annual National Cardiac Arrest Audit with trends and benchmarks to be presented when published.	Deputy Director for Patient Safety	Nov 16– moved to Jan 17	
17	Oct 2016	MD2 – Risk Register DP to check on whether the date was correct for the Information Governance awareness week.	Deputy Director for Patient Safety	Nov 16	

21	Oct 2016	Night Owl Initiative update following receipt of the National Inpatient Survey.	Deputy Chief Nurse	Following receipt of National Inpatient Survey – May 2017	
23	Oct 2016	Patient Experience Volunteer findings to be reported back to the Committee.	Deputy Chief Nurse	March 2017	
24	Oct 2016	SI backlog to be brought to the next meeting.	Deputy Director for Patient Safety	Nov 16– moved to Jan 17	
25	Oct 2016	DP to provide further information on the trial of paper incident forms in the next Medical Director's Report.	Deputy Director for Patient Safety	Nov 16– moved to Jan 17	
26	Nov 2016	JT to review the wording of the risks included on the MD Risk Register.	Medical Director	Jan 17	
27	Nov 2016	Review the number of medicines administration errors to identify themes.	Medical Director	Jan 17	
29	Nov 2016	High level governance overview of SI numbers.	Medical Director	To be provided on a 6 monthly basis	

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Providing care together in York, Scarborough, Bridlington, Malton, Whitby, Selby and Easingwold communities.

York Teaching Hospital NHS
NHS Foundation Trust

Patient Safety and Quality Performance Report

November 2016

Our ultimate objective: To be trusted to deliver safe, effective and sustainable healthcare within our communities.

Patient Safety & Quality Performance Report
Chapter Index

Quality and Safety Summary: Trust

Patient Experience	Target/ Threshold 2016/17	Monthly Target/ Threshold	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Litigation - Clinical Claims Settled	-	-	10	4	5	1	2	3	6	2	5	9	5	1
Complaints	-	-	38	28	25	40	46	36	30	33	33	50	44	36

Care of the Deteriorating Patient	Target/ Threshold 2016/17	Monthly Target/ Threshold	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
12 hour Post Take - York	85%	85%	85%	84%	85%	85%	87%	90%	84%	87%	84%	84%	82%	82%
12 hour Post Take - Scarborough	80%	80%	56%	56%	55%	53%	64%	63%	60%	58%	58%	52%	52%	53%
14 hour Post Take - Trust	100%	100%	80%	82%	81%	80%	86%	86%	83%	84%	82%	80%	79%	80%
Acute Admissions seen within 4 hours	80%	80%	83%	77%	84%	85%	84%	87%	83%	81%	87%	80%	74%	77%
NEWS within 1 hour of prescribed time	90%	90%	87.1%	87.3%	87.2%	85.6%	85.2%	86.8%	87.6%	87.1%	87.7%	87.8%	88.1%	87.8%
All Elective patients to have an Expected Discharge Date (EDD) recorded within 24 hours of admission	Q1 91% Q2 91% Q3 93% Q4 93%	93%	88%	90%	88%	93%	94%	89%	87%	86%	88%	88%	88%	88%

Measures of Harm	Target/ Threshold 2016/17	Monthly Target/ Threshold	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Serious Incidents	-	-	19	13	11	27	21	17	12	31	15	17	12	9
Incidents Reported	-	-	1358	1269	1313	1370	1313	1281	1196	1229	1253	1252	1058	1156
Incidents Awaiting Sign Off	-	-	889	1149	1344	1389	1348	987	780	724	686	763	813	752
Patient Falls	-	-	308	281	314	315	274	273	236	255	225	218	194	229
Pressure Ulcers - Newly Developed	-	-	82	58	61	69	86	69	73	62	56	65	96	129
Pressure Ulcers - Transferred into our care	-	-	147	159	145	132	126	125	116	123	150	109	62	60
Degree of harm: serious or death	-	-	12	5	8	7	7	7	4	11	10	12	11	5
Degree of harm: medication related	-	-	112	102	105	97	132	129	118	107	143	144	112	134
VTE risk assessments	95%	95%	98.5%	97.9%	98.2%	98.4%	98.5%	98.6%	98.9%	98.7%	98.6%	98.3%	98.5%	98.7%
Never Events	0	0	0	0	0	1	0	1	0	1	1	1	0	0

Drug Administration	Target/ Threshold 2016/17	Monthly Target/ Threshold	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Insulin Errors	-	-	8	9	6	6	16	7	9	10	9	10	9	13
Omitted Critical Medicines	-	-	12	11	16	17	11	19	13	12	8	15	17	15
Prescribing Errors	-	-	21	23	21	24	27	26	28	25	35	42	32	30
Preparation and Dispensing Errors	-	-	10	9	17	10	10	15	13	13	12	14	10	24
Administrating and Supply Errors	-	-	51	50	45	39	68	60	57	46	64	56	41	54

Safety Thermometer	Target/ Threshold 2016/17	Monthly Target/ Threshold	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
% Harm Free Care - York	-	-	96.1%	92.7%	96.7%	96.3%	96.4%	95.3%	97.5%	95.6%	95.1%	97.1%	96.7%	96.5%
% Harm Free Care - Scarborough	-	-	91.0%	90.2%	93.3%	95.5%	91.7%	93.3%	95.6%	94.5%	94.1%	91.2%	90.9%	93.2%
% Harm Free Care - Community	-	-	88.8%	83.5%	83.3%	88.1%	92.1%	93.1%	90.5%	91.2%	83.6%	93.5%	92.3%	91.0%
% Harm Free Care - District Nurses	-	-	95.4%	97.2%	94.2%	97.8%	95.0%	97.7%	93.8%	96.5%	96.3%	95.4%	95.6%	95.4%

Mortality Information	Target/ Threshold 2016/17	Monthly Target/ Threshold	Jul 12 - Jun 13	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sep 14	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15	Jan 15 - Dec 15	Apr 15 - Mar 16
Summary Hospital Level Mortality Indicator (SHMI)	100	100	101	97	98	99	102	103	101	101	99	99	99	100

Infection Prevention	Target/ Threshold 2016/17	Monthly Target/ Threshold	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Clostridium Difficile - meeting the C.Diff objective	48 (year)	48 (year)	3	7	7	5	3	3	1	3	3	2	1	3
Clostridium Difficile -meeting the C.Diff objective - cumulative	48 (year)	48 (year)	43	50	57	62	65	3	4	7	10	12	13	16
MRSA - meeting the MRSA objective	0	0	0	0	1	1	0	1	0	1	0	2	0	2
MSSA	30 (year)	30 (year)	2	2	2	2	3	9	2	2	2	5	0	8
MSSA - cumulative	30 (year)	30 (year)	28	30	32	34	37	9	11	13	15	20	20	28
ECOLI			8	8	11	15	7	5	5	7	8	14	10	4
ECOLI - cumulative			55	63	74	89	96	5	10	17	25	39	49	53
MRSA Screening - Elective	95%	95%	79.9%	89.9%	78.2%	69.2%	74.1%	82.9%	84.5%	85.8%	89.9%	83.7%	85.0%	88.7%
MRSA Screening - Non Elective	95%	95%	72.7%	79.7%	75.6%	73.9%	75.6%	82.2%	83.6%	86.3%	86.6%	86.7%	86.4%	82.9%

Stroke (one month behind due to coding)	Target/ Threshold 2016/17	Monthly Target/ Threshold	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Proportion of patients spending >90% on their time on stroke unit	80%	80%	89.0%	92.4%	88.2%	86.9%	82.4%	84.9%	92.1%	85.2%	82.9%	88.3%	93.6%	1 month behind
Proportion of patients who experience a TIA who are assessed & treated within 24 hrs	75%	75%	76.9%	81.8%	87.5%	85.7%	100.0%	88.9%	100.0%	68.8%	79.0%	73.7%	n/a	1 month behind
Scanned within 1 hour of arrival	50%	50%	77.8%	75.0%	82.4%	70.0%	72.2%	73.3%	76.2%	50.0%	60.0%	54.2%	63.6%	1 month behind
Scanned within 24 hours of hospital arrival	90%	90%	90.4%	97.1%	92.6%	95.4%	90.8%	93.4%	94.1%	93.2%	92.9%	93.5%	92.5%	1 month behind
Proportion of stroke patients with new or previously diagnosed AF who are anti-coagulated on discharge or have a plan in the notes or discharge letter after anti-coagulation	n/a	n/a	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	1 month behind

AMTS	Target/ Threshold 2016/17	Monthly Target/ Threshold	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
AMTS Screening	90.0%	90.0%	92.0%	88.6%	94.2%	90.1%	89.7%	92.1%	91.3%	90.4%	92.5%	85.4%	86.5%	91.2%

Patient Experience

279 PALs contacts were recorded across the Trust in October. There were 21 complaints at York, 12 at Scarborough and 3 in Community in October; a total of 262 have been reported year to date.

The Friends & Family Test (FFT) is no longer a CQUIN but forms part of the Trust's Commissioner contracts. The Trust achieved a 26.9% response rate to the Inpatient FFT in October 2016 compared to 20.3% in October 2015. A total of 2,832 responses were received from Inpatients across the Trust. The 90% target for the % of respondents recommending the Trust was achieved across all sites.

The Trust achieved a 17.7% response rate to the ED FFT in October (York: 18.9%, Scarborough 12.7%). The Trust is yet to achieve the 90% target for the % of respondents recommending the ED departments, the Trust has consistently achieved 70-80% between April and October 2016.

The Trust achieved a 0.8% response rate to the Community FFT in October. This includes a 31.1% response rate achieved by the Community Hospitals alone. The Trust continues to consistently achieve the 90% target for the % of respondents recommending the Trust.

Response rates to the Maternity FFT saw a drop in October to 21.01% (September 37.7%). The biggest decrease was seen in Postnatal Community who achieved a response rate of 12.1%, their lowest performance since December 2015. The 90% target for the % of respondents recommending the Trust was achieved across all areas in October.

Measures of Harm

No Never Events were declared in October. 4 have been declared year to date under 'Wrong Site Surgery' and 'Wrong Route Administration'.

9 Serious Incidents were declared in October (1 x York, 6 x Scarborough & 2 x Community).
3 of the SIs were attributed to 'clinical incident', 5 were attributed to 'slips, trips and falls' and 1 to pressure ulcers. A total of 113 SI's have been declared YTD.

Infection Prevention

2 cases of healthcare associated MRSA bacteraemia were identified during October. 6 have been declared YTD, 3 at York, 2 at Scarborough and 1 Community.

3 cases of Cdiff were identified in October, this takes the YTD total to 16. The yearly threshold for 2016/17 remains at 48 cases however monthly allocation allows for more cases during the winter months. The Trust is currently within threshold.

8 MSSA cases were identified during October. A total of 28 cases have been identified YTD.

4 cases of E-Coli were identified during October. A total of 53 cases have been identified YTD.

Quality and Safety - Miscellaneous

Stroke (reported 1 month behind due to coding)
Targets achieved for 90% stay on a stroke ward, urgent scans within 1 hour and scans within 24 hours for September. Data currently unavailable for High Risk TIA patients seen within 24 hours.

Cancelled Operations
48 operations were cancelled within 48 hours of the TCI due to lack of beds in October; 40 at Scarborough and 8 at York. This is up from 3 across the Trust in September.

Cancelled Clinics/Outpatient Appointments
218 clinics were cancelled with less than 14 days notice across the Trust in October; 153 at York and 65 at Scarborough. 828 outpatient appointments were cancelled for non clinical reasons; 506 at York and 322 at Scarborough. This is a small improvement from the 222 cancelled in September.

Ward Transfers between 10pm and 6am
The number of inappropriate ward transfers saw an increase in October to 98 but remain within the monthly maximum threshold of 100. The Trust has consistently achieved this target YTD. This is a small rise from the 93 that occurred in September.

AMTS
The Trust achieved the 90% target for AMTS screening in October following failures in August and September. Performance was 91.2% in October.

Care of the Deteriorating Patient

The Trust achieved 70.5% in the proportion of Medicine and Elderly patients receiving a senior review within 12 hours of admission in October. This is a slight improvement on September (70%), however performance has deteriorated month on month since April 2016. Scarborough achieved 53% in October, York 82%.

The Trust achieved 77.4% in the proportion of Medicine and Elderly patients seen by a doctor within 4 hours of admission against the 80% target. This is the second consecutive month the Trust has failed to achieve this target since December 2015.

The Trust has an internal target of 90% of routine observations being undertaken within 1 hour of the prescribed time. The Trust has continually failed to achieve target throughout 2015/16 and achieved 87.8% in October.

Drug Administration

There were 13 insulin errors reported in October; 12 at York and 1 Community. A total of 67 have been reported YTD.

24 Dispensing errors were reported in October; 20 at York, 2 at Scarborough and 2 Community. A total of 101 have been declared YTD. Please note, the increase seen at York reflects an increased number of errors from Healthcare at Home (who supply outpatient dispensing and some discharge medication on our behalf). An action plan is in place to address this issue

Mortality

The latest SHMI report indicates the Trust to be in the 'as expected' range. The April 2015 - March 2016 SHMI saw a 1 point increase for the Trust and York, and a 1 point reduction for Scarborough. Trust - 100, York 95 and Scarborough 107.

There were 171 Inpatient deaths across the Trust in October, including 101 at York and 54 at Scarborough.

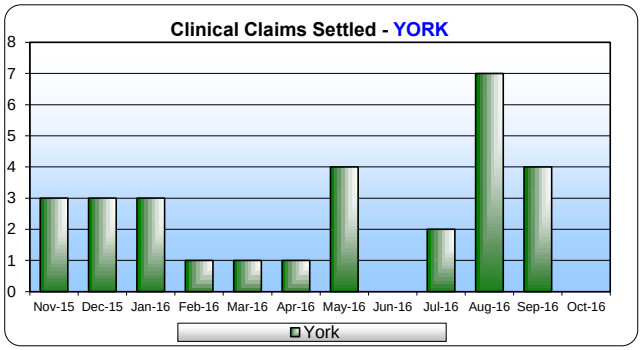
6 ED deaths were reported in October at York and 7 at Scarborough.

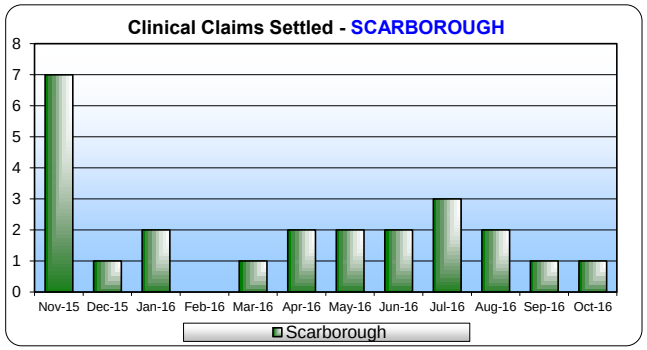
CQUINS update (Operations Team)

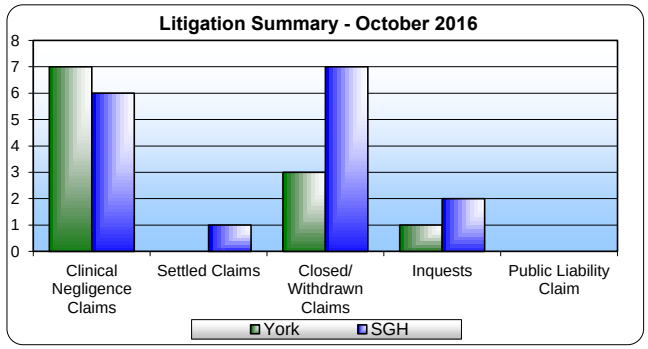
The Trust will receive payment for CQUINS in Q2 in line with predictions: full payment with the exception of Sepsis Screening in ED and Inpatient Treatments, where part payment is currently being negotiated with the CCGs. Partial payment will also be received for Adult Critical Care Timely Discharge, work is on-going to reduce delayed discharges where possible.

Litigation

Indicator	Site	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Clinical Negligence Claims Received	York	14	7	9	3	6	8	9	9	4	7	6	7
	Scarborough	7	8	3	9	6	10	7	8	8	3	4	6
Clinical Claims Settled	York	3	3	3	1	1	1	4	0	2	7	4	0
	Scarborough	7	1	2	0	1	2	2	2	3	2	1	1
Closed/ Withdrawn Claims	York	4	5	2	10	5	2	2	5	13	7	6	3
	Scarborough	3	0	1	12	14	0	3	5	4	17	7	7
Coroners Inquests Heard	York	2	2	2	3	1	1	2	2	1	5	5	1
	Scarborough	2	5	4	3	2	6	3	6	3	2	2	2







Patient Experience

PALS Contacts
There were 279 PALS contacts in October.

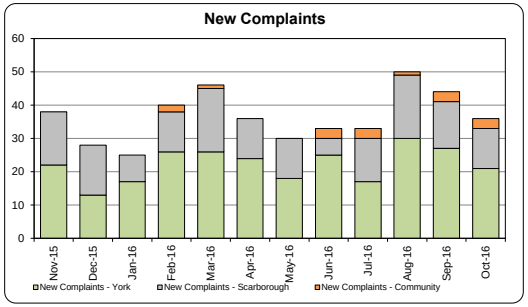
Complaints
There were 36 complaints in October; 21 attributed to York, 12 Scarborough and 3 Community.

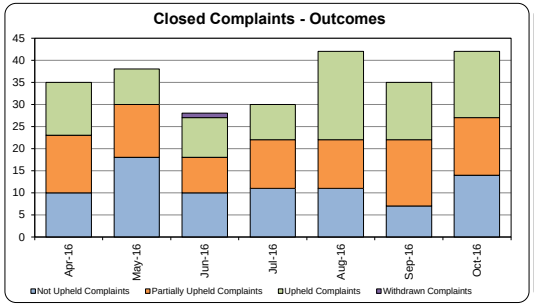
New Ombudsman Cases
There were no New Ombudsman Cases in October.

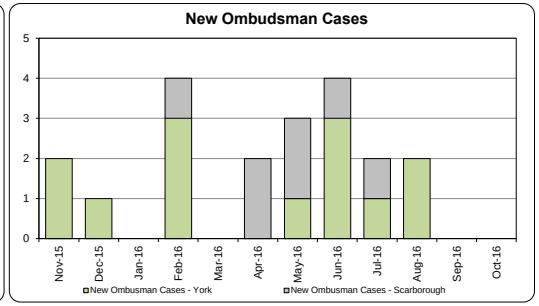
Compliments
22 compliments were received by the Chief Executive in October 2016. This is in addition to the many cards and letters received directly by wards and departments.

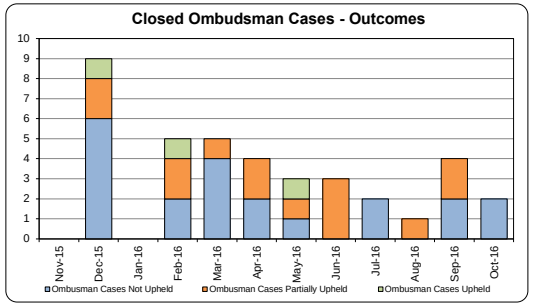
Patient Experience

November 2016

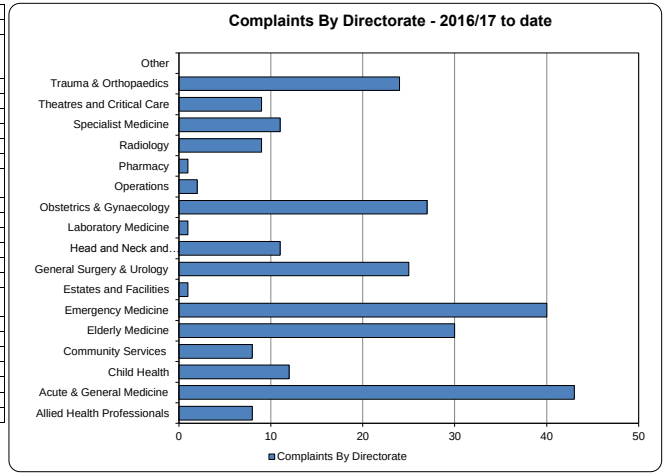






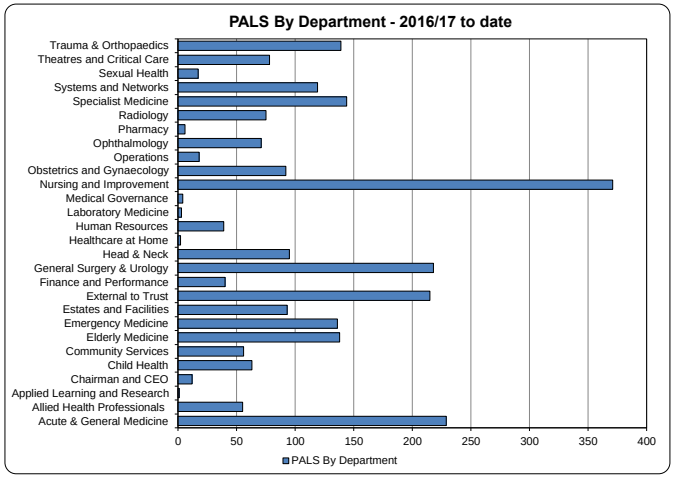


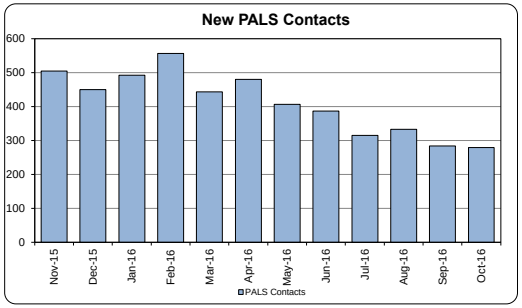
Complaints By Subject	Oct-16	YTD
Access to treatment or drugs	0	20
Admissions, Discharge and Transfer Arrangements	5	68
All aspects of Clinical Treatment	40	219
Appointments, Delay/Cancellation	8	85
Commissioning	0	1
Comms/info to patients (written and oral)	19	159
Complaints Handling	0	0
Consent	3	6
End of Life Care	0	7
Facilities	0	14
Mortuary	0	0
Others	0	0
Patient Care	13	99
Patient Concerns	1	13
Prescribing	5	21
Privacy and Dignity	7	20
Restraint	0	0
Staff Numbers	0	3
Transport	0	7
Trust Admin/Policies/Procedures	2	60
Values and Behaviours (Staff)	11	107
Waiting times	1	15
TOTAL	**115**	**923**

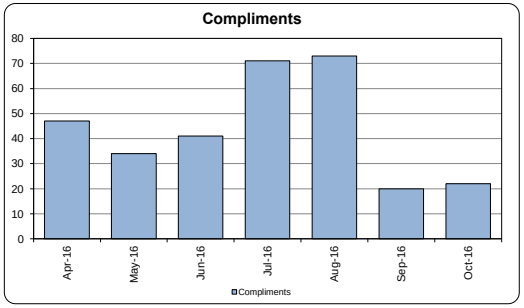


PALS By Subject	Oct-16	YTD
Access to Treatment or Drugs	14	71
Admissions and Discharges (Excluding Delayed Discharge due to absence of care package)	19	69
Appointments	50	202
Clinical Treatment	23	109
Commissioning	2	6
Communication	51	222
End of Life Care	2	7
Facilities	11	32
Integrated Care (including Delayed Discharge Due to Absence of a Care Package	1	3
Patient Care	24	69
Patient Concerns	13	47
Prescribing	4	14
Privacy, Dignity & Respect	0	1
Staff Numbers	1	3
Transport	4	16
Trust Admin/Policies/Procedures Inc. pt. record management	34	188
Values and Behaviours (Staff)	15	107
Waiting Times	11	40
Total	**279**	**1211**

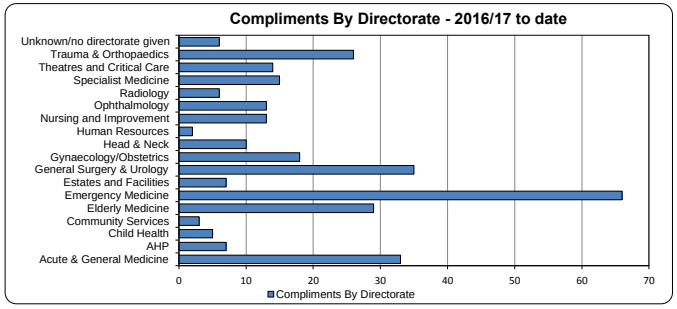
Since July 2016 there was a change in how PALS log cases. Issues such as misplaced calls from switchboard or requests to speak to other departments are no longer logged. The new IT system allows cases to be updated rather than creating new logs.







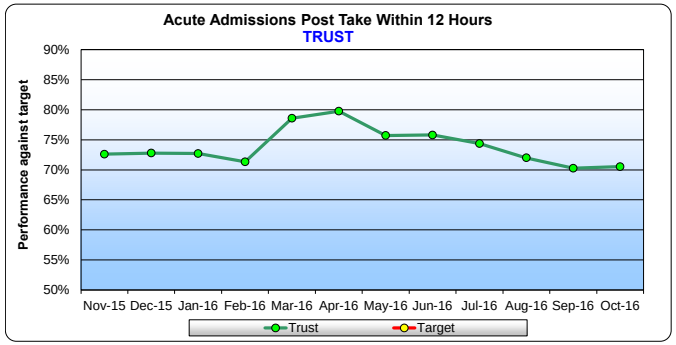
Compliments By Directorate	Oct-16	YTD
Acute & General Medicine	2	33
AHP	0	7
Child Health	1	5
Community Services	1	3
Elderly Medicine	2	29
Emergency Medicine	3	66
Estates and Facilities	2	7
General Surgery & Urology	0	35
Gynaecology/Obstetrics	2	18
Head & Neck	1	10
Human Resources	0	2
Nursing and Improvement	3	13
Ophthalmology	0	13
Radiology	0	6
Specialist Medicine	0	15
Theatres and Critical Care	1	14
Trauma & Orthopaedics	2	26
Unknown/no directorate given	2	6
Total	**22**	**308**

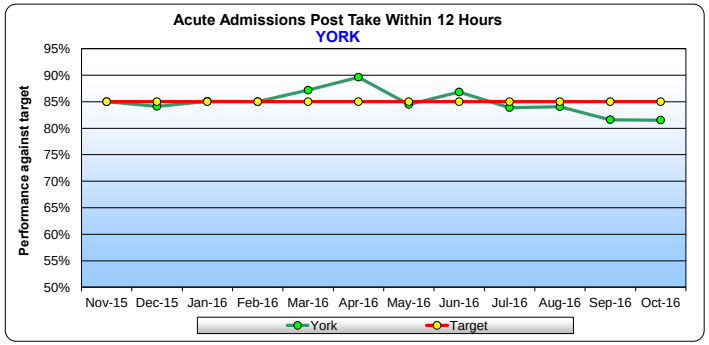


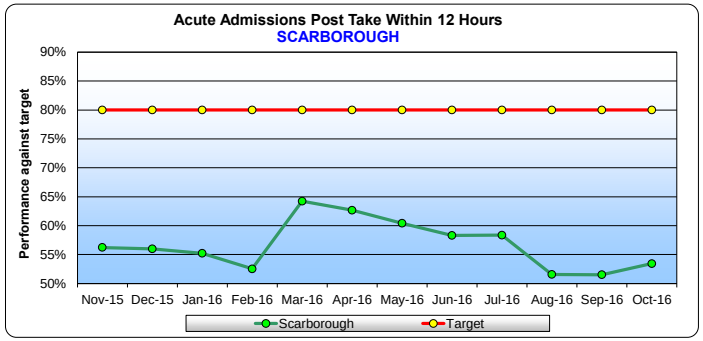
Note re compliment numbers: These include letters received by our Chief Executive and PALS. They are in addition to the large number of cards, letters and in-person thank yous which are received directly by our wards and departments.

Quality and Safety: Care of the Deteriorating Patient

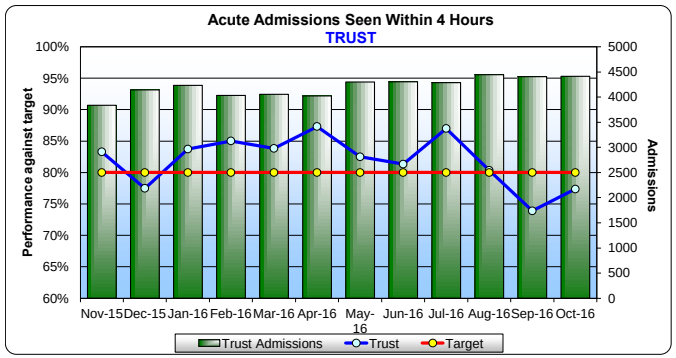
Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Aug	Sep	Oct
Care of the Deteriorating Patient on Acute Medical Assessment Units. Admissions - senior review within 12 hours of arrival (SCARBOROUGH)	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI	80%	57%	57%	60%	54%	52%	52%	53%
Care of the Deteriorating Patient on Acute Medical Assessment Units. Admissions - senior review within 12 hours of arrival (YORK)	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI	85%	85%	85%	87%	83%	84%	82%	82%

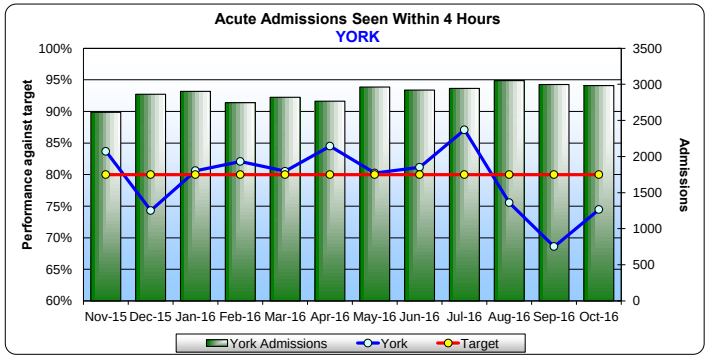


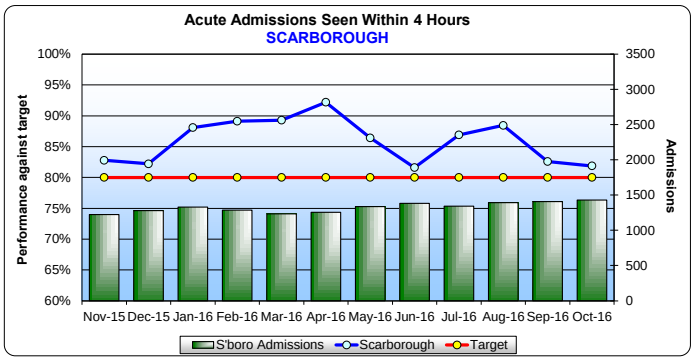




Care of the Deteriorating Patient: All acute medical, elderly medical and orthogeriatric (FNoF) admissions through AMU to be seen by a senior decision maker (registrar or nurse)	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI	**80% by site**	82.0%	84.0%	83.7%	80.4%	80.3%	73.9%	77.4%

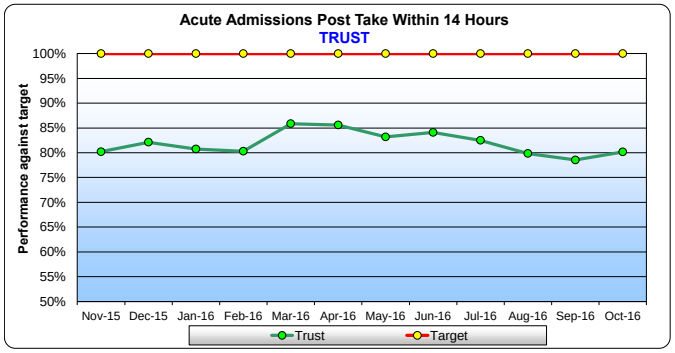


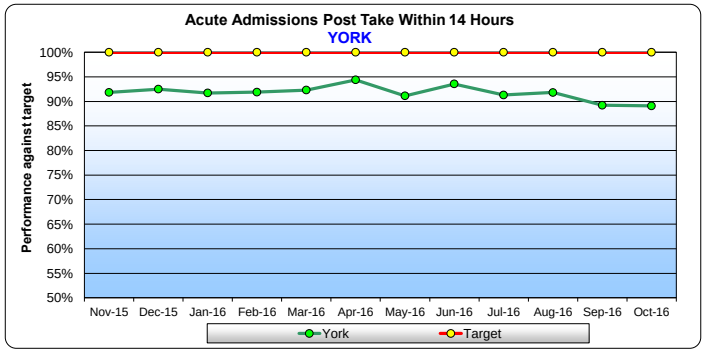


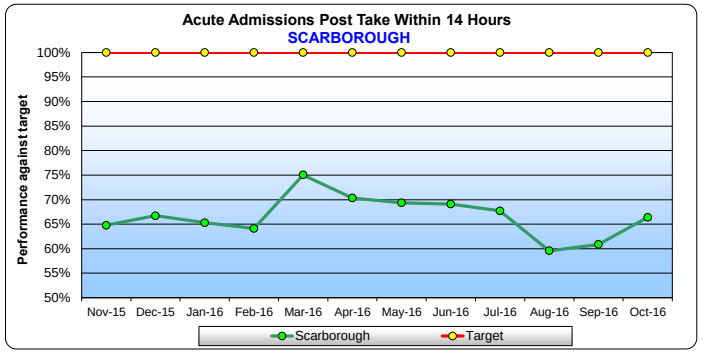


Quality and Safety: Care of the Deteriorating Patient

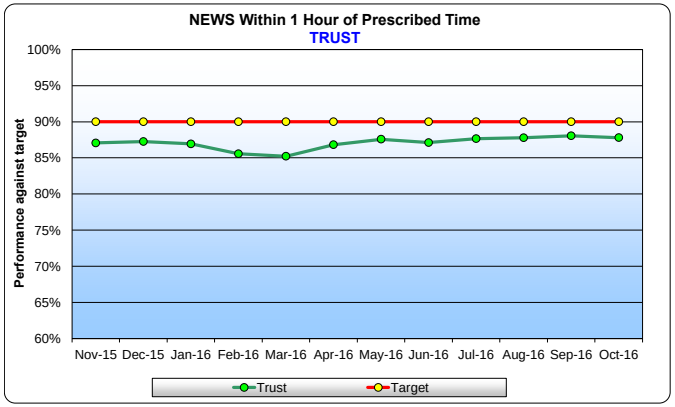
Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Aug	Sep	Oct
Care of the Deteriorating Patient on Acute Medical Assessment Units. Admissions - senior review within 14 hours of arrival - Royal College Standard - 100%	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI		81.8%	82.3%	83.9%	80.3%	79.8%	78.5%	80.2%

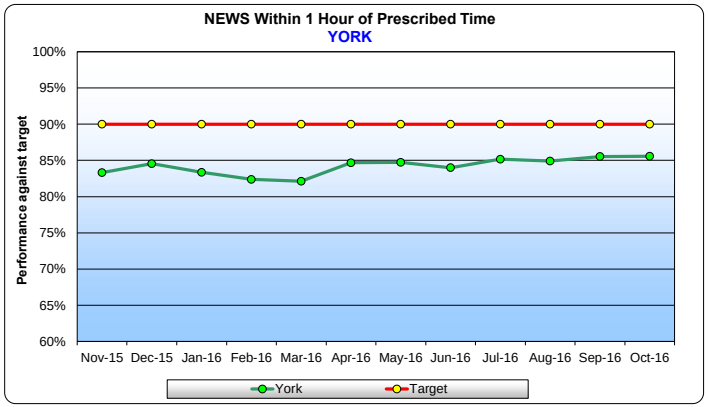


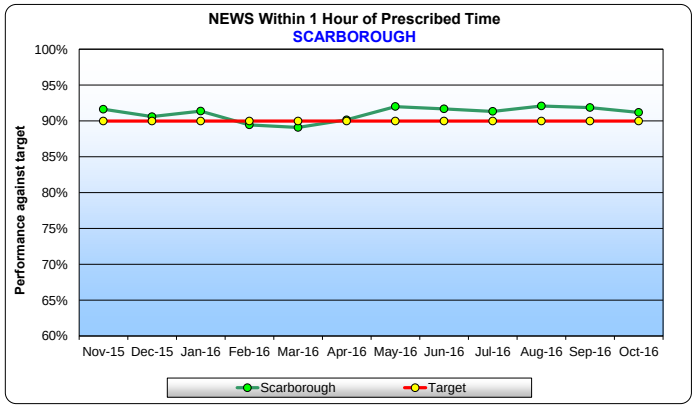




NEWS within 1 hour of prescribed time	None - Monitoring Only		86.9%	85.9%	87.3%	87.9%	87.8%	88.1%	87.8%







Measures of Harm

Serious Incidents (SIs) declared (source: Datix)
There were 9 SIs reported in October; York 1, Scarborough 6 & Community 2.
Clinical Incidents: 3; 1 York, 2 Scarborough.
Slips Trips & Falls: 5; Scarborough 4 & Community 1.
Pressure Ulcers: 1; Community.

Patients Falls and Found on Floor (source: Datix)
Reduction in the number of patients who incur a fall while in hospital remains a priority for the Trust. During October there were 102 reports of patients falling at York Hospital, 71 patients at Scarborough and 56 patients within the Community Services (229 in total). For the same period last year there were a total of 287, however figures may increase as more investigations are completed.

Number of Incidents Reported (source: Datix)
The total number of incidents reported in the Trust during October was 1,156; 647 incidents were reported on the York site, 348 on the Scarborough site and 161 from Community Services.

Number of Incidents Awaiting Sign Off at Directorate Level (source: Datix)
At the time of reporting there were 752 incidents awaiting sign-off by the Directorate Management Teams.

Pressure Ulcers (source: Datix)
During October 61 pressure ulcers were reported to have developed on patients since admission to York Hospital, 34 pressure ulcers were reported to have developed on patients since admission to Scarborough and 34 pressure ulcers were reported as having developed on patients in our community hospitals or community care. These figures should be considered as approximations as not all investigations have been completed.

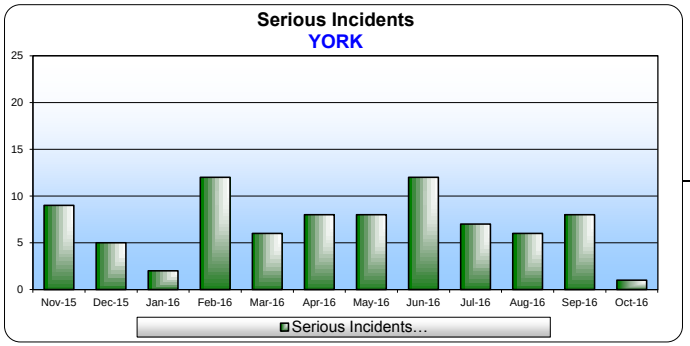
Degree of Harm: Serious/Severe or Death (source: Datix)
During October 5 patient incidents were reported which resulted in serious or severe harm or death. Numbers are subject to change as levels of harm are reviewed and investigations are completed.

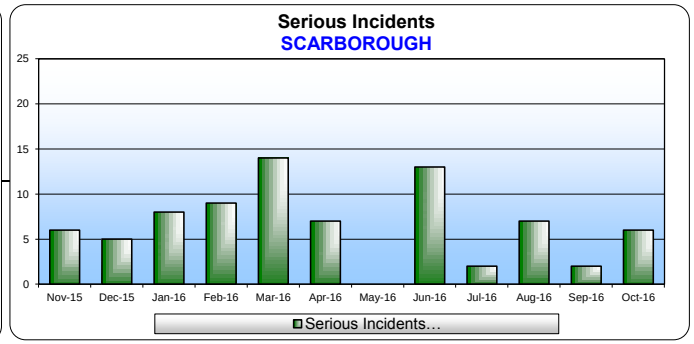
Medication Related Issues (source: Datix)
During October there was a total of 134 medication related incidents reported although this figure may change following validation.

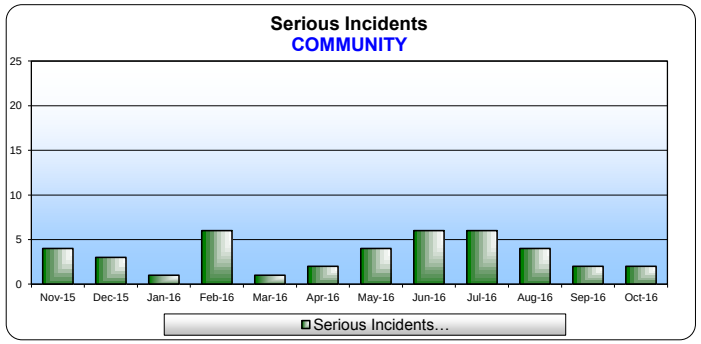
Never Events – No Never Events were declared during October.

Measures of Harm

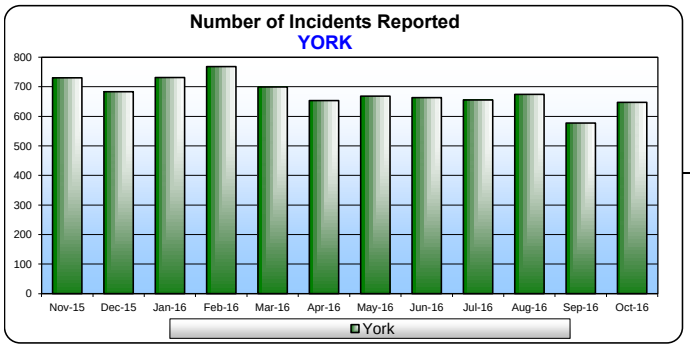
Indicator		Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16
Serious Incidents source: Risk and Legal	York	9	5	2	12	6	8	8	12	7	6	8	1
	Scarborough	6	5	8	9	14	7	0	13	2	7	2	6
	Community	4	3	1	6	1	2	4	6	6	4	2	2
Serious Incidents Delogged source: Risk and Legal (Trust)		0	0	0	0	0	0	0	0	0	0	0	0

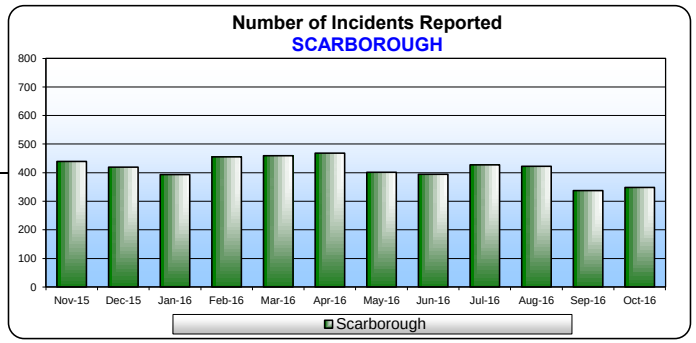


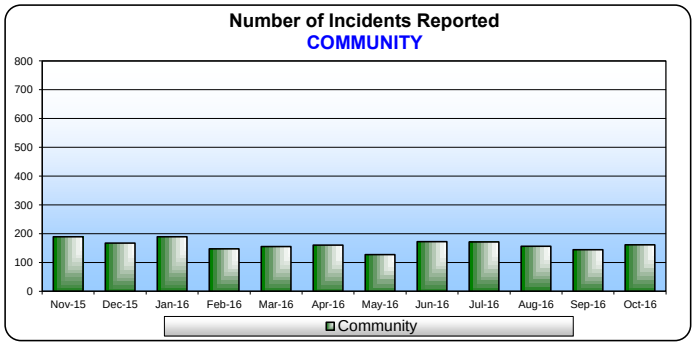




Indicator		Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16
Number of Incidents Reported source: Risk and Legal	York	730	683	731	768	699	653	668	663	655	674	577	647
	Scarborough	439	419	393	455	459	468	401	394	427	422	337	348
	Community	189	167	189	147	155	160	127	172	171	156	144	161
Number of Incidents Awaiting sign off at Directorate level		889	1149	1344	1389	1348	987	780	724	686	763	813	752

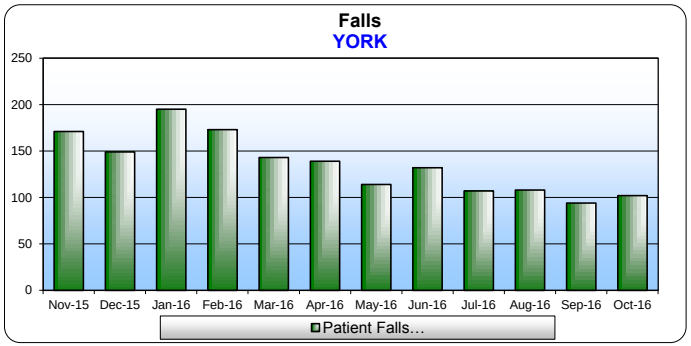


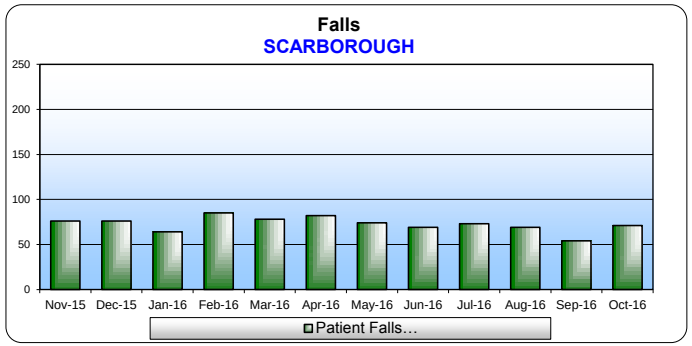


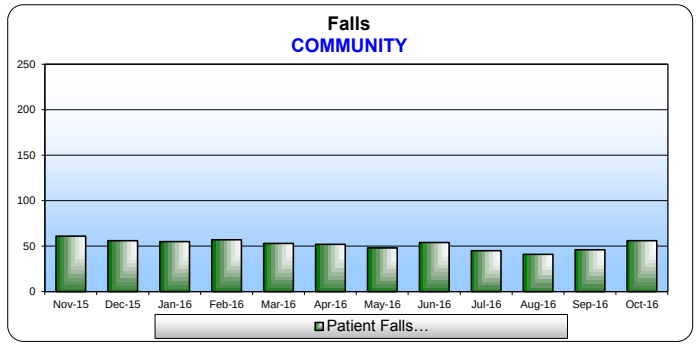


Measures of Harm

Indicator		Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16
Patient Falls source: DATIX	York	171	149	195	173	143	139	114	132	107	108	94	102
	Scarborough	76	76	64	85	78	82	74	69	73	69	54	71
	Community	61	56	55	57	53	52	48	54	45	41	46	56

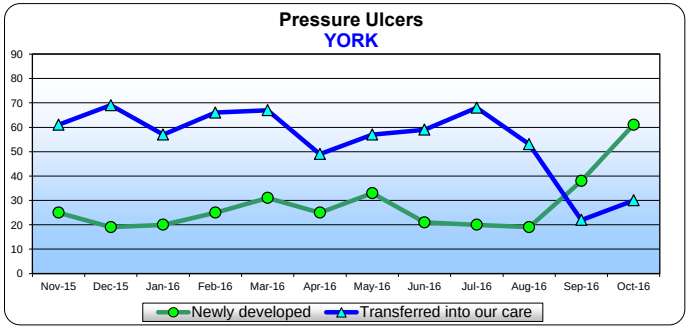


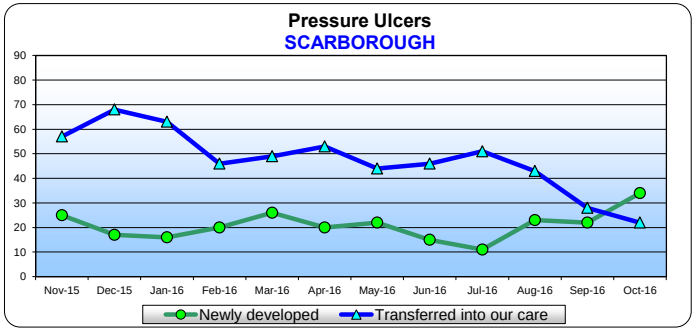


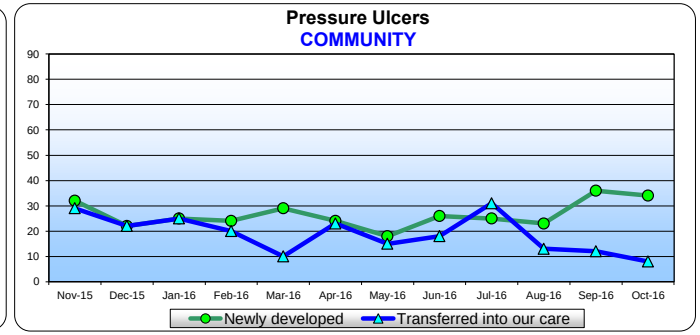


Note - Falls are reviewed retrospectively therefore totals will change month on month. Monthly figures will be refreshed each time the report is updated.
Totals include all degrees of harm, and incidents which have been 'Rejected' are excluded.

Indicator			Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16
Pressure Ulcers source: DATIX	York	Newly developed	25	19	20	25	31	25	33	21	20	19	38	61
		Transferred into our care	61	69	57	66	67	49	57	59	68	53	22	30
	Scarborough	Newly developed	25	17	16	20	26	20	22	15	11	23	22	34
		Transferred into our care	57	68	63	46	49	53	44	46	51	43	28	22
	Community	Newly developed	32	22	25	24	29	24	18	26	25	23	36	34
		Transferred into our care	29	22	25	20	10	23	15	18	31	13	12	8



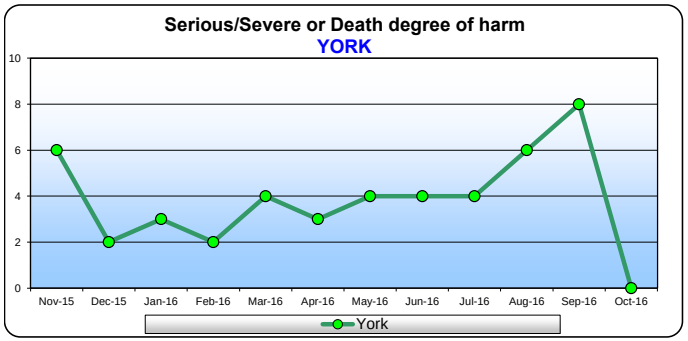


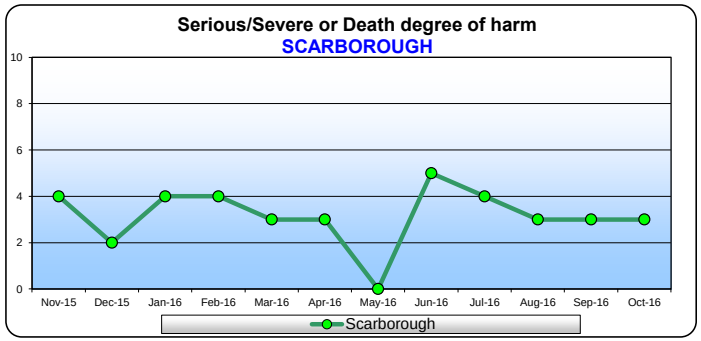


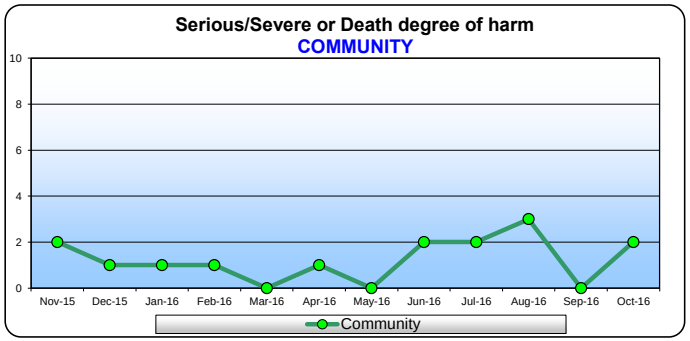
Note - Pressure Ulcers are reviewed retrospectively therefore totals will change month on month. Monthly figures will be refreshed each time the report is updated.
Totals include all degrees of harm, incidents which have been 'Rejected' are excluded as are pressure ulcers which have been categorised as a 'Deterioration of a previously reported ulcer'.
The increase in newly developed or deteriorated under our care is thought to be attributable to a re-classification of the data on the Datix system implemented on 01/09/16, recognising more accurately our responsibility for patients in the community.

Measures of Harm

Indicator		Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16
Degree of harm: serious/severe or death source: Datix	York	6	2	3	2	4	3	4	4	4	6	8	0
	Scarborough	4	2	4	4	3	3	0	5	4	3	3	3
	Community	2	1	1	1	0	1	0	2	2	3	0	2

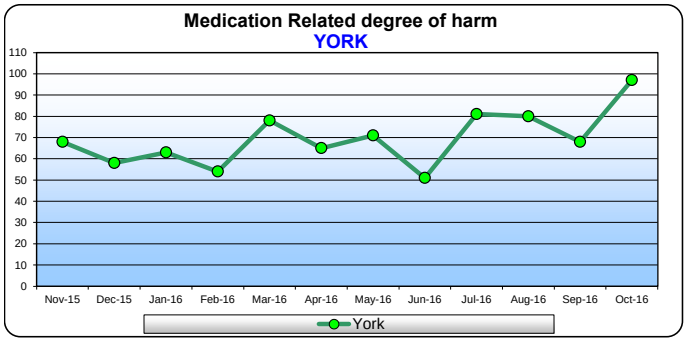


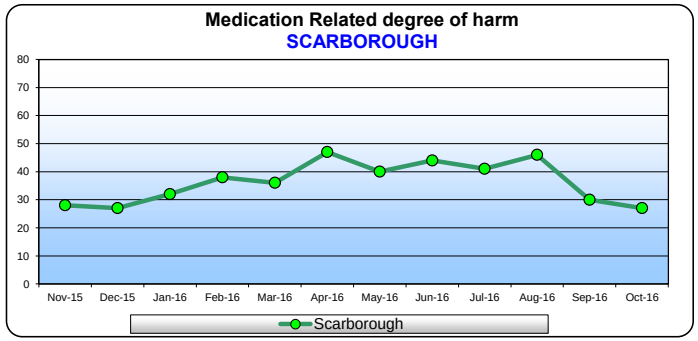


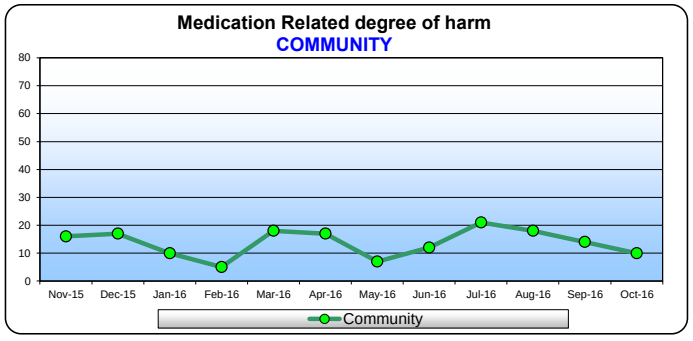


Indicator		Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16
Degree of harm: Medication Related Issues source: Datix	York	68	58	63	54	78	65	71	51	81	80	68	97
	Scarborough	28	27	32	38	36	47	40	44	41	46	30	27
	Community	16	17	10	5	18	17	7	12	21	18	14	10

Please note: December increase in Medication Related issues is due to a new option of Medication being added to DATIX at the beginning of December. These were not previously recorded on DATIX.

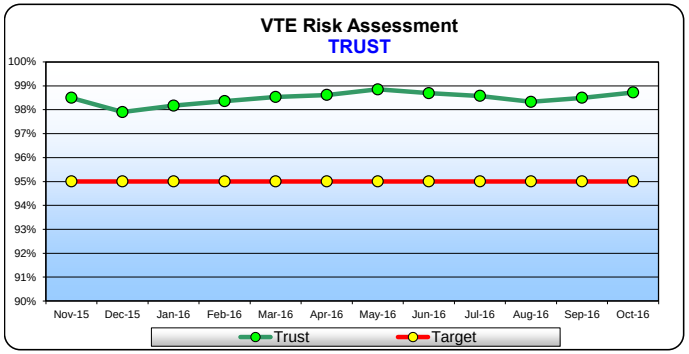


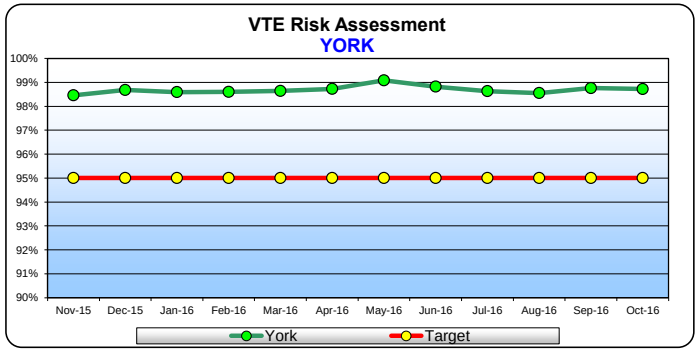


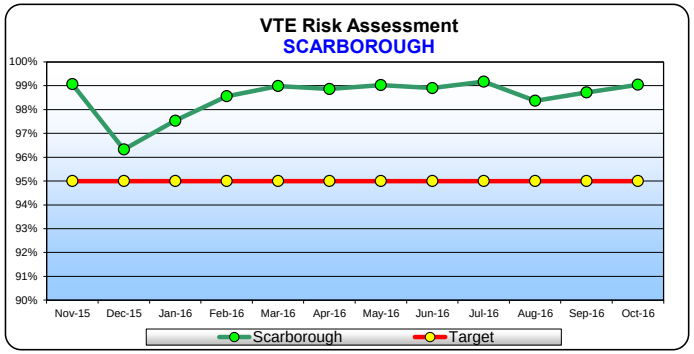


Measures of Harm

Indicator	Consequence of Breach	Site	Threshold	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Aug	Sep	Oct
VTE risk assessment: all inpatient undergoing risk assessment for VTE, as defined in Contract Technical Guidance source: CPD	£200 in respect of each excess breach above threshold	Trust	95%	97.9%	98.4%	98.7%	98.5%	98.3%	98.5%	98.7%
		York	95%	98.3%	98.6%	98.9%	98.7%	98.6%	98.8%	98.7%
		Scarborough	95%	97.3%	98.3%	98.9%	98.8%	98.4%	98.7%	99.0%







Never Events

Indicator	Consequence of Breach	Threshold	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Aug	Sep	Oct
SURGICAL									
Wrong site surgery	As below	**>0**	**0**	**0**	**2**	**1**	1	0	0
Wrong implant/prosthesis		**>0**	**0**	**0**	**0**	**0**	0	0	0
Retained foreign object post-operation		**>0**	**0**	**0**	**0**	**0**	0	0	0
MEDICATION									
Wrongly prepared high-risk injectable medication	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure or episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	**>0**	**0**	**0**	**0**	**0**	0	0	0
Maladministration of potassium-containing solutions		**>0**	**0**	**0**	**0**	**0**	0	0	0
Wrong route administration of chemotherapy		**>0**	**0**	**0**	**0**	**0**	0	0	0
Wrong route administration of oral/enteral treatment		**>0**	**0**	**0**	**0**	**1**	0	0	0
Intravenous administration of epidural medication		**>0**	**0**	**0**	**0**	**0**	0	0	0
Maladministration of insulin		**>0**	**0**	**1**	**0**	**0**	0	0	0
Overdose of midazolam during conscious sedation		**>0**	**0**	**0**	**0**	**0**	0	0	0
Opioid overdose of an opioid-naïve Service User		**>0**	**0**	**0**	**0**	**0**	0	0	0
Inappropriate administration of daily oral methotrexate		**>0**	**0**	**0**	**0**	**0**	0	0	0
GENERAL HEALTHCARE									
Falls from unrestricted windows	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure or episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	**>0**	**0**	**0**	**0**	**0**	0	0	0
Entrapment in bedrails		**>0**	**0**	**0**	**0**	**0**	0	0	0
Transfusion of ABO incompatible blood components		**>0**	**0**	**0**	**0**	**0**	0	0	0
Transplantation of ABO incompatible organs as a result of error		**>0**	**0**	**0**	**0**	**0**	0	0	0
Misplaced naso- or oro-gastric tubes		**>0**	**0**	**0**	**0**	**0**	0	0	0
Wrong gas administered		**>0**	**0**	**0**	**0**	**0**	0	0	0
Failure to monitor and respond to oxygen saturation		**>0**	**0**	**0**	**0**	**0**	0	0	0
Air embolism		**>0**	**0**	**0**	**0**	**0**	0	0	0
Misidentification of Service Users		**>0**	**0**	**0**	**0**	**0**	0	0	0
Severe scalding of Service Users		**>0**	**0**	**0**	**0**	**0**	0	0	0
	MATERNITY								
Maternal death due to post-partum haemorrhage after elective caesarean section	As above	**>0**	**0**	**0**	**0**	**0**	0	0	0

Drug Administration

Omitted Critical Medicines
The audit of critical medicines missed during October indicated 1.29% for York and 2.54% for Scarborough.

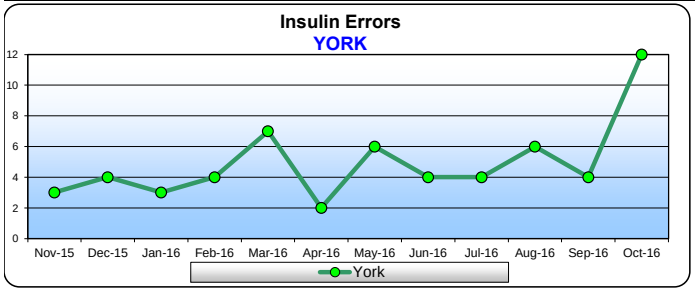
Prescribing Errors
There were 30 prescribing related errors in October; 24 from York, 4 from Scarborough and 2 from Community.

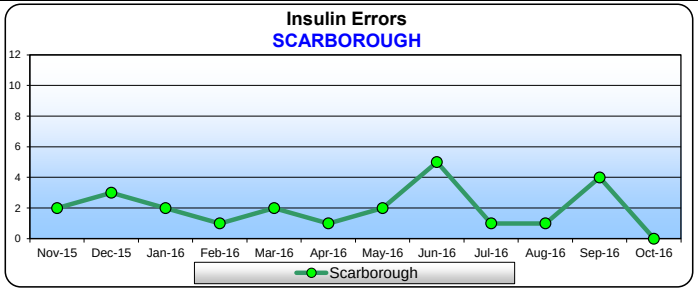
Preparation and Dispensing Errors
There were 24 preparation/dispensing errors in October; 20 from York, 2 from Scarborough and 2 from Community.

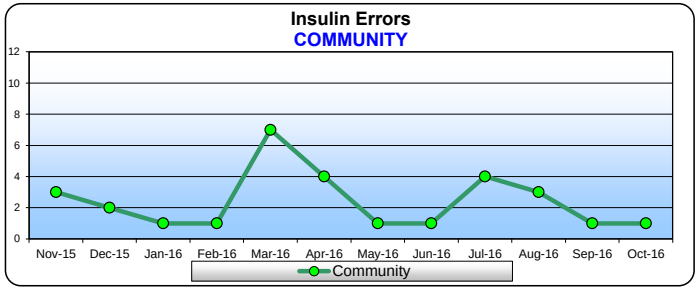
Administrating and Supply Errors
There were 54 administrating/supplying errors in October; 37 were from York, 11 from Scarborough and 6 from Community.

Drug Administration

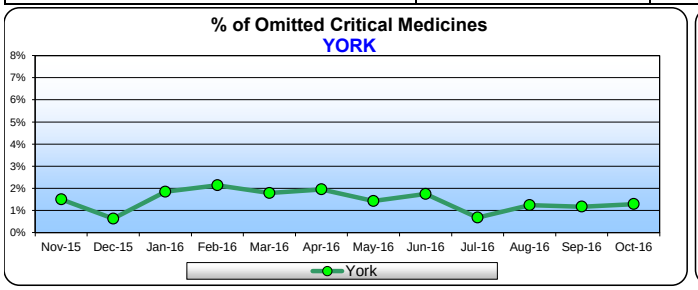
Indicator		Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16
Insulin Errors source: Datix	York	3	4	3	4	7	2	6	4	4	6	4	12
	Scarborough	2	3	2	1	2	1	2	5	1	1	4	0
	Community	3	2	1	1	7	4	1	1	4	3	1	1

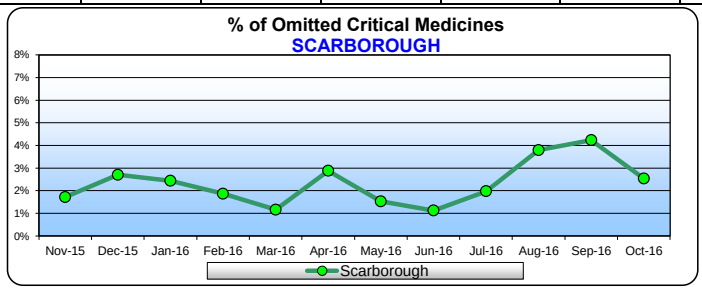


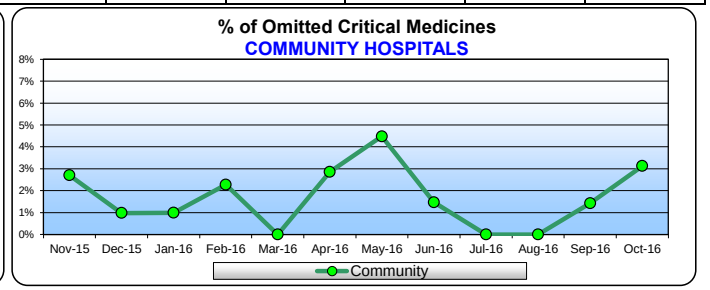




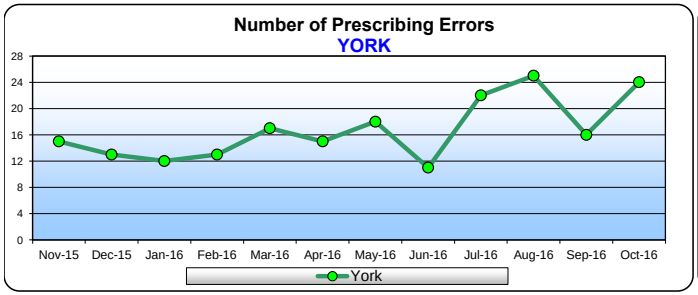
Indicator		Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16
Number of Omitted Critical Medicines source: Datix	York	6	3	9	10	8	9	6	8	3	5	5	6
	Scarborough	4	7	6	5	3	8	4	3	5	10	11	7
	Community Hospitals	2	1	1	2	0	2	3	1	0	0	1	2

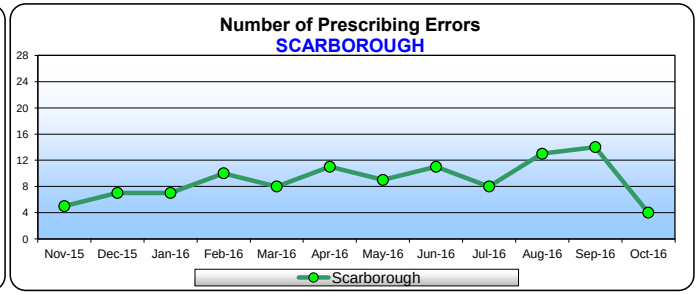


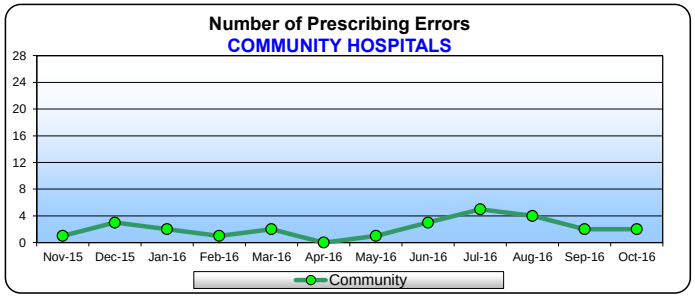




Indicator		Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16
Number of Prescribing Errors source: Datix	York	15	13	12	13	17	15	18	11	22	25	16	24
	Scarborough	5	7	7	10	8	11	9	11	8	13	14	4
	Community Hospitals	1	3	2	1	2	0	1	3	5	4	2	2

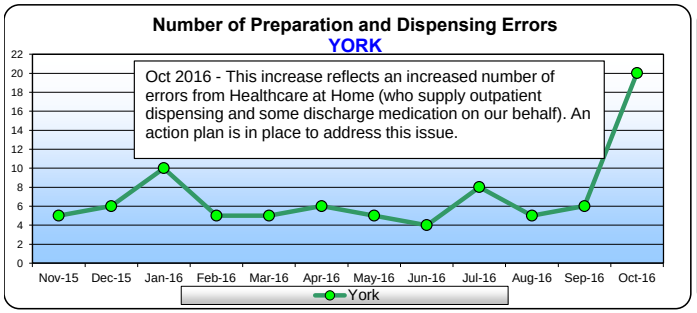


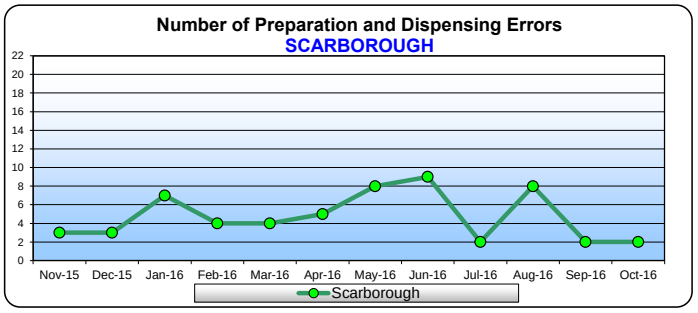


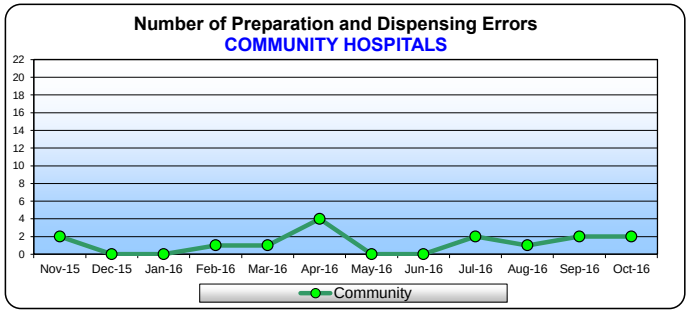


Drug Administration

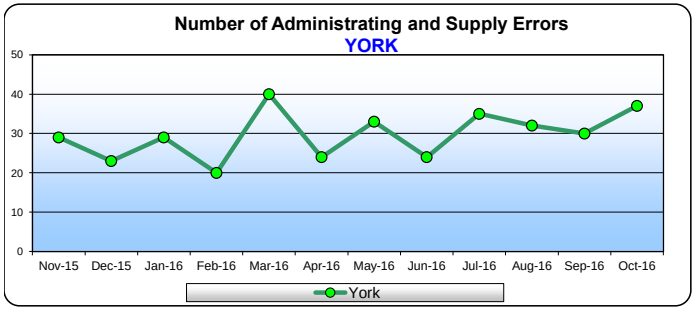
Indicator		Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16
Number of Preparation and Dispensing Errors source: Datix	York	5	6	10	5	5	6	5	4	8	5	6	20
	Scarborough	3	3	7	4	4	5	8	9	2	8	2	2
	Community Hospitals	2	0	0	1	1	4	0	0	2	1	2	2

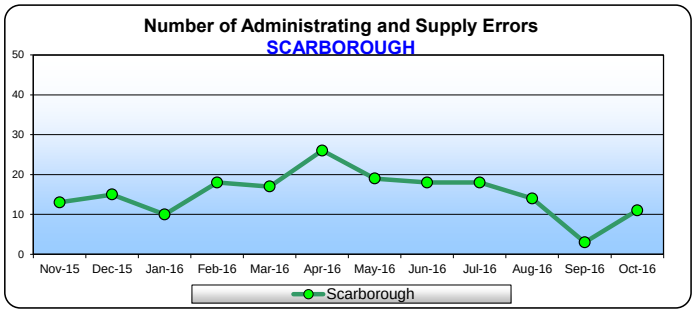


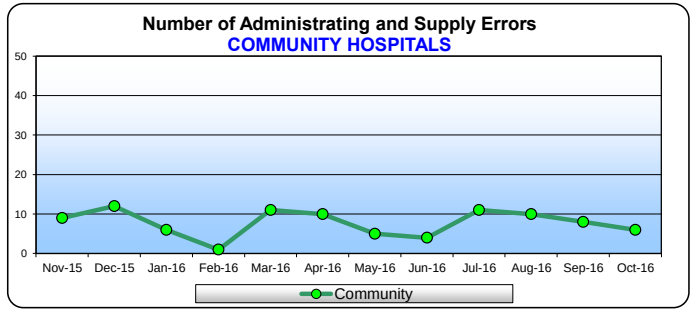




Indicator		Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16
Administrating and Supply Errors source: Datix	York	29	23	29	20	40	24	33	24	35	32	30	37
	Scarborough	13	15	10	18	17	26	19	18	18	14	3	11
	Community Hospitals	9	12	6	1	11	10	5	4	11	10	8	6







Measures of Harm: Safety Thermometer

Please note this Safety Thermometer is a snapshot taken on the first Wednesday of the month.

Harm Free Care

The percentage of patients harm free from pressure ulcers, catheter associated urinary tract infection (CAUTI), falls and VTE is measured as a monthly prevalence score. In October the percentage receiving care “free from harm” following audit is below:

·York: 96.5%
·Scarborough: 93.2%
·Community Hospitals: 91.0%
·Community care: 95.4%

Harm from Catheter Associated Urinary Tract Infection

The percentage of patients affected by CAUTI as measured by the Department of Health data definition, monthly measurement of prevalence:

·York: 0.2%
·Scarborough: 3.5%
·Community Hospitals: 1.5%
·Community Care: 0.8%

VTE

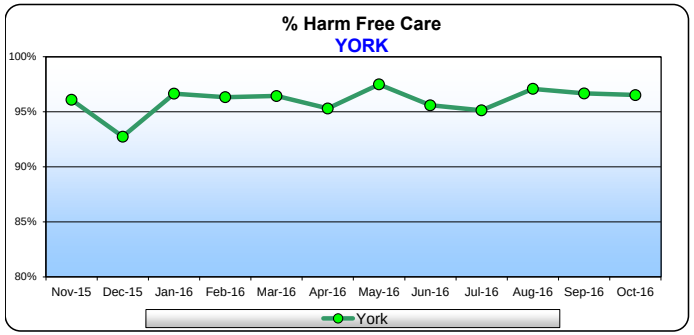
The percentage of patients affected by VTE as measured by the Department of Health definition, monthly measurement of prevalence:

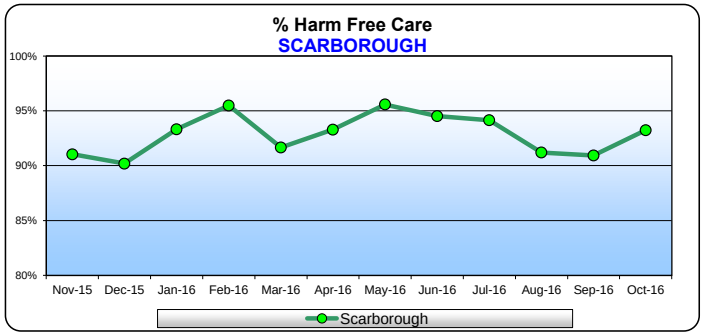
·York: 0.3%
·Scarborough: 1.0%
·Community Hospitals: 0.0%

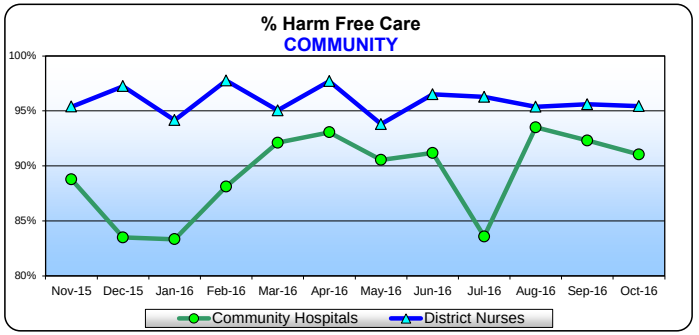
Safety Thermometer

Please note this Safety Thermometer is a snapshot taken on the first Wednesday of the month. Whitecross Court and St Helen's are not included in the Community Hospital figures as they are part of the acute bed base.

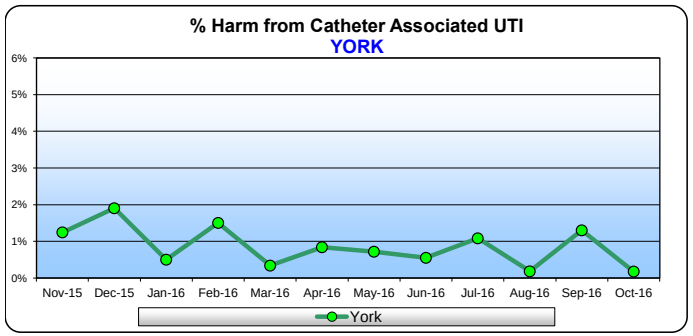
Indicator		Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16
% of Harm Free Care source: Safety Thermometer	York	96.1%	92.7%	96.7%	96.3%	96.4%	95.3%	97.5%	95.6%	95.1%	97.1%	96.7%	96.5%
	Scarborough	91.0%	90.2%	93.3%	95.5%	91.7%	93.3%	95.6%	94.5%	94.1%	91.2%	90.9%	93.2%
	Community Hospitals	88.8%	83.5%	83.3%	88.1%	92.1%	93.1%	90.5%	91.2%	83.6%	93.5%	92.3%	91.0%
	District Nurses	95.4%	97.2%	94.2%	97.8%	95.0%	97.7%	93.8%	96.5%	96.3%	95.4%	95.6%	95.4%

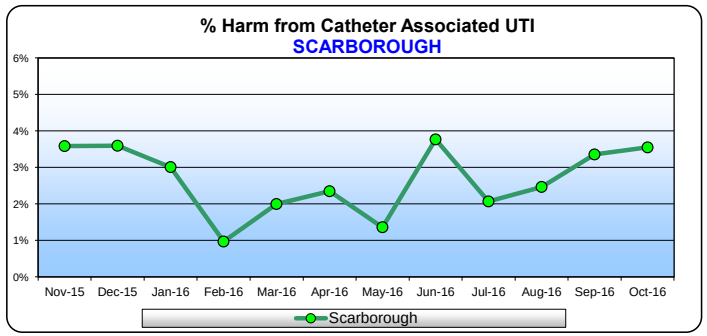


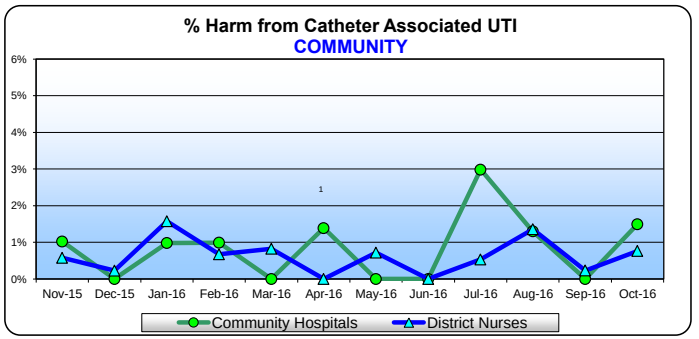




Indicator		Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16
% of Harm from Catheter Associated Urinary Tract Infection source: Safety Thermometer	York	1.2%	1.9%	0.5%	1.5%	0.3%	0.8%	0.7%	0.6%	1.1%	0.2%	1.3%	0.2%
	Scarborough	3.6%	3.6%	3.0%	1.0%	2.0%	2.3%	1.4%	3.8%	2.1%	2.5%	3.4%	3.5%
	Community Hospitals	1.0%	0.0%	1.0%	1.0%	0.0%	1.4%	0.0%	0.0%	3.0%	1.3%	0.0%	1.5%
	District Nurses	0.6%	0.2%	1.6%	0.7%	0.8%	0.0%	0.7%	0.0%	0.5%	1.4%	0.2%	0.8%



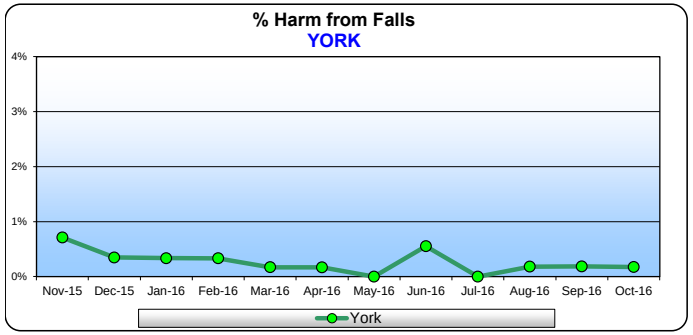


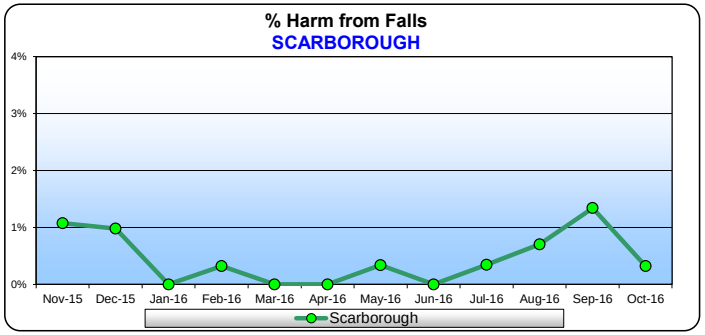


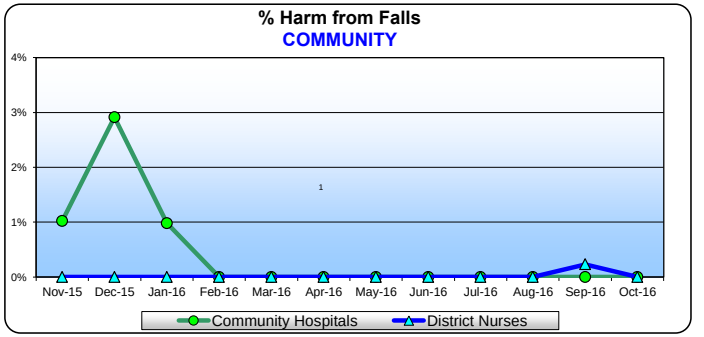
Safety Thermometer

Please note this Safety Thermometer is a snapshot taken on the first Wednesday of the month. Whitecross Court and St Helen's are not included in the Community Hospital figures as they are part of the acute bed base.

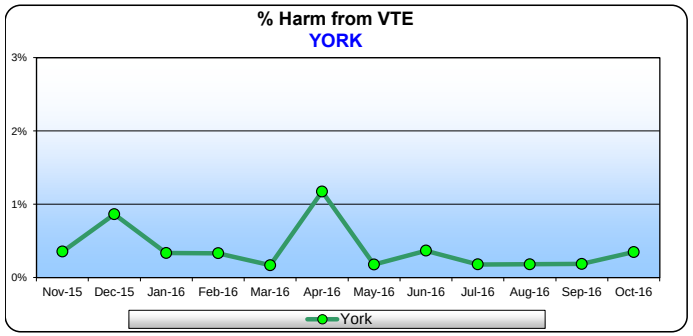
Indicator		Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16
% of Harm from Falls source: Safety Thermometer	York	0.7%	0.3%	0.3%	0.3%	0.2%	0.2%	0.0%	0.6%	0.0%	0.2%	0.2%	0.2%
	Scarborough	1.1%	1.0%	0.0%	0.3%	0.0%	0.0%	0.3%	0.0%	0.3%	0.7%	1.3%	0.3%
	Community Hospitals	1.0%	2.9%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	District Nurses	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%

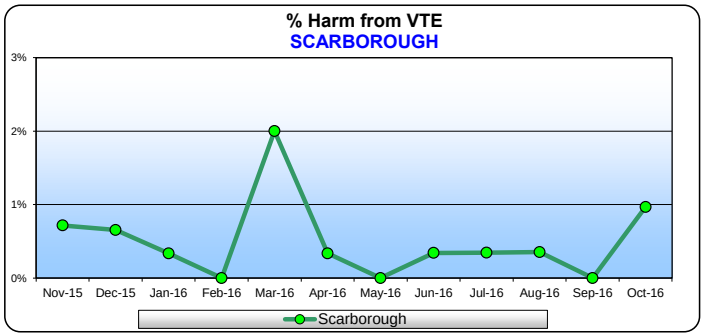


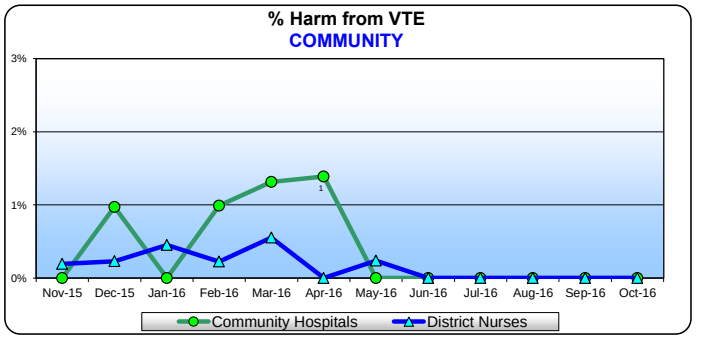




Indicator		Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16
% of VTE source: Safety Thermometer	York	0.4%	0.9%	0.3%	0.3%	0.2%	1.2%	0.2%	0.4%	0.2%	0.2%	0.2%	0.3%
	Scarborough	0.7%	0.7%	0.3%	0.0%	2.0%	0.3%	0.0%	0.3%	0.3%	0.4%	0.0%	1.0%
	Community Hospitals	0.0%	1.0%	0.0%	1.0%	1.3%	1.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	District Nurses	0.2%	0.2%	0.5%	0.2%	0.6%	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%



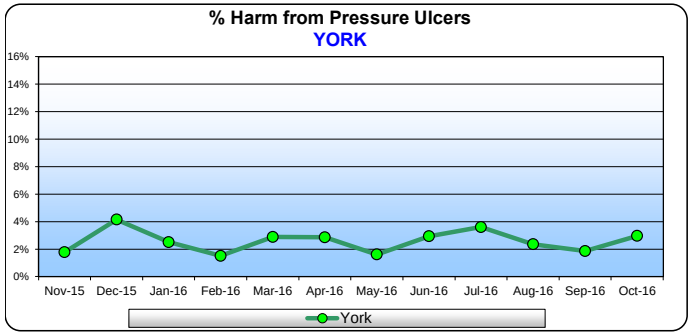


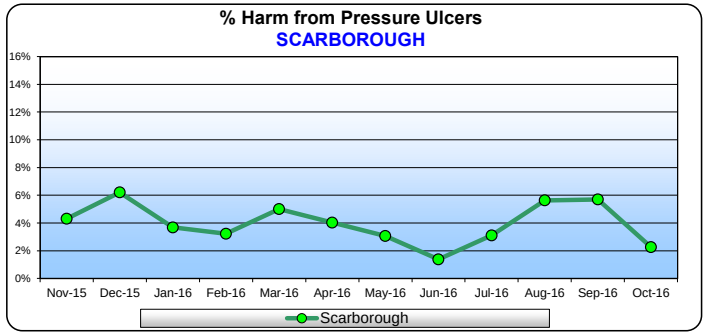


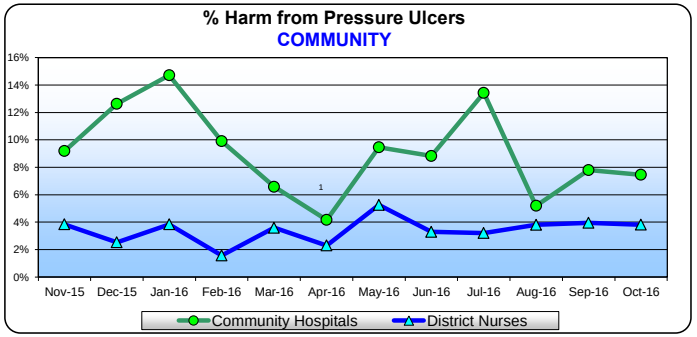
Safety Thermometer

Please note this Safety Thermometer is a snapshot taken on the first Wednesday of the month. Whitecross Court and St Helen's are not included in the Community Hospital figures as they are part of the acute bed base.

Indicator		Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16
% of Pressure Ulcers source: Safety Thermometer	York	1.8%	4.2%	2.5%	1.5%	2.9%	2.9%	1.6%	2.9%	3.6%	2.4%	1.9%	3.0%
	Scarborough	4.3%	6.2%	3.7%	3.2%	5.0%	4.0%	3.1%	1.4%	3.1%	5.6%	5.7%	2.3%
	Community Hospitals	9.2%	12.6%	14.7%	9.9%	6.6%	4.2%	9.5%	8.8%	13.4%	5.2%	7.8%	7.5%
	District Nurses	3.8%	2.5%	3.8%	1.6%	3.6%	2.3%	5.3%	3.3%	3.2%	3.8%	4.0%	3.8%







Mortality

Indicator	Jul 12 - Jun 13	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sep 14	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15	Jan 15 - Dec 15	Apr 15 - Mar 16
SHMI – York locality	96	93	93	95	98	99	97	96	95	93	94	95
SHMI – Scarborough locality	108	104	105	107	108	109	107	108	107	107	108	107
SHMI – Trust	**101**	**97**	**98**	**99**	**102**	**103**	**101**	**101**	**99**	**99**	**99**	**100**

Definition

SHMI: The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at Trust level across the NHS in England using a standard methodology. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It covers all deaths reported of patients who were admitted to non-specialist acute NHS trusts in England and either die while in hospital or within 30 days of discharge.

RAMI: Risk Adjusted Mortality Index uses a methodology to calculate the risk of death for hospital patients on the basis of clinical and hospital characteristic data including age, sex, length of stay, method of admission, HRG, ICD10 primary and secondary diagnosis, OPCS primary and secondary procedures and discharge method. Unlike SHMI, it does not include deaths after discharge. The Trust is not managed externally on its RAMI score.

Analysis of Performance

The latest SHMI report indicates the Trust to be in the 'as expected' range. The April 2015 - March 2016 SHMI saw a 1 point increase for the Trust and York, and a 1 point reduction for Scarborough. Trust - 100, York 95 and Scarborough 107.

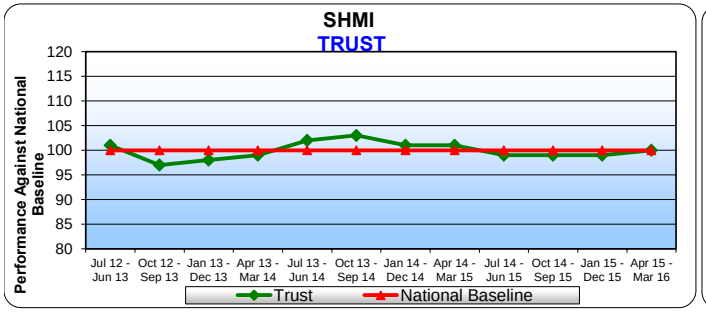
There were a total of 171 inpatients deaths across the Trust in October, including 54 at Scarborough and 101 at York. This is a 2% decrease for the Trust compared with October 2015 (175 inpatient deaths). Year to date there have been a total of 1,177 inpatient deaths across the Trust compared to 1,161 YTD 2015/16. This is a 1.4% increase year on year.

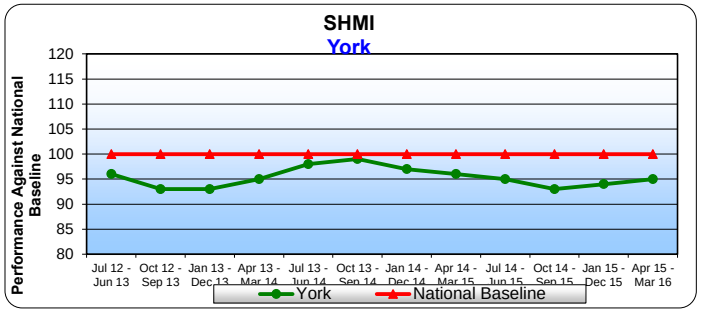
6 deaths occurred in York Emergency Department and 7 occurred in Scarborough Emergency Department in October. In October 2015 there were 12 deaths in York ED and 4 in Scarborough ED. Year to date there have been a total of 97 ED deaths across the Trust compared to 104 YTD 2015/16. This is a 7% decrease year on year.

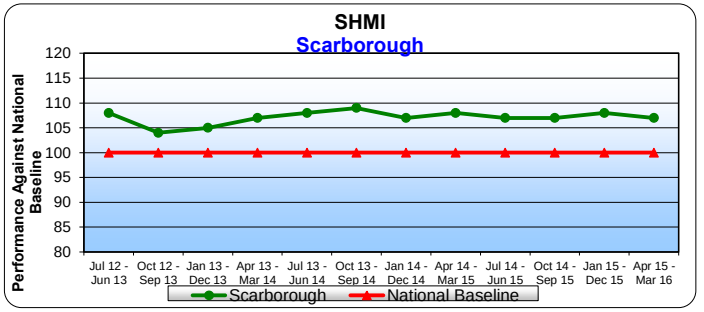
Mortality

York Teaching Hospital NHS
NHS Foundation Trust

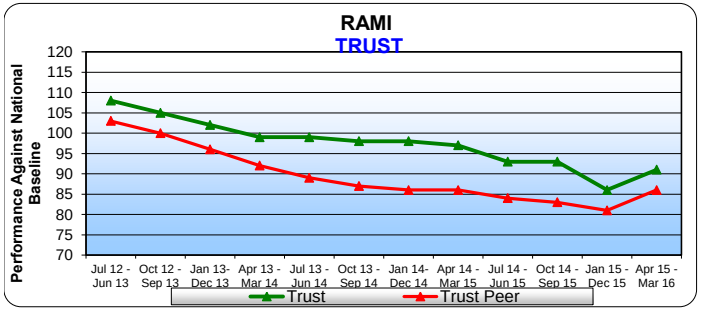
Indicator	Consequence of Breach (Monthly unless specified)	Oct 13 - Sep 14	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15	Jan 15 - Dec 15	Apr 15 - Mar 16
Mortality – SHMI (TRUST)	**Quarterly:** General Condition 9	103	101	101	99	99	99	100
Mortality – SHMI (YORK)	**Quarterly:** General Condition 9	99	97	96	95	93	94	95
Mortality – SHMI (SCARBOROUGH)	**Quarterly:** General Condition 9	109	107	108	107	107	108	107

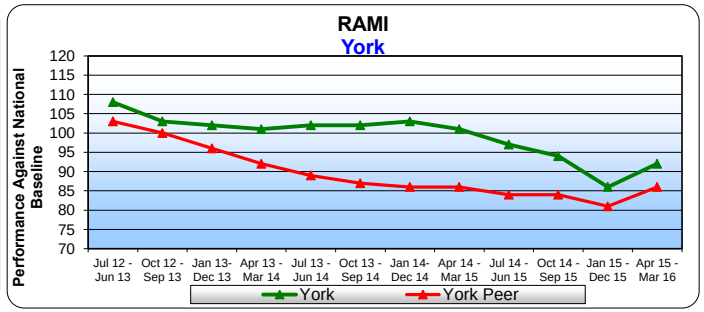


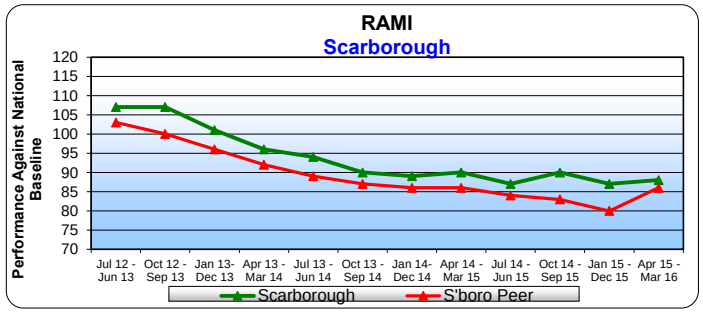




Indicator	Consequence of Breach (Monthly unless specified)	Oct 13 - Sep 14	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15	Jan 15 - Dec 15	Apr 15 - Mar 16
Mortality – RAMI (TRUST)	**none - monitoring only**	98	98	97	93	93	86	91
Mortality – RAMI (YORK)	**none - monitoring only**	102	103	101	97	94	86	92
Mortality – RAMI (SCARBOROUGH)	**none - monitoring only**	90	89	90	87	90	87	88



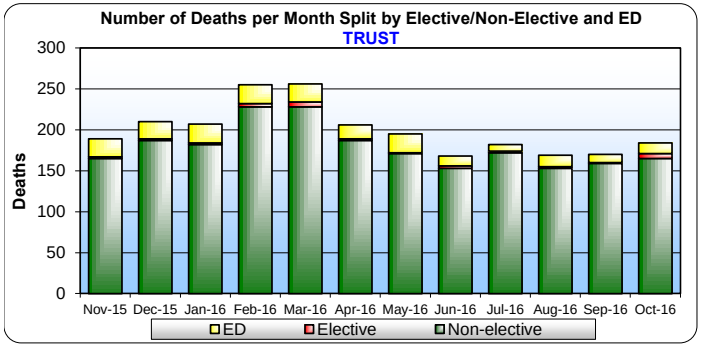


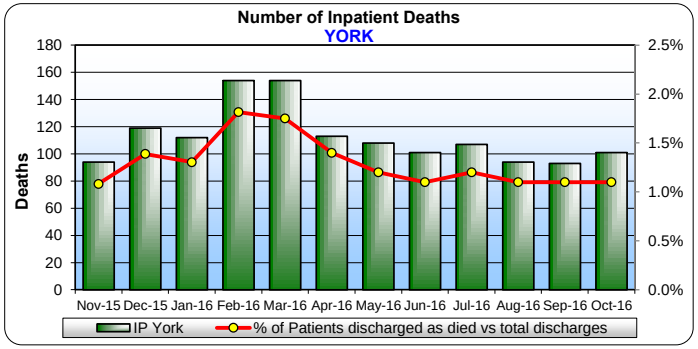


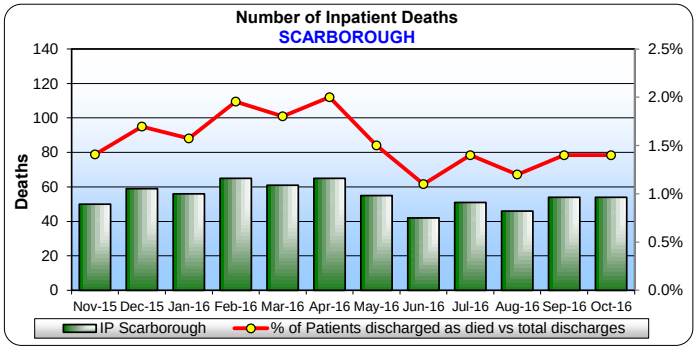
Mortality

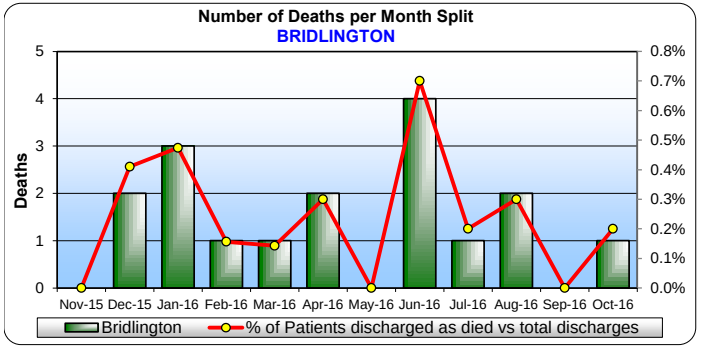
York Teaching Hospital NHS
NHS Foundation Trust

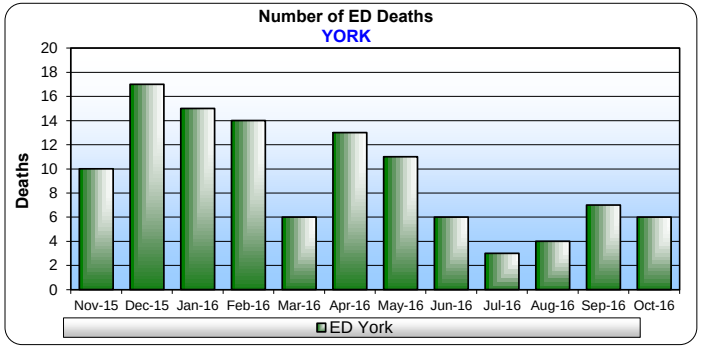
Indicator	Consequence of Breach (Monthly unless specified)	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Aug	Sep	Oct
Number of Inpatient Deaths	None - Monitoring Only	531	650	517	489	155	160	171
Number of ED Deaths	None - Monitoring Only	59	68	52	32	14	10	13

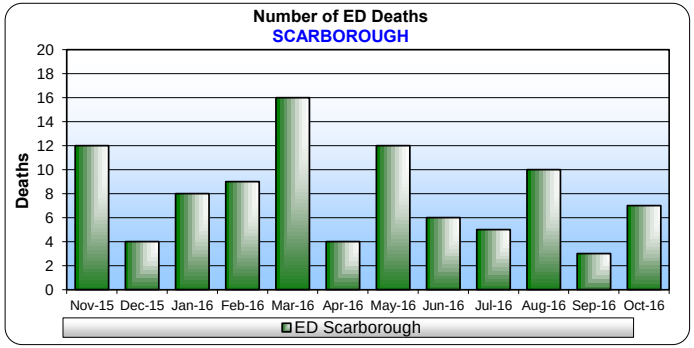


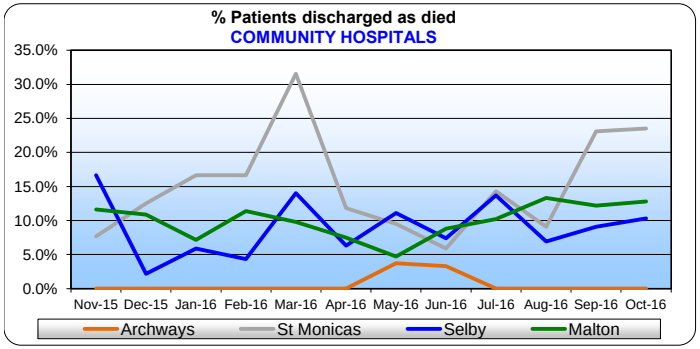


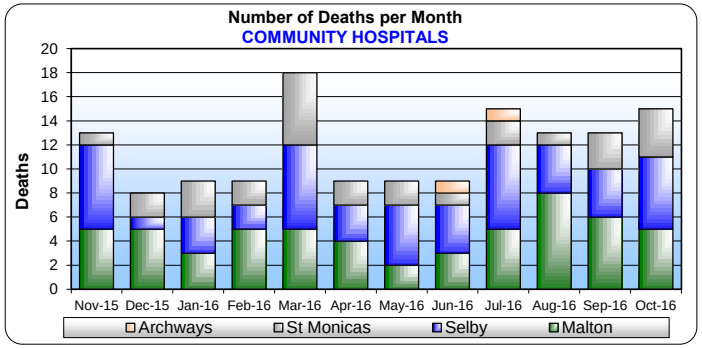












Month	Malton	Selby	St Monicas	Archways	Brid
Nov-15	5	7	1	0	0
Dec-15	5	1	2	0	2
Jan-16	3	3	3	0	3
Feb-16	5	2	2	0	1
Mar-16	5	7	6	0	1
Apr-16	4	3	2	0	2
May-16	2	5	2	0	0
Jun-16	3	4	1	1	4
Jul-16	5	7	2	1	1
Aug-16	8	4	1	0	2
Sep-16	6	4	3	0	0
Oct-16	5	6	4	0	1

Patient Safety Walkrounds – October 2016

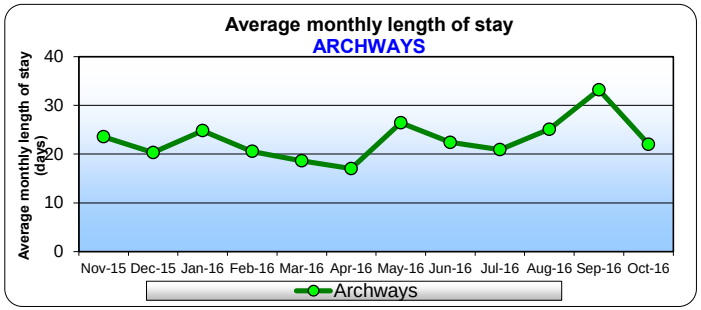
Date	Location	Participants	Actions & Recommendations
14/09/2016	Renal Unit	Andy Bertram – Executive Director Nigel Durham – Clinical Director Maggie Higginbotham – Clinical Educator for Renal Services Christine Morris – Matron Sue Symington- Chair	**Ward 33** Not visited but noted unable to carry out remedial work during HPV. **Renal Unit** Due to vacancies, staffing the acute unit/acute patients takes priority which has a knock on effect to training of long term patients. Safety related incidents include: • Staff member – fall on wet floor • Violence and aggression – patient disposition • Needle-stick injury.
23/09/2016	Endoscopy	Andy Bertram - Director Liz Hill – Directorate Manager Pauline Guyan – Matron Julie Jackson – Sister	Electronic recording of cannula/catheter insertion is not available in Endoscopy. Action – Matron to explore access to nursing assessment and inpatient care record on CPD so that this information can be recorded. Lack of access to scan scopes in the endoscopy rooms leads to risk that unclean scope is not recognised. Action – Recommend purchase of PC.
04/10/2016	Pathology – Scarborough Hospital	Juliet Walters – Executive Director Neil Todd – Clinical Director Paul Sudworth – Directorate Manager Jennie Adams – Non Executive Director	**Mortuary at SGH** Both the body storage facility and the relatives' areas are outdated. Action - Rebuild or refurbish the body storage /body viewing facility. Incidents reported relate to: • handling • devices left in place • skin damage from small fridges. Action - staff training on handling and identification. **Pathology** High agency/locum usage means that staff are often unfamiliar with and untrained in process to request and retrieve blood from the blood bank. Action - improve training for temporary staff unfamiliar with protocols. Pathology staff frequently experience difficulties reporting urgent test results by telephone out of hours, due to delay in answering on busy wards. Action – Executive Director to discuss possibility of a technology based solution – a CPD alert or a pager system/ night-time runner. The Out of Hours service on the Scarborough site requires 2 staff – one for haematology and blood transfusion, one for biochemistry, which is challenging due to staff shortages. Action – to develop an in-house training programme to attract graduates from local universities. Consolidation of microbiology service onto the York site will require an increase for sample transfers by road (5 times a day) but there will be greater efficiency and accuracy from equipment available in the York labs.
05/10/2016	Ward 15	Jim Taylor – Clinical Director Michael Bewell – Directorate Manager Wendy Brown – Matron Philip Ashton - Non Executive Director	Report to follow
5//10/2016	Duke of Kent Ward, Children's Clinic and SCBU	Helen Noble – Head of Patient Safety Udupa Venkatesh – Clinical Director Liz Vincent – Directorate Manager Nichola Lockwood – Matron Hannah Robinson – Sister	**Duke of Kent Ward** The new assessment area is causing an increased flow of patients, relatives and staff up and down the ward. Action - on-going discussions and plans for refurbishment/re location of the ward within the directorate. The CAMHS team are unable to meet the demand. Action – training has been organised for our staff into responding to the needs of anxious teenagers. Matron has liaised with lead nurse at Bootham Hospital to undertake a risk assessment on the ward. There are currently 2 consultants on Maternity leave therefore there is long term locum cover being used, which can result in inconsistency to the service. Action – consultants have recently moved to a new model of care providing a presence on site 24 hours a day 5 days a week and 12 hour cover on a weekend. **Special Care Baby Unit (SCBU)** Delay in prescribing gentamycin leads to delay in administration. Action – agreed to prescribe 3 doses with a clear time and date for administration and blood sampling. Pharmacy to arrange training for all junior doctors and midwives in relation to prescribing of gentamycin and administration. There have been delays in the blood spot forms being collected from SCBU. Action - Sister to escalate to the Directorate Manager when it appears there is a reduction in clerical cover. Communicate with staff on what is expected of them in relation to the blood spot test. The new escalation process for staffing has on occasion led to delays in filling gaps, at times leaving the unit unsafe. Action – shortfalls to be escalated to the Assistant Director of Nursing. Some of the storage facilities in the nursery and milk kitchen need to be changed to comply with good IPC practice. Action –review of stock and the necessity of some items to ensure robust stock control is in place. Review actions from recent SI in York to share learning.
18/10/2016	Dermatology OPD – Scarborough Hospital Bronte Unit Macmillan Unit	Helen Noble – Head of Patient Safety Mark Quinn- Clinical Director Karen Cowley – Directorate Manager Carol Halton – Matron	**Dermatology OPD** Space and staff capacity to meet the demand on the service is challenging. Action – a business case to relocate to Springhill is to be submitted to address the staffing and physical space. **Chemotherapy Unit** Space and staff capacity to meet the demand on the service is challenging. Action - capital planning aware the unit needs to be relocated to meet the regulated specification level of unit for this service. **Bronte Unit** Space to meet the demand on the service is very challenging. Action - looking at reconfiguring the existing unit. Additional storage area has been identified and the small office space will be given some natural lighting so that the admin function can be moved into this space which in turn will create more space in the unit itself.

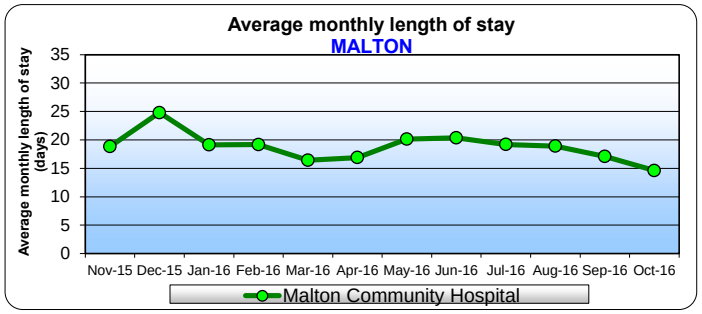
YORK - MATERNITY DASHBOARD			Measure	Data source	No Concerns (Green)	Of Concern (Amber)	Concerns (Red)	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Activity	Births	Bookings	1st m/w visit	CPD	≤302	303-329	≥330	309	276	319	294	294	277	255		
		Bookings <13 weeks	No. of mothers	CPD	≥90%	76%-89%	≤75%	88.7%	90.4%	84.6%	80.6%	83.7%	83.4%	85.5%		
		Bookings ≥13 weeks (exc transfers etc)	No. of mothers	CPD	< 10%	10.1%-19.9%	>20%	4.2%	3.6%	4.7%	4.1%	6.8%	6.9%	4.3%		
		Bookings ≥ 13wks seen within 2 wks	No. of mothers	CPD	≥90%	76%-89%	≤75%	92.30%	80.00%	66.70%	50.00%	85.00%	78.90%	63.60%		
		Births	No. of babies	CPD	≤295	296-309	≥310	249	292	282	291	290	298	303		
		No. of women delivered	No. of mothers	CPD	≤295	296-310	≥311	245	291	279	288	284	296	297		
	Closures	Homebirth service suspended	No. of suspensions	Comm. Manager	0-3	4-6	7 or more	0	0	0	0	0	0	0		
		Women affected by suspension	No. of women	Comm. Manager	0	1	2 or more	0	0	0	0	0	0	0		
		Community midwife called in to unit	No. of times	Comm. Manager	3	4-5	6 or more	10	2	4	5	5	9	5		
		Maternity Unit Closure	No. of closures	Matron	0		1 or more	0	0	0	0	0	0	1		
		SCBU at capacity of intensive cots	No. of times	SCBU	0	1	2 or more	2	6	4	5	0	0	0		
		SCBU no of babies affected	No. of babies affected	SCBU	0		1 or more	1	0	2	0	0	0	0		
Workforce	Staffing	M/W per 1000 births	Ratio	Matron	≥35.0	35-31	≤31.0	28	28	31	28	28	28	28		
		1 to 1 care in Labour	CPD	CPD	≥100%		<100%	72.7%	74.6%	74.9%	73.6%	72.9%	67.9%	67.8%		
		L/W Co-ordinator supernumary %	Shift Handover Sheets	Risk Team	≥100%		<100%	67.0%	63.0%	60.0%	61.2%	55.0%	43.0%	56.0%		
		Consultant cover on L/W	av. hours/week	DM / CD	40		≤39	76	76	76	76	76	76	76		
		Anaesthetic cover on L/W	av.sessions/week	DM / CD	10		≤9	10	10	10	10	10	10	10		
		Supervisor : M/w ratio	Ratio	Rota - Contact SOM	15	16-18	≥19	12	12	12	12	12	12	12		
Clinical Indicators	Neonatal/Maternal	Normal Births	No. of svd - %	CPD	≥60.6%	60.5-55%	<55%	68.1%	62.8%	65.0%	66.1%	66.0%	63.1%	62.6%		
		Assisted Vaginal Births	No. of instr. Births - %	CPD	≤13.2	13.3-17.9%	≥18%	9.4%	9.6%	12.2%	12.8%	11.3%	12.5%	14.5%		
		C/S Births	Em & elect - %	CPD	≤26%	26.1-27.9%	>28%	22.9%	27.1%	22.6%	21.2%	23.6%	24.7%	23.2%		
		Eclampsia	No. of women	CPD	0		1 or more	0	0	0	0	0	0	0		
		Undiagnosed Breech in Labour	No. of women	CPD	2 or less	3-4	5 or more	0	0	0	1	0	0	0		
		HDU on L/W	No. of women	LW Activity Sheet	3 or less	4	5 or more	17	14	7	14	8	29	20		
		BBA	No. of women	Risk Team - Datix	2 or less	3-4	5 or more	1	2	6	3	3	1	2		
		Diagnosis of HIE	No. of babies	SCBU Paed	0	1	2 or more	0	0	0	1	0	0	1		
	Morbidity	Neonatal Death	No of babies	Risk team- EBC	0		1 or more	0	0	0	1	0	0	0		
		Antepartum Stillbirth	No. of babies	Risk Team	0	1	2 or more	3	1	1	1	0	1	0		
		Intrapartum Stillbirths	No. of babies	Risk Team	0		1 or more	0	0	0	0	0	0	0		
	Risk Management	Breastfeeding Initiation rate	% of babies feeding at birth	CPD	>74.4%	74.3-70.1%	<70%	80.8%	76.6%	74.2%	76.7%	74.3%	75.7%	78.1%		
		Smoking at time of delivery	% of women smoking at del.	CPD	<11%	12-14%	>15%	9.4%	12.7%	10.4%	8.7%	10.2%	10.5%	8.4%		
		SI's	No. of Si's declared	Risk Team	0		1 or more	1	1	0	1	0	1	0		
		PPH > 1.5L	No. of women	CPD	2 or less	3-4	5 or more	9	9	4	9	3	9	9		
		PPH > 1.5L as % of all women	% of births	CPD				3.7%	2.9%	1.4%	3.1%	1.1%	3.0%	3.0%		
		Shoulder Dystocia	No. of women	CPD	2 or less	3-4	5 or more	3	2	3	3	1	1	1		
		3rd/4th Degree Tear	% of tears (vaginal births)	CPD	≤2.5%	2.6- 3.9%	≥4%	0.5%	1.5%	1.8%	3.0%	2.2%	1.3%	3.0%		
	New Complaints	Informal	No. of Informal complaints	Risk Matrix	0	1-4	5 or more	1	0	1	3	2	0	1		
		Formal	No. of Formal complaints	Risk Matrix	0	1-4	5 or more	1	0	2	3	3	1	0		

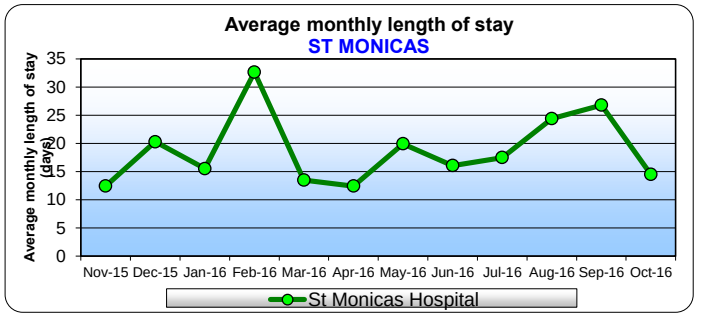
SCARBOROUGH - MATERNITY DASHBOARD			Measure	Data source	No Concerns (Green)	Of Concern (Amber)	Concerns (Red)	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Activity	Births	Bookings	1st m/w visit	CPD	≤210	211-259	≥260	174	198	212	193	217	191	124		
		Bookings <13 weeks	No. of mothers	CPD	≥90%	76%-89%	≤75%	88.5%	86.9%	83.5%	88.6%	92.6%	84.3%	88.7%		
		Bookings ≥13 weeks (exc transfers etc)	No. of mothers	CPD	< 10%	10%-20%	>20%	7.5%	11.1%	10.8%	8.3%	4.6%	11.0%	6.5%		
		Bookings ≥ 13wks seen within 2 wks	No. of mothers	CPD	≥90%	76%-89%	≤75%	77%	100%	83%	63%	90%	100%	100%		
		Births	No. of babies	CPD	≤170	171-189	≥190	118	148	134	135	141	154	135		
		No. of women delivered	No. of mothers	CPD	≤170	171-189	≥190	115	148	134	135	140	152	133		
	Closures	Homebirth service suspended	No. of suspensions	Comm. Manager	0-3	4-6	7 or more	2	1	0	0	1	0	0		
		Women affected by suspension	No. of women	Comm. Manager	0	1	2 or more	0	0	0	0	0	0	0		
		Community midwife called in to unit	No. of times	Comm. Manager	3	4-5	6 or more	0	0	0	0	1	0	0		
		Maternity Unit Closure	No. of closures	Matron	0		1 or more	0	0	0	0	0	0	0		
		SCBU at capacity	No. of times	SCBU	0	1	2 or more	9	5	8	3	11	7	8		
		SCBU no of babies affected	No. of babies affected	SCBU	0		1 or more	0	0	2	1	6	0	2		
Workforce	Staffing	M/W per 1000 births	Ratio	Matron	≥35.0	35-31	≤31.0	39.4	38.3	38.1	38.0	38.8	38.5	40.2		
		1 to 1 care in Labour	CPD	CPD	≥100%		<100%	89.6%	84.0%	85.1%	85.9%	87.1%	92.8%	92.5%		
		L/W Co-ordinator supernumary %	Shift Handover Sheets	Risk Team	≥100%		<100%	87%	80%	85%	81%	91%	70%	89%		
		Consultant cover on L/W	av. hours/week	DM / CD	40		≤39	40	40	40	40	40	40	40		
		Anaesthetic cover on L/W	av.sessions/week	DM / CD	10		≤9	3	3	3	3	3	3	3		
		Supervisor : M/w ratio	Ratio	Rota - Contact SOM	15	16-18	≥19	12	12	12	12	12	12	12		
Clinical Indicators	Neonatal/Maternal	Normal Births	No. of svd - %	CPD	≥60.6%	60.5-55%	<55%	66.9%	74.3%	63.2%	67.4%	70.9%	72.7%	67.2%		
		Assisted Vaginal Births	No. of instr. Births - %	CPD	≤13.2	13.3-17.9%	≥18%	11.3%	9.5%	7.5%	8.1%	7.1%	5.3%	7.5%		
		C/S Births	Em & elect - %	CPD	≤26%	26.1-27.9%	>28%	22.6%	16.2%	29.9%	24.4%	22.1%	22.4%	25.6%		
		Eclampsia	No. of women	CPD	0		1 or more	0	0	0	0	0	0	0		
		Undiagnosed Breech in Labour	No. of women	CPD	2 or less	3-4	5 or more	0	0	0	0	2	1	0		
		HDU on L/W	No. of women	LW Activity Sheet	3 or less	4	5 or more	1	4	2	8	4	5	2		
		BBA	No. of women	Risk Team - Datix	2 or less	3-4	5 or more	1	1	1	3	3	1	1		
		Diagnosis of HIE	No. of babies	SCBU Paed	0	1	2 or more	1	0	0	0	0	0	0		
	Morbidity	Neonatal Death	No of babies	Risk team- EBC	0		1 or more	0	0	0	1	0	0	0		
		Antepartum Stillbirth	No. of babies	Risk Team	0	1	2 or more	0	2	0	0	1	0	0		
		Intrapartum Stillbirths	No. of babies	Risk Team	0		1 or more	0	0	0	0	0	0	0		
	Risk Management	Breastfeeding Initiation rate	% of babies feeding at birth	CPD	>74.4%	74.3-70.1%	<70%	58.3%	60.8%	61.9%	60.7%	57.9%	55.3%	63.2%		
		Smoking at time of delivery	% of women smoking at del.	CPD	<11%	12-14%	>15%	23%	20%	22%	20%	18%	25%	18%		
		SI's	No. of Si's declared	Risk Team	0		1 or more	0	0	0	1	0	0	1		
		PPH > 1.5L	No. of women	CPD	2 or less	3-4	5 or more	2	3	1	6	1	5	2		
		PPH > 1.5L as % of all women	% of births	CPD				2	2	0	4	1	3	2		
		Shoulder Dystocia	No. of women	CPD	2 or less	3-4	5 or more	2	1	0	2	0	0	2		
		3rd/4th Degree Tear	% of tears (vaginal births)	CPD	≤2.5%	2.6- 3.9%	≥4%	2.2%	1.6%	0.0%	2.0%	2.7%	3.3%	1.0%		
	New Complaints	Informal	No. of Informal complaints	Risk Matrix	0	1-4	5 or more	0	0	0	0	1	2	1		
		Formal	No. of Formal complaints	Risk Matrix	0	1-4	5 or more	1	1	0	2	1	0	0		

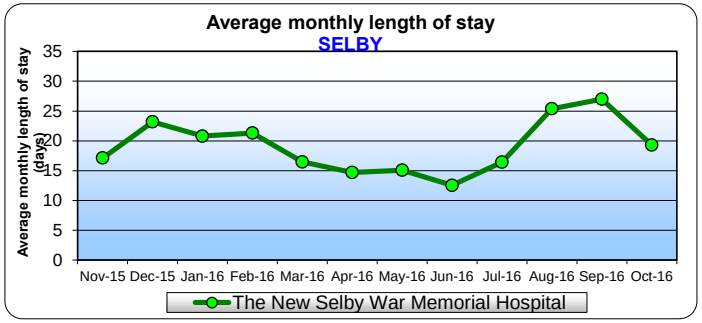
Community Hospitals

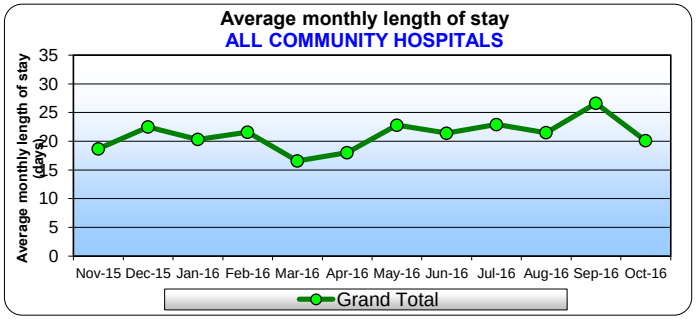
Indicator	Hospital	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Aug	Sep	Oct
Community Hospitals average length of stay (days) Excluding Day cases	**Archways**	21.2	21.1	21.7	26.2	25.1	33.2	22.0
	Malton Community Hospital	19.1	18.2	18.8	18.5	18.9	17.1	14.6
	St Monicas Hospital	16.7	18.9	16.4	22.7	24.4	26.8	14.5
	The New Selby War Memorial Hospital	19.9	19.5	14.1	23.0	25.4	27.0	19.3
	Total	22.6	22.8	20.6	23.7	21.5	26.6	20.1





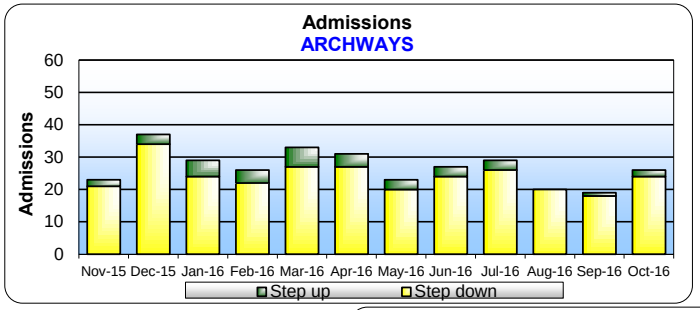


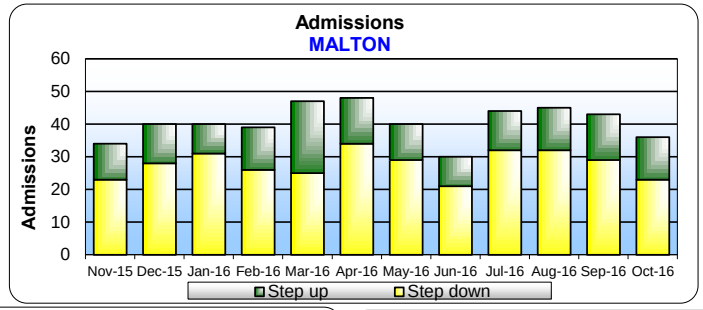


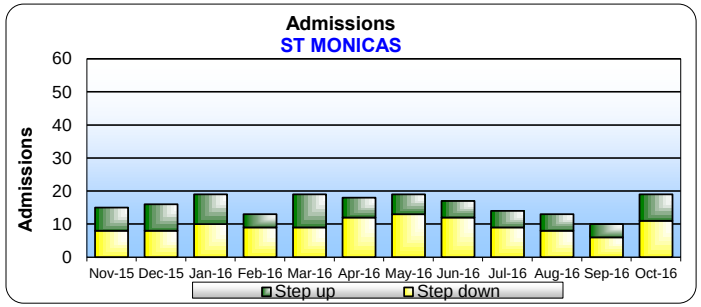


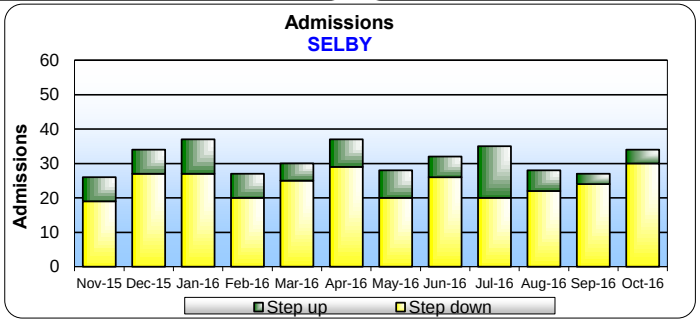
Community Hospitals

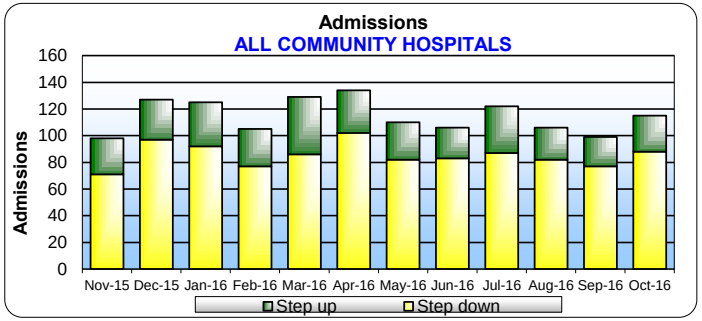
Indicator	Hospital		Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Aug	Sep	Oct
Community Hospitals admissions Please note: Patients admitted to Community Hospitals following a spell of care in an Acute Hospital have the original admission method applied, i.e. if patient is admitted as a non-elective their spell in the Community Hospital is also non-elective.	**Archways**	**Step up**	12	15	10	4	0	1	2
		Step down	77	73	71	64	20	18	24
	Malton Community Hospital	**Step up**	41	44	34	39	13	14	13
		Step down	84	82	84	93	32	29	23
	St Monicas Hospital	**Step up**	23	23	17	14	5	4	8
		Step down	30	28	37	23	8	6	11
	The New Selby War Memorial	**Step up**	27	22	22	24	6	3	4
		Step down	69	72	75	66	22	24	30
	Total	**Step up**	103	104	83	81	24	22	27
		Step down	260	255	267	246	82	77	88











Quality and Safety: Misc.

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Aug	Sep	Oct
All Patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days	Non-payment of costs associated with cancellation and non- payment or reimbursement (as applicable) of re-scheduled episode of care	**0**	8	4	13	2	1	1	1
No urgent operation should be cancelled for a second time	£5,000 per incidence in the relevant month	**0**	0	0	0	0	0	0	0
Sleeping Accommodation Breach	£250 per day per Service User affected	**0**	0	3	0	0	0	0	0
% Compliance with WHO safer surgery checklist	No financial penalty	**100%**	100%	100%	100%	100%	100%	100%	100%
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	**99%**	99.8%	99.9%	99.9%	To follow	99.8%	To follow	To follow
Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	**95%**	98.4%	99.0%	98.8%	To follow	98.6%	To follow	To follow
Failure to ensure that 'sufficient appointment slots' are made available on the Choose and Book System	General Condition 9	**>4% slot unavailability if utilisation >90% >6% unavailability if utilisation <90%**	n/a	4.1%	5.0%	n/a	6.0%	n/a	n/a
Delayed Transfer of Care – All patients medically fit for discharge and issued a 'notification notice' as per joint protocol for the transfer of care	As set out in Service Condition 3 and General Condition 9	**Set baseline in Q1 and agree trajectory**	Monthly Provider Report						
Trust waiting time for Rapid Access Chest Pain Clinic	General Condition 9	**99%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Stroke Performance against Sentinel Stroke National Audit Programme (SSNAP)	As set out in Service Condition 3 and General Condition 9	**Best Practice Standards**	Quarterly summary of performance against SSNAP indicators as submitted to RCP. Stroke service exception action plan to be produced and tabled at sub CMB quarterly.						
Number/Percentage women who have seen a midwife by 12 weeks and 6 days (as per IPMR definition)	General Condition 9	**90%**	99.7%	99.2%	99.8%	n/a	99.8%	99.8%	99.5%
Number/Percentage of maternity patients recorded as smoking by 12 weeks and 6 days that are referred to a smoking cessation service subject to patient consent	General Condition 9	**95%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
All Red Drugs to be prescribed by provider effective from 01/04/15, subject to agreement on list	Recovery of costs for any breach to be agreed via medicines management committee	**100% list to be agreed**	CCG to audit for breaches						
All Amber Drugs to be prescribed as per shared care guidelines from 01/04/15	Recovery of costs for any breach to be agreed via medicines management committee	**100% list to be agreed**	CCG to audit for breaches						

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 November 2016

Medical Director's Report

Action requested/recommendation

Board of Directors are requested to:

- Consider the summary reports and learning from recent serious incidents
- Be aware of waiting lists in ophthalmology
- Encourage staff to have the influenza vaccination
- Discuss the revision of mortality review process
- Note the consultants new to the Trust
- Consider the update on progress with the antimicrobial CQUIN
- Be aware of Duty of Candour requirements.

Summary

This report provides an update from the Medical Director on Patient Safety related issues.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

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

Progress of report	This report is only written for the Board of Director's.
Risk	No additional risks have been identified other than those specifically referenced in the paper.
Resource implications	None identified.
Owner	Mr James Taylor, Medical Director
Author	Diane Palmer, Deputy Director of Patient Safety
Date of paper	November 2016
Version number	Version 1

Board of Directors – 30 November 2016

Medical Director's Report

1. Introduction and background

In the report this month:

Patient Safety-

- Influenza Campaign
- Mortality review
- Waiting lists in ophthalmology

Clinical Effectiveness-

- Consultants new to the Trust
- Antimicrobial CQUIN progress

Patient Experience-

- Duty of Candour.

2. Patient Safety

2.1 Influenza Campaign - update

Phase 1 & 2 of the influenza plan ended on 31 October 2016. This included super vaccination clinics held in York, Scarborough & Bridlington condensed over a four week period, primarily ring fenced to frontline healthcare workers. A two week period of vaccination centres held in community areas was also incorporated within this timescale.

Phase 3 of the campaign commenced 1 November 2016 offering the vaccine to all Trust staff at 'drop in' clinic sessions.

The influenza plan outlined a time limited period for staff to access the vaccine; the end of November concludes the programme.

During November:

- All unvaccinated frontline staff will receive an email to remind them to attend for vaccine. The reminder will include a request for all staff vaccinated elsewhere to inform the OH&WBS via an email link.
- 'Drop in' clinic sessions planned for November in York, Scarborough & Bridlington will continue.
- The OH&WBS to maintain an 'all contacts count' approach for staff to access the vaccine.

Frontline staff vaccinated up to and including 04/11/2016 = **3,028**

This equates to an uptake of **49%**

To reach the 75% target we must vaccinate a further **1,579** staff

2.2 Revision of mortality review proforma & processes

The Trust is an early implementer site for the new national mortality review programme which includes mortality screening and in-depth independent case note review in some instances.
To support this programme a revised mortality review proforma has been drafted (Appendix 1) to simplify the process but also to facilitate decision making where an in-depth review may be necessary.
The draft proposed process is attached as Appendix 2 for discussion.

2.3 Waiting lists in ophthalmology

As a result of changes to requirements for surveillance, some historical process failings with appointment systems and failure to recruit to senior clinician vacancies, there is a risk of patient harm caused by delays in follow up appointments within the Ophthalmology Service. The patient risk could be significant and specifically may result in loss of patient sight.

Strategies to reduce the risk have been proposed following serious incident analysis and due to the level of risk and continued concern this remains on the Corporate Risk Register.

3. Clinical Effectiveness

3.1 Consultants new to the Trust

The following consultants jointed the Trust in October:

Greg Heath
Consultant Ophthalmologist
York

Sundeep Sandhu
Consultant Paediatrics
York

3.2 Antimicrobial CQUIN 4a & 4b – progress update

The current national CQUIN 'Reduction in antibiotic consumption' tasks each acute trust with reducing antibiotic consumption by at least 1% on selected classes of antibiotics as follows:

1. Reducing total antibiotic consumption per 1,000 admissions
2. Reducing consumption of carbapenems per 1,000 admissions
3. Reducing consumption of piperacillin-tazobactam per 1,000 admissions.

Currently, we are on track with 1 and close to target with 2. Our Trust is a very low user of carbapenems – of the Trusts who have submitted their data to Public Health England, we are currently the 4th lowest in the country in this indicator (we are also the 4th lowest for total antibiotic use). This makes it challenging to reduce carbapenem usage as it is already closely monitored. Our plan for this part of the indicator is to target early review of patients on these agents, with the goal of shortening course lengths or de-escalating therapy as soon as possible. To help this we have recently increased the frequency of our consultant microbiologist ward rounds from once to twice per week.

However in relation to the 3rd aspect of the CQUIN indicator, piperacillin-tazobactam is commonly used in the Trust and we are currently running at a 15% increase from our baseline year. To have a realistic chance of meeting this target we would need to change our antibiotic guidelines to reduce the number of infections for which piperacillin-tazobactam is indicated for empiric treatment (treatment started quickly, prior to culture results being available).

Unfortunately, our preferred option (aztreonam) in place of piperacillin-tazobactam has been

out-of-stock from the manufacturers for some months now, possibly partly due to increased national demand caused by the national CQUIN. Although was can get small amounts of stock on a named-patient basis the supply chain is not robust enough at present to enable a full change.

Our second option (temocillin) would present a significant cost pressure. The current daily cost of piperacillin-tazobactam is £3.24. The daily cost of temocillin is £71.28 and a second antibiotic would also need to be combined with it for some indications (piperacillin-tazobactam can be used alone for most infections).

In the first six months of this year we have used 10,520 vials of piperacillin-tazobactam, which equates to 3,507 days treatment. In those six months, if we had swapped half of our piperacillin-tazobactam days to temocillin it would have cost approximately an additional £120,000 or if we had swapped one third it would have cost an additional £80,000. This does not include any estimated costs for additional antibiotics required.

4. Patient Experience

4.1 Duty of Candour

The duty of candour was been imposed by law on NHS bodies and is an integral part of our culture of honesty and openness locally.

The requirements are that patients and their families:

- are told about serious (those graded moderate or serious harm or death) incidents that affect them
- receive appropriate apologies
- are kept informed of investigations
- are supported to deal with the consequences.

Incidents relevant to the duty of candour are:

- Any patient incident that results in a moderate increase in treatment (e.g. increase in length of hospital stay by 4-15 days) and which caused significant but not permanent harm, including psychological harm for a minimum of 28 continuous days to one or more persons receiving NHS care.
- Any patient incident that appears to have resulted in permanent harm to one or more persons receiving NHS care.
- Any patient safety incident that directly resulted in the death of one or more persons receiving NHS care.

Specifically the statutory duty requires that where a notifiable safety incident has occurred the Trust must, as soon as reasonably practicable:

- notify the patient in person that the incident has occurred and *apologise*
- provide a true, clear account of all the facts known about the incident
- advise the patient of what further enquires and actions into the incident are planned
- provide support to the patient
- follow up with a written notification of the incident an apology and the results of further enquires and actions.

Results from a recent internal audit have indicated that there is limited evidence that we are meeting the requirements related to written notification of the incident. Therefore Executive

Board are reminded that the discussion (verbal notification) must be followed up in writing using the template letter available from the Risk and Legal Department and should include:

- a brief account of the incident
- an apology
- details and results of further enquiries and actions

A copy of the written notification should be attached to the incident reporting (Datix) form.

5. Recommendations

Board of Directors are requested to:

- Encourage staff to have the influenza vaccination
- Discuss the revision of mortality review process
- Waiting lists in ophthalmology
- Note the consultants new to the Trust
- Consider the update on progress with the antimicrobial CQUIN
- Be aware of Duty of Candour requirements.

Author	**Diane Palmer, Deputy Director of Patient Safety**
Owner	**Mr James Taylor, Medical Director**
Date	**November 2016**

York Teaching Hospital NHS
NHS Foundation Trust

FIRST NAME:	SURNAME:
DOB:	HOSP NO:
N.H.S NO:	

Mortality Review Proforma

Date of admission:	Time of admission (to organisation)	Date of death:

Ward stays (include consultant care)

Did patient have appropriate reviews? Y ☐ N ☐	Appropriate ward / wards during stay? Y ☐ N ☐
Patient under the care of the appropriate clinical speciality? Y ☐ N ☐	
Admitting Diagnosis:	
Main condition being treated if different from admitting diagnosis:	
Certified cause of death:	
Do you agree with the certified cause of death? Y ☐ N ☐	
If not, please indicate the cause of death in your opinion:	
Referral to coroner? Y ☐ N ☐	If no would this have been appropriate? Y ☐ N ☐
Post Mortem examination? Y ☐ N ☐	
Was key treatment initiated promptly (e.g., antibiotics / fluids / chest drain)? Y ☐ N ☐ N/A ☐	
Is there evidence of appropriate clinical decision making? Y ☐ N ☐ N/A ☐	
Were agreed pathways followed where appropriate? (e.g Trust Guidelines / Care Bundles for Stroke / Sepsis / Pneumonia etc.) Y ☐ N ☐ N/A ☐	
Failure to recognise deterioration? Y ☐ N ☐	Failure to escalate? Y ☐ N ☐

DNACPR in place? Y ☐ N ☐	Ceiling of care / end of Life care defined? Y ☐ N ☐

Is there anything that could have been done differently / what went well?

For cases requiring mandatory reporting such as:
Learning Disabilities
Elective admissions
Reported as a serious incident
Requiring an inquest
These must have an in depth case note review completed.

Avoidability of death judgement score:

We are interested in your view on the avoidability of death in this case.
Please choose from the following scale/score

1. Definitely avoidable
2. Strong evidence of avoidability
3. Probably avoidable, >50 – 50
4. Possibly avoidable but unlikely, <50-50
5. Slight evidence of avoidability
6. Definitely not avoidable

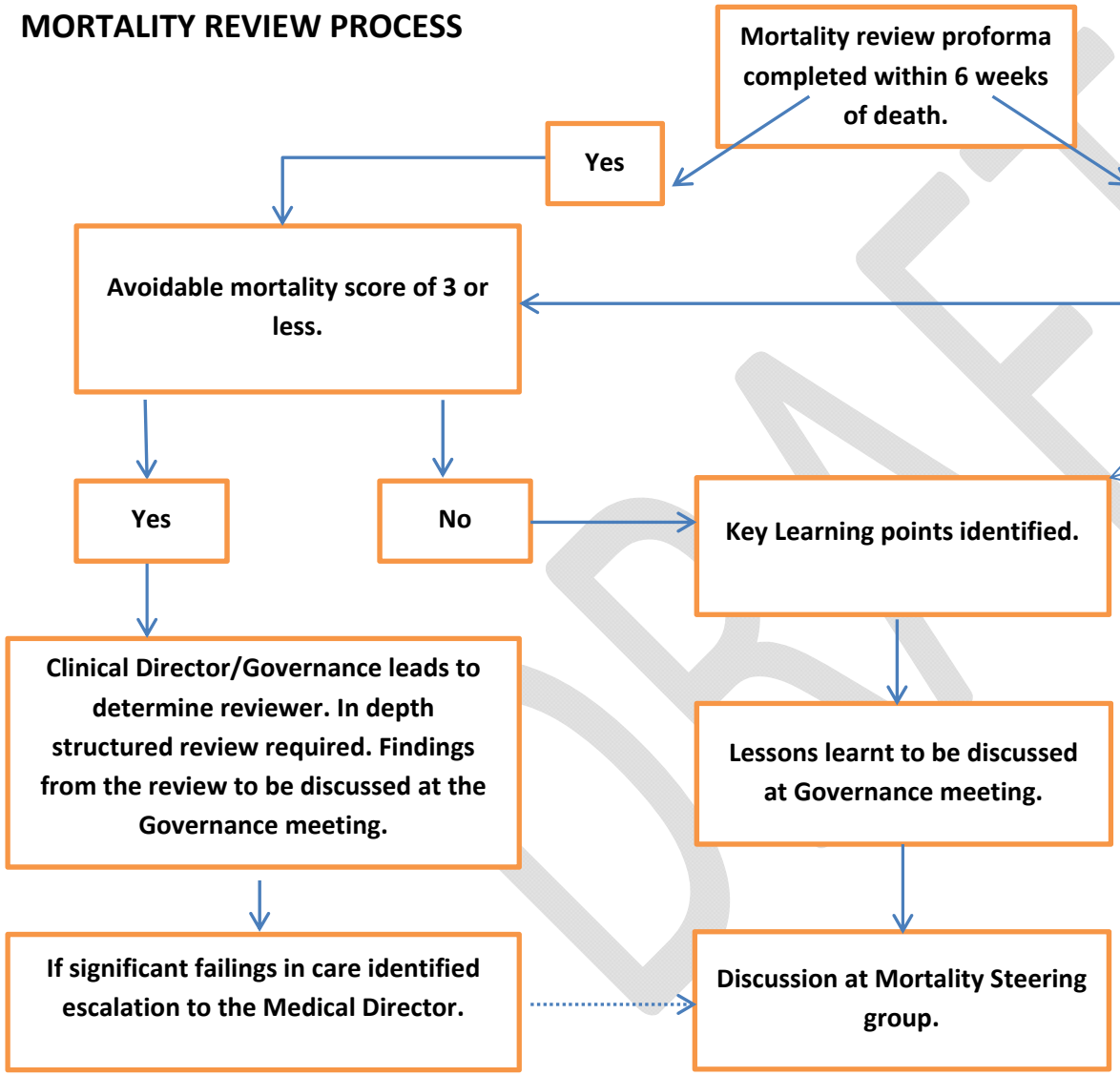
Definitely or probably avoidable Y ☐ N ☐

Name of person completing form:	
Signature:	Date review completed:

Appendix 2

York Teaching Hospital NHS
NHS Foundation Trust

MORTALITY REVIEW PROCESS



Avoidability of death judgement score:

1. Definitely avoidable
2. Strong evidence of avoidability
3. Probably avoidable, >50 – 50
4. Possibly avoidable but unlikely
5. Slight evidence of avoidability
6. Definitely not avoidable

Mortality review process v2 July 2016-H.Noble Head of Patient Safety

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 November 2016

Chief Nurse Report

Action requested/recommendation

The Board is asked to note the report.

Executive Summary

The Chief Nurse report provides information on progress towards the delivery of our quality priorities, updates on the implementation; and highlights any risks to delivery of the Nursing & midwifery and Patient Experience Strategies.

The nursing and midwifery strategy has four main focus areas:

- Patient experience
- Patient safety
- Measuring the impact of care delivery
- Staff experience

The nursing dashboard gives an overview of the quality of care delivered across the organisation and identifies key risks.

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

Implications for equality and diversity

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

It is anticipated that the recommendations of this paper are not likely to have

any particular impact upon the requirements of or the protected groups identified by the Equality Act.

Reference to CQC regulations

There are no references to CQC regulations direct from this update report.

Progress of report	Executive Board Quality and Safety Committee Board of Directors
Risk	No risk.
Resource implications	No resource implications.
Owner	Beverley Geary, Chief Nurse
Author	Beverley Geary, Chief Nurse
Date of paper	November 2016
Version number	Version 1

Board of Directors – 30 November 2016

Chief Nurse Report

1. Background

The Chief Nurse report provides information on progress towards the delivery of our quality priorities, updates on the implementation; and highlights any risks to delivery of the Nursing & midwifery and Patient Experience Strategies.

The nursing and midwifery strategy has four main focus areas:

- Patient experience
- Patient safety
- Measuring the impact of care delivery
- Staff experience

The nursing dashboard (appendix 1) gives an overview of the quality of care delivered across the organisation and identifies key risks.

2. Patient Safety

2.1 Nursing and Midwifery Staffing

The newly registered nurses have continued to arrive during October 2016, improving our staff in post position. At the end of October 2016, there were 105.5fte RN vacant posts and, 75.68fte Care Staff positions. Of these, 35.19fte RN posts and 75.72fte Care Staff posts have been recruited and the individuals will commence in post over the coming months. The remaining RN vacancy position is 70.31fte and 4.08fte for Care Staff.

Registered nurse recruitment is on-going across the Trust and at the Recruitment Market Place held in Scarborough on 13th October 2016 over 20 people were interviewed for Nursing positions at the Trust. A number of these were final year nursing students who are seeking employment from September 2017 onwards.

The Trust will be undertaking further Care Staff interviews during November with expected start dates in early 2017.

The Trust is also commencing with its 2017 nurse recruitment campaign including attendance at recruitment fairs during November and the winter months as well as holding bespoke recruitment for post-graduate diploma nursing students on 17th November

The Safer Staffing return for October 2016 is detailed in a separate paper and includes Care Hours per Patient Day, a new metric introduced in the Lord Carter Report.

CHPPD
At a recent meeting of Directors of Nursing NHSI fed back some of the findings of their data collection of CHPPD.

This is currently being collected nationally (via unify) and whilst the information is available no one is being performance managed or benchmarked.

Their findings are that there is some significant variability across wards; which is to be expected (ITU) and work has now begun to comparing like with like (for example T&O).

It was acknowledged that in order to get the right CHPP acuity should be assessed and it is key to have accurate rostering.

Much more work is planned around CHPPD which will be led by NHSI, this will include effective rostering and 'what good looks like'

2.2 Nurse Rostering project

A number of ward level 'deep dives' into rostering practice have been completed. Improvements are required; for example:

- Management of annual leave and study leave
- Under / over rostering
- Staff owing hours whilst working on the bank
- Equity in the application of the flexible working policy
- Creation of additional duties

The duty rota policy review has now commenced and the initial meeting with HR and staff side colleagues has taken place.

2.3 Nursing Associate

The Trust has been identified as a 'fast follower' site for the national pilot of the Nursing Associate role. This is an exciting opportunity for us to participate and influence the future role which will supplement the registered nursing workforce. A steering group has been established to oversee the development of the programme and the recruitment to a cohort of trainees. A national job description and curriculum framework is being developed and discussions are on-going at parliament level around regulation of the role.

2.4 Maternity

Maternity Dashboard
The Yorkshire and Humber Clinical Network commenced a regional maternity dashboard a year ago. An event was held in Leeds in October 2016 to review the current dashboard and definitions for collection of data and consider how this will feed into national work on maternity dashboards (as recommended in the National maternity review report, Better Births)

A regional dashboard group has formed to undertake this work. The Head of Midwifery is a member of this group and has requested that Trusts in Yorkshire and the Humber share their data (named) in order to benchmark and share good practice and learning.

Maternity services have received Quarter 1 regional data 2016/17 and regularly review the local maternity dashboard data. Of note on the maternity dashboards;

Stillbirths
The number of stillbirths per 1000 births fell by 50% in 2015, the rate in Quarter 1 is 2.6 per 1000 which is below the regional average of 4.4 per 1000.
Work continues implementing the national stillbirth care bundles;

1. Reducing smoking in pregnancy

2. Risk assessment and surveillance for fetal growth restriction

3. Raising awareness of reduced fetal movement

4. Effective fetal monitoring during labour

The Supervisors of Midwives had a Local Supervising Authority (LSA) annual audit
This statutory audit was undertaken by a team on Wednesday 9 November. The LSA Midwifery Officer audited the supervisors function against the NMC midwives rules and standards.
Verbal feedback on the day was very positive. Highlights included:

The Supervisors of Midwives work very well together as one team covering York and Scarborough sites.
Overall very good rating against the NMC standards. Mainly green; two amber.
The 2 amber rating were a Trust policy which was found to be out of date and the Supervisors personal record of activity on the database not fully completed in each case.

Feedback from women questioned on the day regarding care received was excellent with confidence in the service, supportive in choice, quote; 'amazing' 'brilliant' and all aware of the role of the Supervisor of Midwives and how to contact them.

Midwives and students valued the support of the Supervisors however recognised the uncertainty of the future role in 2017 when Supervision of midwives is removed from statute. It was recognised that morale can be low at times and shortfalls in staffing levels can affect this.

A notes audit was carried out with results to follow.

A draft report will be submitted in 4 to 6 weeks

The Head of Midwifery annual report will be submitted in January 2017 to provide a full review of 2016 and include an updated workforce strategy.

2.5 Medicines Management

During November the Matrons will be undertaking a comprehensive audit of missed doses of medication. This audit builds on the data collected as part of safety thermometer and actions following this audit will be managed through the Nursing and Midwifery Medicines Management Group.

A task and finish group comprising trust wide nursing and pharmacy representatives are commencing working to provide greater clarity on ward based controlled drug processes and practice.

2.6 Internal Audit

A programme of internal audit is agreed annually in order to provide assurance to the committee and Board of Directors. Working with Senior Managers the audit team identify areas of risk or concerns to be included in internal audits. This approach aims to identify current strengths and weaknesses and gives an opinion of assurance with agreed parameters. In addition recommendations are given as to actions that should be completed within an agreed timeframe to give full assurance.

A briefing on recent audits that have been undertaken on behalf of the Chief Nurse with areas of

good practice and those for improvement is included at appendix 2

3. Effectiveness

3.1 Healthcare Associated Infection (HCAI)

HCAI incidence continues on a downward trend towards national and regional means with the exception of MRSA bacteraemia, currently at 6 cases against a target of 0. Further IP reduction initiatives have been developed and are in place alongside staff briefing via PNLF, Senior Nurse meetings, Ward Safety Briefings and HUB events. Daily follow up of all cases of MRSA, including those colonised to enable monitoring of implementation and compliance

MSSA incidence
Whilst the incidence of MSSA bacteraemia continues to reduce we are still at 29 cases against a target of 30. However, Post Infection Reviews indicate that 75% of trust attributable MSSA bacteraemia is unavoidable and not demonstrably linked to invasive devices or procedures. The common unifying theme is significant skin conditions such as dermatitis, pruritus, chronic skin lesions and lower limb oedema; this is usually in association with other serious comorbidities.'

CDifficile
The current incidence of CDI is 15 cases against a target of 48,
Post Infection Reviews demonstrate the 6 cases so far have been deemed unavoidable by the CCG (no lapses in care) 6 cases were assessed as avoidable in relation to delay in sampling and inappropriate use of antimicrobials.

MRSA
The committee are aware that we have found an increased incidence (on screening) of MRSA in SCBU on York site. A major work-stream to identify potential causation and to agree and monitor actions has been on-going and carefully monitored. There have been no further cases since 12th September therefore it was agreed at the IP Steering group that the outbreak is officially closed and a reflection and lessons learned session take place. Decant and refurbishment proposal currently being evaluated by Capital Projects Management Team following Options Appraisal by the Directorate

Fit testing
A fit testing programme is in place across emergency admission areas by IPT, supported by a staff nurse from medicines management to ensure both staff and patient safety. There is a detailed action plan in place to monitor progress and sustainability.

4. Patient Experience

Friend and Family Test
The Trust continues to meet our target for 90% of patients to recommend the Trust. The inpatient recommend rate was 97.2% compared to a national average of 95%.

The ED recommend rate was 84.9% compared to a national average of 87%. The Scarborough ED % recommend rate remains lower than York at 76%. This has been flagged to the ED team – narrative comments indicate the majority of dissatisfaction is linked to waiting times and communication whilst waiting.

The response rate for inpatients in September 2016 is 27.9% (up from 25.2% in August). The national average inpatient response rate is 25.2%. Scarborough response rates have risen

significantly to 27% (from 13.8% in August). The ED response rate is 16.3% (national average 13.7%).

Themes from the September FFT results include food (particularly meeting specialist dietary requirements, eg diabetic or gluten free); noise; access to toilets and comments about agency staff. These are shared with sisters and matrons to be handled at ward-level.

The ADN for Community has set up a Task and Finish Group with the Patient Experience Team, Locality Managers and Community Team Leaders to look at a model for Community across District Nursing, Rapid Response Teams and Community Specialist Nursing Teams.

Complaints
The draft of a new Policy for Handling Complaints and Concerns has been approved by Patient Experience Steering Group subject to consultation with directorate managers regarding the supporting procedure. Engagement with directorate managers is on-going regarding their role in the process, particularly regarding quality checking responses.

The top two directorates receiving complaints in October were: Emergency Department (10) and Trauma and Orthopaedics (5). There are no clear themes across this month's complaints and concerns for Trauma and Orthopaedics.

ED has received a higher than usual number of complaints (10 in total - 5 York, 5 Scarborough). Themes include missed fractures and missed diagnosis. There are 2 Scarborough complaints from patients who were sent home from ED then subsequently readmitted with acute appendicitis. This follows 2 similar complaints (1 York and 1 Scarborough) in July and August.

The Parliamentary and Health Service Ombudsman will be publishing a national report covering learning from 100 complaints against NHS Trusts. One of these complaints relates to care provided by York Hospital in January 2014 to a patient admitted with respiratory problems. The patient's wife complained that the Trust did not follow the recommendations of the admitting consultant and that the medical treatment he received was inadequate and contributed to his death. The complaint was partially upheld by the Ombudsman who found that there were failings in care and treatment which caused distress to the patient, but that his death could not have been avoided. A comprehensive action plan was completed and accepted by the Ombudsman.

PALS

The PALS team have now moved to the new office on the main corridor of York Hospital. This now provides a private meeting space for patients or families to speak to a PALS adviser. A large notice board is being produced which will advertise PALS and provide some *you-said-we-did* examples.
A second meeting of the PALS review group has taken place place. The group agreed a plan for the internal and external re-launch of PALS. It was agreed the re-launch would be in Q4 2016-17 and that the immediate focus would be to revise the information leaflets and web information about PALS. This would be done in conjunction with Healthwatch and include accessible versions. A review of PALS advertising at Scarborough, Bridlington and for community patients would be completed.

Volunteers
The Volunteering Service team are moving over from their manual process of recruitment to the Trust's new TRAC system. The next cohort recruitment in January will be through TRAC. This will improve the processing times.

Volunteering is also moving from an excel spread-sheet to a volunteering module within the

Harlequin database (used to manage our Fundraising Service) in November. The volunteering module will allow us to accurately and consistently (across sites) record information on our volunteers and also highlight areas where there are gaps in provision. The module will allow us to understand the value that volunteers bring and the costs saved by their service to the Trust.

The Night Owl initiative
This initiative was launched in September 2016. Each ward has been asked to discuss as a team how they can reduce noise and make a pledge; which will then be displayed on a poster on the ward. Wards are being encouraged to look at all feedback from patients, including Friends and Family Test results, to identify the main sources of noise and monitor their success in reducing it.

The York Hospital Charity has funded 1000 sleep packs (eye masks and ear plugs) to be offered to patients struggling to sleep. Friends of York Hospital has funded a further 1000 packs.

To date: 701 sleep packs have been distributed (with good feedback from the wards involved); 32 wards have made pledges (18 York, 3 Community and 11 Scarborough/Bridlington).

Safegaurding Adults Ward Wanders
Building on the success of the ward wanders to raise the awareness of the Deprivation of Liberty the programme has re-commenced. The Ward Wanders aim to provide wards with on the spot advice and support with Safeguarding Adults, Mental Capacity Act, Deprivations of Liberty Safeguards and Learning Disability Awareness. They will run on a monthly basis covering Scarborough and York Wards. There are plans to look to ways to expand this to community services.

5. Recommendation

The Board is asked to note the Chief Nurse Report for November 2016.

Author	**Beverley Geary, Chief Nurse**
Owner	**Beverley Geary, Chief Nurse**
Date	**November 2016**

Nursing Dashboard - Trustwide

York Teaching Hospital NHS
NHS Foundation Trust

		Metric	Measure	Data Source	Trajectory	RAG	Cumm. Total (Financial Year	Nov	Dec	Jan	Feb	March	April	May	June	July	August	September	October
Patient Safety	Pressure Ulcers	PURP Overall	No. of Patients (PP)	Safety Thermometer - New PU				18	16	15	16	21	8	17	16	13	9	15	17
		Cat 4	No. of Patients (PP)	Safety Thermometer - New PU				0	0	0	2	0	1	1	1	1	0	0	0
		Cat 3	No. of Patients (PP)	Safety Thermometer - New PU				4	3	1	5	1	2	3	4	1	1	2	3
		Cat 2	No. of Patients (PP)	Safety Thermometer - New PU				12	9	8	7	17	3	10	4	6	4	11	7
		Unstageable	No. of Patients (PP)	Safety Thermometer - New PU				2	4	6	2	3	2	3	7	5	4	1	7
		Deep Tissue Injury	No. of Patients (PP)	Safety Thermometer - New PU				0	0	0	0	0	0	0	0	0	0	1	0
	Falls	Falls	No. of Patients (PP)	Safety Thermometer - FALLS				33	31	28	36	35	21	31	32	27	20	28	23
		Falls With Harm (Moderate/Severe)	No. of Patients (PP)	Safety Thermometer - FALLS				4	0	0	0	0	1	0	1	1	2	3	0
	Safety Thermometer	Safety Thermometer Overall (Harm Free Care)	%	Safety Thermometer -CQUIN HARM FREE %	95%	Red		94.28	92.79	94.4	95.99	94.13	95.52	95.33%	95.33%	94.31%	95.07%	94.71%	95.15%
	Catheter acquired UTI	New UTI	No. of Patients (PP)	Safety Thermometer - UTI - NEW UTI				17	21	20	17	19	19	19	14	17	17	15	19
	Critical Missed Meds	Critical Missed Meds	No. of Patients (PP)	Safety Thermometer - OMITTED CRITICAL MEDS				12	10	19	18	14	21	16	13	8	18	17	15
	Drug Errors			Datix												89	135	101	133
	NEWS			Signal						87.20%	85.60%	85.20%	86.80%	87.60%	87.40%	87.70%	87.80%	88.10%	87.90%
	Deep Vein Thrombosis	New DVT	No. of Patients (PP)	Safety Thermometer - VTE Treatment Type				3	3	1	0	6	8	1	0	0	0	0	2
	Pulmonary Embolism	New PE	No. of Patients (PP)	Safety Thermometer - VTE Treatment Type				2	3	2	3	1	2	1	3	2	2	1	3
	VTE Other	VTE Other	No. of Patients (PP)	Safety Thermometer - VTE Treatment Type				0	1	0	1	4	0	0	0	0	0	0	0
Workforce	Vacancies	Inpatient area vacancies -RN (month end)	Number	CN Team				127.31	158.87	125.36	128.13	147.27	120.72	133.76	130.35	142.28	149.99	141.91	105.5
		Inpatient area vacancies - HCA (month end)	Number	CN Team				34.15	31.05	55.57	58.53	34.83	54.54	59.11	56.82	47.56	62.63	80.38	75.65
	Turnover	Registered Nurses	%	Workforce Info				12.24%	11.68%	11.83%	14.10%	15.04%	11.10%	11.32%	11.03%	10.62%	10.63%	10.70%	10.03%
		Healthcare Assistants	%	Workforce Info				12.01%	12.24%	10.06%	13.23%	12.81%	9.26%	9.22%	9.80%	10.36%	8.19%	9.84%	8.22%
	Sickness	Trustwide nursing / HCA sickness	%	Workforce Info				4.37%	4.64%	4.64%	4.45%	4.31%	3.87%	3.89%	3.79%	3.84%	3.73%	5.01%	
	Maternity Leave	Trustwide nursing / HCA	%	Workforce Info				2.71%	2.56%	2.42%	2.51%	2.56%	2.70%	2.84%	2.95%	2.90%	2.78%	2.84%	2.65%
	Appraisals	Registered Nurses	%	Workforce Info		75%									66.10%	68.64%	70.95%	70.99%	71.53%
		Healthcare Assistants	%	Workforce Info		75%									67.79%	69.31%	72.11%	71.63%	71.27%
	Safer Staffing Return	**Qualified** Fill Rated - Day	%	Safer Staffing Return	Between 80 - 100%	Green		92.00%	91.20%	90.40%	92.80%	88.80%	91.74%	92.80%	93.70%	90.19%	90.30%	91.32%	94.04%
		Qualified Fill Rated - Night	%	Safer Staffing Return	Between 80 - 100%	Red		95.40%	88.90%	89.70%	91.10%	91.60%	87.89%	92.00%	97.80%	89.05%	84.50%	97.01%	94.42%
		Unqualified Fill Rates - Day	%	Safer Staffing Return	Between 80 - 100%	Green		100.70%	93.70%	98.00%	96.30%	97.84%	97.02%	97.80%	94.10%	99.94%	98.90%	91.19%	99.23%
		Unqualified Fill Rates - Night	%	Safer Staffing Return	Between 80 - 100%	Red		104.50%	114.20%	115.00%	110.70%	108.48%	119.50%	111.50%	108.20%	118.64%	122.00%	117.34%	108.50%
	Care Hours per patient Day	Registered Nurses		Safer Staffing Return										5.4	5.1	5.1	4.8	3.01	3.12
		Healthcare Assistants		Safer Staffing Return										3.0	2.9	3.1	3.1	2.9	3.01
		Total		Safer Staffing Return										8.4	8.0	8.2	7.9	5.91	6.14
	Bank & Agency	**Overall** Fill Rate	%	Workforce Info				77.04%	70.76%	79.40%	75.30%	74.67%	73.19%	78.55%	75.92%	78.33%	77.41%	79.86%	81.33%
		Bank Fill Rate RN	%	Workforce Info				36.98%	36.20%	46.38%	42.94%	34.71%	45.41%	50.67%	46.18%	46.74%	40.97%	47.60%	46.28%
		Bank Fill Rate HCA	%	Workforce Info				53.85%	52.56%	67.07%	60.31%	60.18%	58.63%	60.76%	53.75%	56.69%	56.79%	51.78%	51.35%
		Bank - RN Hours filled	Number of Hours	Workforce Info				10,100	10,499	14,508	14,266	15,115	14,122	15,569	14,186	15,273	14,845	15,194	15,047
		Bank - HCA Hours filled	Number of Hours	Workforce Info				10,711	11,161	13,716	13,879	15,494	14,286	14,273	14,395	16,829	17,562	16,872	16,282
		Agency Fill Rate RN	%	Workforce Info				40.36%	32.56%	30.26%	29.82%	31.09%	23.05%	22.48%	25.47%	26.47%	29.55%	30.82%	33.90%
		Agency Fill Rate HCA	%	Workforce Info				22.78%	20.93%	16.55%	18.66%	20.17%	20.61%	24.84%	27.07%	27.26%	28.71%	29.49%	31.16%
		Agency - RN Hours filled	Number of Hours	Workforce Info				11,021	9,444	9,465	9,905	11,824	7,168	6,908	7,823	8651	10,706	9,840	11,023
		Agency - HCA Hours filled	Number of Hours	Workforce Info				4,530	4,444	3,385	4,295	5,193	5,022	5,835	7,250	8,078	8,878	9,609	9,882
Stat & Mand Training	Statutory & Mandatory Training	Statutory Training		CLAD	75%			67.61%	70%	66.78%	81.91%	83%	78.95%	85%	85.62%	84.23%	75.54%	69.78%	70.21%
		Mandatory Traiing		CLAD	&%%			58.27%	83.32%	73.51%	79.07%	80%	77.69%	83.60%	85.18%	84.23%	78.94%	78.61%	79.24%

		Metric	Measure	Data Source	Trajectory	RAG	Cumm. Total (Financial Year	Nov	Dec	Jan	Feb	March	April	May	June	July	August	September	October
Infection Prevention	MRSA	MRSA Bacteraemia	Cummulative	IC Team	0	Red	1.00	0	0	1	1	0	1	0	1	0	2	0	2
		MRSA Screening - Elective	Compliance %	Signal	95%	Red		94.32	89.85	78.4	70.83	73.81	68.21	62.96	64.24	62.52	63.89	58.77%	61.75%
		MRSA Screening - Non-Elective	Compliance %	Signal	95%	Red		83.55	83.58	79.94	79.62	80.28	82.21	83.7	78.91	84.19	83.88	82.29%	82.62%
	C.Difficile	C DIF Toxin Trust Attributed	Cummulative	IC Team		Green	3.00	2	8	7	5	3	3	1	3	3	2	1	3
	MSSA	MSSA Bacteraemia	Cummulative	IC Team		Red	9.00	2	2	2	2	3	9	2	2	2	5	0	8
	E-Coli	E-Coli Bacteraemia	Cummulative	IC Team			5.00	3	14	11	15	7	5	5	9	6	14	10	4
	Hand Hygiene	Hand Hygiene Compliance 95%	Compliance %	IC Team	95%	Amber		94.93%	94%	94%	94%	97%	95%	93%	94%	95%	93%	94%	94%
Risk Management (Trust wide)	Serious Incidents	SI's declared	Number	Datix - Healthcare Goverance Team				19	12	11	27	21	17	12	31	15	17	12	9
	Critical Incidents	CI's reported	Number	Datix - Healthcare Goverance Team				0	0	0	0	0	0	0	0	6	5	4	3
	Never Events	Never Events declared	Number	Datix - Healthcare Goverance Team				0	0	0	1	0	1	0	1	1	1	0	0

		Metric	Measure	Data Source	Trajectory	RAG	Mar	Nov	Dec	Jan	Feb	March	April	May	June	July	August	September	October
Patient Experience	Friends and Family	Inpatient Friends and Family Test	%Recommend	Signal				95.46%	95.26%	96%	96.01%	96.19%	98.89%	96.92%	96.47%	96.52%	96.53%	96.70%	
			%Not Recommend	Signal				1.26%	1.83%	1.19%	1.44%	1.20%	0.83%	0.73%	1.13%	0.89%	0.93%	1.03%	
		A&E Friends and Family Test	% Recommend	Signal				76.10%	85.61%	83.31%	80.95%	80.86%	79.21%	81.09%	80397%	83.84%	85.58%	82.76%	
			% Not Recommend	Signal				16.90%	8.70%	11.36%	11.41%	13.02%	12.70%	11.16%	12.01%	10.44%	9.51%	10.81%	
		Maternity (Ante Natal)	% Recommend	Signal				100%	97.22%	99.01%	100%	95.65%	100%	95.35%	98.37%	97..4%	100%	98.65%	
			% Not Recommend	Signal				0	0	0	0	1.09%	0%	0%	0%	0%	0%	0%	
		Labour & Birth	% Recommend	Signal				93.75%	98.97%	98.75%	100%	95.65%	100%	98.99%	99.33%	99.30%	97.89%	99.09%	
			% Not Recommend	Signal				6.25%	0	0	0	4.35%	0%	0%	0%	0%	0%	0%	
		Maternity (Post Natal)	% Recommend	Signal				100%	0	100%	97.87%	99.15%	96.43%	97.16%	100%	99.26%	98.32%	97.80%	
			% Not Recommend	Signal				0	0	0	1.06%	0%	0%	0.57%	0%	0%	0.84%	0%	
		Community Post Natal	% Recommend	Signal				100%	94.44%	98.31%	98.41%	94.85%	100%	99.15%	99.12%	98.81%	97.44%	100%	
			% Not Recommend	Signal				0	5.56%	1.69%	0	1.03%	0%	0%	0%	1.19%	1.71%	0%	
	Complaints	Complaints Total	Number	PE Team				Not Available	Not Available	19	31	36	27	30	33	26	28	33	31
		Staff Attitude	Number	PE Team				Not Available	Not Available	1	3	3	3	2	4	4	1	2	1
		Patient Care	Number	PE Team				Not Available	Not Available	5	3	5	1	5	2	4	7	1	3
		Communication	Number	PE Team				Not Available	Not Available	2	3	8	4	2	3	4	3	5	5

Nursing Dashboard - York

York Teaching Hospital NHS
NHS Foundation Trust

		Metric	Measure	Data Source	Trajectory	RAG	Cum.Total	Nov	Dec	Jan	Feb	March	April	May	June	July	August	September	October
Patient Safety	Pressure Ulcers	PURP Overall	No. of Patients (PP)	Safety Thermometer - NEW PU				1	8	2	4	4	2	1	3	3	2	4	4
		Cat 4	No. of Patients (PP)	Safety Thermometer - NEW PU				0	0	0	0	0	0	0	0	0	0	0	0
		Cat 3	No. of Patients (PP)	Safety Thermometer - NEW PU				0	1	0	0	1	2	0	1	0	0	0	0
		Cat 2	No. of Patients (PP)	Safety Thermometer - NEW PU				1	5	1	3	3	0	0	2	2	2	3	3
		Unstageable	No. of Patients (PP)	Safety Thermometer - NEW PU				0	2	1	1	0	0	1	0	0	0	1	1
		Deep Tissue Injury	No. of Patients (PP)	Safety Thermometer - NEW PU				0	0	0	0	0	0	0	0	1	0	0	0
	Falls	Falls	No. of Patients (PP)	Safety Thermometer - FALLS				18	23	18	18	21	9	12	20	10	8	9	6
		Falls With Harm (Moderate/Severe)	No. of Patients (PP)	Safety Thermometer - FALLS				2	0	0	0	0	1	0	1	0	1	0	0
	Safety Thermometer	Safety Thermometer Overall (Harm Free Care)	%	Safety Thermometer - CQUIN HARM FREE %	95%			96.09%	92.73%	96.66%	96.33%	96.44%	95.30%	97.50%	95.59%	95.14%	97.71%	96.66%	96.52%
	Catheter acquired UTI	New UTI	No. of Patients (PP)	Safety Thermometer - CQUIN HARMS				7	11	3	9	2	5	4	3	6	1	7	1
	Critical Missed Meds	Critical Missed Meds	No. of Patients (PP)	Safety Thermometer - OMITTED CRITICAL MEDS				6	3	9	10	8	9	6	8	3	5	5	6
	Drug Errors	Drug Errors (inpatient wards only)		Datix												54	72	62	95
	NEWS	Compliance with NEWs (inpatient wards only)		Signal						79%	78.15%	77.64%	79.455	79.76%	80.62%	80.33%	80.40%	77.31%	77.88%
	Deep Vein Thrombosis	New DVT	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE				2	3	0	0	1	6	0	0	0	0	0	0
	Pulmonary Embolism	New PE	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE				0	2	2	2	0	1	1	2	1	1	1	2
	VTE Other	VTE Other		Safety Thermometer - VTE TREATMENT TYPE				0	0	0	0	0	0	0	0	0	0	0	0
Workforce	Vacancies	Inpatient area vacancies -RN	Number	CN Team				85.39	98.15	68.51	68.75	86.14	70.2	74.63	67.66	71.16	78.07	73.81	51.9
		Inpatient area vacancies - HCA	Number	CN Team				34.15	31.05	55.87	58.53	34.83	24.8	41.43	37.9	30.11	41.3	47.8	53.07
	Sickness	Sickness (In Patient Areas)	%	Workforce Info				3.96%	3.74%	3.99%	4.36%	3.56%	4.27%	3.96%	3.55%	3.74%	3.51%	3.46%	
	Maternity Leave	Trustwide nursing / HCA	%	Workforce Info				4.45%	3.83%	3.85%	3.71%	3.30%	3.34%	3.45%	3.21%	3.09%	3.60%	3.28%	3.18%
	Appraisals	Registered Nurses (Ward Areas)	%	Workforce Info											61.68%	65.11%	65.17%	69%	69.90%
		Healthcare Assistants (Ward Areas)	%	Workforce Info											73.36%	69.38%	73.52%	74.10%	77.93%
	Safer Staffing Return	Qualified Fill Rated - Day	%	Safer Staffing Return	Between 80 - 100%			90.3	88	88.9	86.7	86.9%	89.55%	86.30%	88.00%	87.90%	85.30%	89.80%	91.00%
		Qualified Fill Rated - Night	%	Safer Staffing Return	Between 80 - 100%			96.6	94.5	93.7	94.2	95.1%	96.43%	95.90%	102.30%	96%	96.90%	106.10%	98%
		Unqualified Fill Rates - Day	%	Safer Staffing Return	Between 80 - 100%			95.4	93.6	95.6	92.4	93.1%	98.06%	102.10%	95.60%	105.10%	105%	96.20%	107.30%
		Unqualified Fill Rates - Night	%	Safer Staffing Return	Between 80 - 100%			108.5	103.1	105.1	103.7	104.3%	106.28%	106.50%	113.30%	113.20%	112.20%	115.80%	114.80%
	Care Hours per patient Day	Registered Nurses		Safer Staffing Return										4.9	4.9	5.1	5	4.1	4
		Healthcare Assistants		Safer Staffing Return										2.6	2.7	3.0	3	3.1	2.9
		Total		Safer Staffing Return										7.5	7.6	8.1	8.0	7.3	6.9
	Internal Bank Fill Rate	Fill Rate	%	Workforce Info				31.9	32.55	33.7	39.2	38.1	41.70%	42.80%	38.20%	43.20%	39%	40.30%	39.40%
	Agency Fill Rate	Fill Rate	%	Workforce Info				43.1	36.69	42.4	33.9	36.8	30.40%	33.40%	37.80%	36.10%	37.40%	40.60%	43.30%
Infection Prevention	MRSA	MRSA Bacteraemia	Cummulative	IC Team	0		3	0	0	0	1	0	1	0	1	0	0	0	1
		MRSA Screening - Elective	Compliance %	Signal	95%			97.85%	94.63%	75.64%	70.54%	74.41%	71.79%	6.59%	64.80%	61.41%	57.78%	52.17%	53.74%
		MRSA Screening - Non-Elective	Compliance %	Signal	95%			79.69%	76.26%	79.09%	74.85%	78.53%	79.41%	82.29%	80.49%	81.76%	81.20%	79.34%	78.63%
	C.Difficile	C DIF Toxin Trust Attributed	Cummulative	IC Team	48		3	3	5	5	4	1	0	1	3	3	2	0	2
	MSSA	MSSA Bacteraemia	Cummulative	IC Team			19	0	1	0	2	3	4	1	2	1	4	0	7
	E-Coli	E-Coli Bacteraemia	Cummulative	IC Team			29	4	4	4	10	6	2	3	4	4	9	6	1
Risk Management (Trust wide)	Serious Incidents	SI's declared	Number	Datix - Healthcare Governance				9	5	2	12	6	7	8	12	4	1	4	1
	Clinical Incidents	CI's reported	Number	Datix - Healthcare Governance				0	0	0	0	0	0	0	0	3	5	4	1
	Never Events	Never Events declared	Number	Datix - Healthcare Governance				0	0	0	1	0	1	0	1	0	0	0	0

		Metric	Measure	Data Source	Trajectory	RAG	Cum.Total	Nov	Dec	Jan	Feb	March	April	May	June	July	August	September	October
Patient Experience	Friends and Family	Inpatient Friends & Family Test	%Recommend	Signal				94.96	94.43	94.68	95.48	95.48	96.46%	96.92%	96.06%	96.30%	95.75%	95.88%	
			%Not Recommend	Signal				1.60	2.46	1.53	1.92	1.34	1.04%	0.73%	1.45%	0.90%	1.11%	1.26%	
		A&E Friends and Family Test	% Recommend	Signal				74.50	86.57	83.70	82.27	83.83	78.93%	80.98%	81.44%	86.48%	88.04%	83.52%	
			% Not Recommend	Signal				18.30	7.89	11.28	10.44	10.92	12.86%	11.63%	11.68%	8.16%	7.12%	9.74%	
		Maternity (Ante Natal)	% Recommend	Signal				100.00	93.75	97.80	100.00	91.00	100.00	95%	97.56%	98.18%	100%	100%	
			% Not Recommend	Signal				0.00	0.00	0.00	0.00	0.02	0.00	0%	0%	0	0%	0%	
		Birth	% Recommend	Signal				91.67	98.50	96.80	100.00	100.00	100.00	99%	99.11%	100.00%	97.27%	100%	
			% Not Recommend	Signal				8.30	0.00	0.00	0.00	0.00	0.00	0%	0.88%	0%	0%	0%	
		Maternity (Post Natal)	% Recommend	Signal				100.00	100.00	100.00	97.10	99.00	100.00	98%	100%	99.10%	97.89%	100%	
			% Not Recommend	Signal				0.00	0.00	0.00	0.00	0.00	0.00	0%	0%	0%	1.05%	0%	
	Complaints *new DATIX system reporting not yet available. Will be populated asap.	Complaints Total	Number	PE Team				not available	not available	18	22	28	23	20	12	17	15	21	19
		Staff Attitude	Number	PE Team				not available	not available	1	2	3	3	2	1	3	5	1	0
		Patient Care	Number	PE Team				not available	not available	5	1	3	1	4	2	2	2	0	2
		Communication	Number	PE Team				not available	not available	2	3	5	3	1	3	2	1	2	4

Assistant Director Narrative - Michael Shanaghey

• Pressure ulcers – no category 3 or 4 PU's reported since June 2016 on safety thermometer. No PU SI's reported in October
• Falls – 0 falls with moderate/severe harm reported in October on safety thermometer. No SI's declared in October. Areas of high risk have been creating bespoke action plan in falls prevention and management.
• Drug errors – rise in number of reported drug incidents during October (increase of 33 from 09/16). September was low and reporting has been encouraged. No themes/trends or particular areas of concern noted.
• CAUTI –trial of new documentation commenced on AMU/B, Ward 33 and 34 to measure indication for catheter insertion, on-going care and daily assessment of need. Plan to roll out across Trust following trial.
• Vacancies – recruitment on-going across the site with particular focus on areas of concern e.g. ward 28 & 34; this includes bespoke adverts. 29.7% reduction in RN vacancies in October 2016.
• Appraisal – Matron's managing compliance directly with ward/department managers and actions in place to address. Slight increase noted October 2016.
• Fill rates – unqualified fill rates continue to be in excess of 100%. This is attributed to reduced RN fill rates, acuity and enhanced supervision requests.
• MRSA screening - Matron's are reviewing/validating their data locally and taking action.
• MRSA Bacteraemia – ward 11; PiR completed and environmental audit undertaken by ADoN and IP&C. IP&C have completed an analysis of all MRSA bacteraemia's and meeting has been planned with ADoN's to drive the actions/recommendations
• Cdiff – x 2 during October 2016; ward 25 & 35. PiR's scheduled in November

Nursing Dashboard - Scarborough

York Teaching Hospital NHS
NHS Foundation Trust

		Metric	Measure	Data Source	Trust Trajectory	Cum Total	Nov	Dec	Jan	Feb	March	April	May	June	July	August	September	October
Patient Safety	Pressure Ulcers	PURP Overall	No. of Patients (PP)	Safety Thermometer - NEW PU			3	5	1	2	7	2	4	2	1	1	2	4
		Cat 4	No. of Patients (PP)	Safety Thermometer - NEW PU			0	0	0	0	0	0	0	0	0	0	0	0
		Cat 3	No. of Patients (PP)	Safety Thermometer - NEW PU			0	0	0	1	0	0	1	0	0	0	0	0
		Cat 2	No. of Patients (PP)	Safety Thermometer - NEW PU			3	3	1	1	5	1	2	0	1	0	0	3
		Unstageable	No. of Patients (PP)	Safety Thermometer - NEW PU			0	2	0	0	2	1	1	2	0	1	0	1
		Deep Tissue Injury	No. of Patients (PP)	Safety Thermometer - NEW PU			0	0	0	0	0	0	0	0	0	0	1	0
	Falls	Falls	No. of Patients (PP)	Safety Thermometer - FALLS			8	8	4	11	6	7	10	4	7	9	15	7
		Falls With Harm (Moderate/Severe)	No. of Patients (PP)	Safety Thermometer - FALLS			2	0	0	0	0	0	0	0	1	1	2	0
	Safety Thermometer	Safety Thermometer Overall (Harm Free Care)	%	Safety Thermometer - CQUIN HARM FREE %	95%		91.04%	90.20%	93.31%	95.48%	91.67%	93.29%	95.58%	94.52%	94.31%	95.07%	90.94%	93.23%
	Catheter acquired UTI	New UTI	No. of Patients (PP)	Safety Thermometer - CQUIN HARMS			10	11	9	3	6	7	4	11	17	15	10	11
	Critical Missed Meds	Critical Missed Meds	No. of Patients (PP)	Safety Thermometer - OMITTED CRITICAL MEDS			4	7	6	10	3	8	4	3	5	10	11	7
	Drug Errors	Drug Errors (inpatient wards only)		Datix											23	44	25	27
	NEWS	Compliance with NEWs (inpatient wards only)		Signal					84%	81%	81.73%	83.66%	85.70%	85.54%	85.45%	85.21%	85.53%	84.78%
	Deep Vein Thrombosis	New DVT	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE			1	0	1	0	2	0	0	0	0	0	0	2
	Pulmonary Embolism	New PE	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE			1	1	0	0	0	1	0	1	1	1	0	1
	VTE Other	VTE Other	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE			0	1	0	0	4	0	0	0	0	0	0	0
Workforce	Vacancies	Inpatient area vacancies -RN	Number	CN Team			29.89	37.93	36.93	42.83	41.67	38.59	38.4	40.27	50.71	49.63	43.01	37.86
		Inpatient area vacancies - HCA	Number	CN Team			1.85	1.35	5.95	2.65	4.24	7.88	7.94	10.28	10.14	13.06	17.8	16.7
	Sickness	Sickness (In Patient Areas)	%	Workforce Info			5.08%	6.67%	6.46%	6.63%	3.43%	4.11%	3.47%	3.88%	4.83%	4.75%	4.54%	
	Maternity Leave	Trustwide nursing / HCA	%	Workforce Info			2.75%	2.41%	2.65%	2.66%	2.36%	2.32%	2.71%	2.23%	2.39%	2.21%	1.92%	1.60%
	Appraisals	Registered Nurses (Ward Areas)	%	Workforce Info										59.69%	64.12%	63.42%	66.97%	63.91%
		Healthcare Assistants (Ward Areas)	%	Workforce Info										45.52%	56.31%	57.24%	59.88%	69.90%
	Safer Staffing Return	Qualified Fill Rated - Day	%	Safer Staffing Return	Between 80 - 100%		83.8	87.5	86.6	83.7	80.8%	85.27%	86.20%	85.00%	82%	82.10%	86%	88.70%
		Qualified Fill Rated - Night	%	Safer Staffing Return	Between 80 - 100%		104.6	102.5	92.6	91.8	88.2%	89.92%	89.70%	96.20%	92.90%	94%	98.20%	95.10%
		Unqualified Fill Rates - Day	%	Safer Staffing Return	Between 80 - 100%		94.1	90.8	104.9	100.5	100.5%	99.61%	99.90%	91.60%	100.20%	97.00%	93.40%	97.10%
		Unqualified Fill Rates - Night	%	Safer Staffing Return	Between 80 - 100%		108.4	108.8	113.5	118.9	114.0%	115.87%	111.70%	108.60%	111%	108.10%	118.60%	110.10%
	Care Hours per patient Day	Registered Nurses		Safer Staffing Return									5.1	4.6	4.9	5.3	3.9	3.9
		Healthcare Assistants		Safer Staffing Return									2.6	2.4	2.7	2.7	2.8	2.7
		Total		Safer Staffing Return									7.7	7.0	7.6	8.0	6.6	6.6
	Internal Bank Fill Rate	Fill Rate	%	Workforce Info			62.00%	57.17%	73.70%	65.80%	58.60%	61.90%	74.90%	63.10%	58.80%	55.50%	59.90%	57.30%
	Agency Fill Rate	Fill Rate	%	Workforce Info			18.70%	14.63%	11.30%	11.20%	12.40%	10%	5.90%	8.30%	14.40%	19.30%	14.80%	18.20%
Infection Prevention	MRSA	MRSA Bacteraemia	Cummulative	IC Team	0	3	0	0	0	0	0	0	0	0	0	2	0	0
		MRSA Screening - Elective	Compliance %	Signal	95%		92.36%	74.38%	66.67%	50%	50.56%	45.71%	34.69%	37.17%	36.69%	43.26%	38.51%	42.37%
		MRSA Screening - Non-Elective	Compliance %	Signal	95%		91.55%	86.69%	87.48%	86.47%	84.13%	87.62%	86.51%	75.82%	88.99%	89.34%	88.08%	90.12%
	C.Difficile	C DIF Toxin Trust Attributed	Cummulative	IC Team	48	16	0	2	1	0	1	2	0	0	0	0	0	0
	MSSA	MSSA Bacteraemia	Cummulative	IC Team	<30	14	2	1	2	0	0	4	0	0	1	2	0	1
	E-Coli	E-Coli Bacteraemia	Cummulative	IC Team		38	4	3	6	3	1	1	2	3	4	4	2	2
Risk Management (Trust wide)	Serious Incidents	SI's declared	Number	Datix - Healthcare Governance			6	4	6	9	12	7	0	11	1	3	1	6
	Critical Incidents	CI's reported	Number	Datix - Healthcare Governance			0	0	0	0	0	0	0	0	1	3	0	2
	Never Events	Never Events declared	Number	Datix - Healthcare Governance			0	0	0	0	0	0	0	0	0	0	0	0

		Metric	Measure	Data Source	Trust Trajectory	Cum Total	Nov	Dec	Jan	Feb	March	April	May	June	July	August	September	October
		Metric	**Measure**	**Data Source**	**Trajectory**	**Mar**	**Nov**	**Dec**	**Jan**	**Feb**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**
Patient Experience	**Friends and Family Test**	Inpatient Friends and Family Test	%Recommend	Signal			95.00	95.32	97.38	95.52	96.45	98.02%	96.35%	96.88%	97.56	98.96%	97.94%	
			%Not Recommend	Signal			1.00	1.10	0.56	1.07	1.62	0.46%	0.42%	0.66%	0.98%	0.78%	0.74%	
		A&E Friends and Family Test	% Recommend	Signal			85.10	80.85	81.10	72.73	65.25	80.74%	81.63%	78.26%	71.43%	75.52%	78.20%	
			% Not Recommend	Signal			9.20	12.77	11.81	17.48	24.11	11.85%	8.84%	13.91%	21.14%	19.27%	17.29%	
		Maternity (Ante Natal)	% Recommend	Signal			100.00	100.00	100.00	100.00	100.00	100.00	96%	100%	95.45%	100%	97.44%	
			% Not Recommend	Signal			0.00	0.00	0.00	0.00	0.00	0.00	0%	0%	0%	0%	0%	
		Birth	% Recommend	Signal			100.00	100.00	98.00	100.00	92.30	100.00	99%	100%	96.55%	100%	97.96%	
			% Not Recommend	Signal			0.00	0.00	0.00	0.00	0.00	0.00	1%	0%	0%	0%	0%	
		Maternity (Post Natal)	% Recommend	Signal			100.00	90.90	97.10	100.00	100.00	100.00	100%	100%	100%	100%	100%	
			% Not Recommend	Signal			0.00	9.10	2.90	0.00	0.00	0.00	0%	0%	0%	0%	0%	
	Complaints *new DATIX system reporting not yet available. Will be populated asap.	Complaints Total	Number	PE Team			Not Available	Not Available	1	5	7	4	2	3	5	12	8	10
		Staff Attitude	Number	PE Team			Not Available	Not Available	0	0	0	0	0	2	1	1	1	1
		Patient Care	Number	PE Team			Not Available	Not Available	0	1	2	0	1	0	2	1	1	1
		Communication	Number	PE Team			Not Available	Not Available	0	0	2	1	1	0	2	0	3	1

Assistant Director Narrative - Emma George

Drug errors incidents are discussed with the ADN and matron and a new medicines management meeting has been set up in Nov 2016 to look at themes and action to be taken re drug errors.

RN vacancies are improving and the recent recruitment fair was very successful for RN and HCA recruitment

Nursing Dashboard - Bridlington

York Teaching Hospital NHS
NHS Foundation Trust

		Metric	Measure	Data Source	Trajectory	RAG	CummTotal	Nov	Dec	Jan	Feb	March	April	May	June	July	August	September	October
	Pressure Ulcers	PURP Overall	No. of Patients (PP)	Safety Thermometer - NEW PU				2	2	0	0	2	0	2	0	1	0	0	0
		Cat 4	No. of Patients (PP)	Safety Thermometer - NEW PU				0	0	0	0	0	0	0	0	0	0	0	0
		Cat 3	No. of Patients (PP)	Safety Thermometer - NEW PU				1	1	0	0	0	0	0	0	0	0	0	0
		Cat 2	No. of Patients (PP)	Safety Thermometer - NEW PU				1	1	0	0	2	0	2	0	1	0	0	0
		Unstageable	No. of Patients (PP)	Safety Thermometer - NEW PU				0	0	0	0	0	0	0	0	0	0	0	0
		Deep Tissue Injury	No. of Patients (PP)	Safety Thermometer - NEW PU				0	0	0	0	0	0	0	0	0	0	0	0
	Falls	Falls	No. of Patients (PP)	Safety Thermometer - FALLS				1	0	0	0	2	3	0	1	0	0	0	0
		Falls With Harm (Moderate/Severe)	No. of Patients (PP)	Safety Thermometer - FALLS				0	0	0	0	0	0	0	0	0	0	0	0
	Safety Thermometer	Safety Thermometer Overall (Harm Free Care)	%	Safety Thermometer - CQUIN HARM FREE %	95%			92.45%	91.49%	96.30%	93.88%	85.11%	94.64%	90.00%	90.63%	82.31%	81.82%	91.84%	92.11%
	Catheter acquired UTI	New UTI	No. of Patients (PP)	Safety Thermometer - CQUIN HARMS				1	1	0	1	1	0	0	0	1	1	1	1
	Critical Missed Meds	Critical Missed Meds	No. of Patients (PP)	Safety Thermometer - OMITTED CRITICAL MEDS				0	0	3	0	1	0	3	0	0	3	0	0
	Drug Errors	Drug Errors (inpatient wards only)		Datix												2	0	0	1
	NEWS	Compliance with NEWs (inpatient wards only)		Signal						93%	93.03%	86.95%	0.89559566	93.04%	91.50%	92.96%	92.09%	92.88%	91.21%
	Deep Vein Thrombosis	New DVT	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE				0	0	0	0	1	1	0	0	0	0	0	0
	Pulmonary Embolism	New PE	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE				0	0	0	0	0	0	0	0	0	0	0	0
	VTE Other	VTE Other		Safety Thermometer - VTE TREATMENT TYPE				0	0	0	0	0	0	0	0	0	0	0	0
Workforce	Vacancies	Inpatient area vacancies -RN	Number	CN Team				5.52	7.08	6.28	6.78	11.68	5.78	7.4	7.4	5	5	5	7
		Inpatient area vacancies - HCA	Number	CN Team				0.08	1.68	2.68	2.68	3.3	1.68	3.44	1.5	2.44	0.7	4.84	5.6
	Sickness (In Patient Areas)	Sickness	%	Workforce Info				6.36%	6.99%	8.65%	6.46%	7.89%	10.89%	14.40%	16.33%	15.49%	13.40%	15.55%	
	Maternity Leave	Trustwide nursing / HCA	%	Workforce Info				0.85%	0.90%	0.92%	0.94%	0.95%	0.95%	0.95%	0.95%	0.72%	0	1.43%	1.56%
	Appraisals	Registered Nurses (Ward Areas)	%	Workforce Info											64.88%	65.37%	66.92%	53.66%	57.16%
		Healthcare Assistants (Ward Areas)	%	Workforce Info											62.36%	60.67%	63.85%	52.78%	70.83%
	Safer Staffing Return	Qualified Fill Rated - Day	%	Safer Staffing Return	Between 80 - 100%			94.7	86.9	92.6	93.4	90.3%	93.42%	88.90%	95.10%	85.00%	89%	83.10%	97.90%
		Qualified Fill Rated - Night	%	Safer Staffing Return	Between 80 - 100%			93.2	90.7	76.7	80.1	76.6%	84.69%	79.40%	84.20%	87.50%	75.30%	92.10%	74.40%
		Unqualified Fill Rates - Day	%	Safer Staffing Return	Between 80 - 100%			73.8	67.9	94.9	92.2	88.9%	93.82%	85.80%	72.70%	72.30%	87.20%	64.50%	84.90%
		Unqualified Fill Rates - Night	%	Safer Staffing Return	Between 80 - 100%			145	166.1	161.3	153.4	140.3%	150.00%	133.90%	143.30%	159.70%	138.70%	191.70%	132.30%
	Care Hours per patient Day	Registered Nurses		Safer Staffing Return										9.1	8.1	7.8	6.7	3.5	3.4
		Healthcare Assistants		Safer Staffing Return										4.0	3.5	4.1	3.7	3.9	3.7
		Total		Safer Staffing Return										13.1	11.6	11.9	10.4	7.5	7.1
	Internal Bank Fill Rate	Fill Rate	%	Workforce Info				83.50%	70.95%	81.40%	81.80%	83.30%	80%	84.70%	76.30%	78.40%	84.80%	85.50%	82.20%
	Agency Fill Rate	Fill Rate	%	Workforce Info				7.78%	3.39%	1.20%	2.80%	2.00%	1.90%	0.80%	2.90%	1.80%	1.60%	0.60%	0.30%
Infection Prevention	MRSA	MRSA Bacteraemia	Accumulated number of patients	IC Team	0	Green	3	0	0	0	0	0	0	0	0	0	0	0	0
		MRSA Screening - Elective	Compliance %	Signal	95%			91.10%	90.78%	82.11%	79.67%	80.92%	75.92%	95.20%	97.32%	97.10%	100%	97.99%	99.34%
		MRSA Screening - Non-Elective	Compliance %	Signal	95%			83.335	100%	100%	--	66.67%	100%	100%	100%	99.28%	--	100%	100%
	C.Difficile	C DIF Toxin Trust Attributed	Accumulated number of patients	IC Team	48	Green	3	0	0	0	0	0	1	0	0	0	0	0	0
	MSSA	MSSA Bacteraemia	Accumulated number of patients	IC Team	<30	Red	0	0	0	0	0	0	1	1	0	0	0	0	0
	E-Coli	E-Coli Bacteraemia	Accumulated number of patients	IC Team			4	0	0	0	2	0	0	0	1	0	0	0	1
Risk Management (Trust wide)	Serious Incidents	SI's declared	Number	Datix - healthcare governance				0	0	2	0	0	0	0	3	0	0	1	0
	Critical Incidents	CI's reported	Number	Datix - healthcare governance				0	0	0	0	0	0	0	0	0	1	0	0
	Never Events	Never Events declared	Number	Datix - healthcare governance				0	0	0	0	0	0	0	0	0	0	0	0

		Metric	Measure	Data Source	Trajectory	RAG	CummTotal	Nov	Dec	Jan	Feb	March	April	May	June	July	August	September	October
		Metric	**Measure**	**Data Source**	**Trajectory**	**RAG**	**Cum.Total**	**Nov**	**Dec**	**Jan**	**Feb**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**
Patient Experience	**Friends and Family**	Inpatient Friends and Family Test	%Recommend	Signal				100.00%	98.73%	98.77%	99.02%	98.40%	97.54%	97.23%	98.31%	96.57%	98.32%	98.74%	
			%Not Recommend	Signal				0.00%	0.00%	0.92%	0.00	0.00	0.62%	0.79%	0%	0%	0%	0.32%	
		A&E Friends and Family Test	% Recommend	Signal				--	--	--	--	--	--	--	--	--	--	--	--
			% Not Recommend	Signal				--	--	--	--	--	--	--	--	--	--	--	--
		Maternity (Ante Natal)	% Recommend	Signal				--	--	--	--	--	--	--	--	--	--	--	--
			% Not Recommend	Signal				--	--	--	--	--	--	--	--	--	--	--	--
		Birth	% Recommend	Signal				--	--	--	--	--	--	--	--	--	--	--	--
			% Not Recommend	Signal				--	--	--	--	--	--	--	--	--	--	--	--
		Maternity (Post Natal)	% Recommend	Signal				--	--	--	--	--	--	--	--	--	--	--	--
			% Not Recommend	Signal				--	--	--	--	--	--	--	--	--	--	--	--
	Complaints *new DATIX system reporting not yet available. Will be populated asap.	Complaints Total	Number	PE Team				not available	not available	0	1	0	0	0	0	0	1	1	0
		Staff Attitude	Number	PE Team				not available	not available	0	0	0	0	0	0	0	1	0	0
		Patient Care	Number	PE Team				not available	not available	0	1	0	0	0	0	0	0	0	0
		Communication	Number	PE Team				not available	not available	0	0	0	0	0	0	0	0	0	0

Assistant Director Narrative - Emma George

HCA staff return is 132.3 % for night this is due to the increase in HCA on night shift and the current reduction of RN on waters ward , the ward is supporting Graham ward in Scarborough.

Board of Directors – 30 November 2016

Safe Nurse and Midwifery Staffing Report

Action requested/recommendation

The Board is asked to receive the exception report for information.

Executive Summary

The Trust continues to submit to NHS Choices, actual against planned staffing data for day and night duty in hours and by ward. A detailed breakdown for October 2016 staffing levels is attached at Appendix 1.

A detailed breakdown for October 2016 staffing levels is contained within the main report.

	Day		Night	
Site Name	**Average fill rate - registered nurses/ midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/ midwives (%)**	**Average fill rate - care staff (%)**
Archways Intermediate Care Unit	96.0%	92.3%	98.4%	100.0%
Bridlington and District Hospital	97.9%	84.9%	74.4%	132.3%
Malton Community Hospital	80.0%	112.4%	100.0%	100.0%
Scarborough General Hospital	88.7%	97.1%	95.1%	110.1%
Selby And District War Memorial Hospital	94.8%	103.9%	91.9%	116.1%
St Helens Rehabilitation Hospital	98.4%	93.5%	96.8%	100.0%
St Monicas Hospital	94.0%	107.5%	100.0%	100.0%
White Cross Rehabilitation Hospital	105.6%	94.2%	95.2%	103.2%
York Hospital	91.0%	107.3%	98.0%	114.8%

As reported last month, The Lord Carter review highlighted the importance of ensuring that workforce and financial plans are consistent, in order to optimise delivery of clinical quality and use of resources. The review recommended that Care hours Per Patient Per Day (CHPPD) is collected monthly from April 2016 and daily from April 2017.

CHPPD is calculated by adding the hours of RN's on shift to the hours of healthcare support workers and dividing the total by every 24 hours of inpatient admissions (or approximating 24 hours by numbers of patients at midnight.)
From May 2016 CHPPD became the principle measure of nursing and care support with the

expectation that it will form part of an integrated quality framework / dashboard. The first return of CHPPD taking place in June 2016. The CHPPD based on the actual staffing provided across the inpatient wards during September 2016 is detailed below:

	Care Hours Per Patient Day (CHPPD)			
	Cumulative count over the month of patients at 23:59 each day	**Registered midwives/ nurses**	**Care Staff**	**Overall**
Archways Intermediate Care Unit	478	2.9	2.5	5.4
Bridlington and District Hospital	1322	3.4	3.7	7.1
Malton Community Hospital	760	2.1	3.3	5.4
Scarborough General Hospital	8884	3.9	2.7	6.6
Selby and District War Memorial Hospital	498	3.5	3.2	6.7
St Helen's Rehabilitation Hospital	573	2.7	2.5	5.2
St Monica's Hospital	296	3.1	4.0	7.2
White Cross Rehabilitation Hospital	641	2.5	2.3	4.8
York Hospital	16433	4.0	2.9	6.9

RN vacancies continued to be a factor in the staffing of wards during October 2016; as in previous months, this is monitored by the senior nursing team and staff are moved across the wards as appropriate.

Significant recruitment to RN vacancies is underway and the 2017 nursing recruitment campaign will also be commencing in November 2016.

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

Implications for equality and diversity

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).
It is anticipated that the recommendations of this paper are not likely to have any particular impact upon the requirements of or the protected groups identified by the Equality Act.

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	Quality & Safety Committee
Risk	No risk
Resource implications	Resources implication detailed in the report
Owner	Beverley Geary, Chief Nurse
Author	Nichola Greenwood, Nursing Workforce Projects Manager
Date of paper	November 2016
Version number	Version 1

Board of Directors – 30 November 2016

Safe Nurse and Midwifery Staffing Report

1. Introduction and background

The Trust continues to submit to NHS Choices, actual against planned staffing data for day and night duty in hours and by ward. A detailed breakdown for October 2016 staffing levels is attached at Appendix 1.

The Trust also continues to report Care Hours per Patient Day (CHPPD) data. This report, at section 3, provides details of the CHPPD based on the actual staffing provided across the inpatient wards during October 2016. CHPPD data has been collected since May 2016 and the Trust is now looking at the six months' worth of data collected as part of its continuous review of nurse staffing levels across all wards.

At present, no national benchmark data is available on CHPPD to compare our Trust against other organisations.

2. High level data by site

	Day		Night	
Site Name	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)
Archways Intermediate Care Unit	96.0%	92.3%	98.4%	100.0%
Bridlington and District Hospital	97.9%	84.9%	74.4%	132.3%
Malton Community Hospital	80.0%	112.4%	100.0%	100.0%
Scarborough General Hospital	88.7%	97.1%	95.1%	110.1%
Selby And District War Memorial Hospital	94.8%	103.9%	91.9%	116.1%
St Helens Rehabilitation Hospital	98.4%	93.5%	96.8%	100.0%
St Monicas Hospital	94.0%	107.5%	100.0%	100.0%
White Cross Rehabilitation Hospital	105.6%	94.2%	95.2%	103.2%
York Hospital	91.0%	107.3%	98.0%	114.8%

3. Care Hours per Patient Day

	Care Hours Per Patient Day (CHPPD)			
	Cumulative count over the month of patients at 23:59 each day	**Registered midwives/ nurses**	**Care Staff**	**Overall**
Archways Intermediate Care Unit	478	2.9	2.5	5.4
Bridlington and District Hospital	1322	3.4	3.7	7.1
Malton Community Hospital	760	2.1	3.3	5.4
Scarborough General Hospital	8884	3.9	2.7	6.6
Selby and District War Memorial Hospital	498	3.5	3.2	6.7
St Helen's Rehabilitation Hospital	573	2.7	2.5	5.2
St Monica's Hospital	296	3.1	4.0	7.2
White Cross Rehabilitation Hospital	641	2.5	2.3	4.8
York Hospital	16433	4.0	2.9	6.9

4. Exceptions

There were 2 wards where RN staffing during the day fell below 80% in October. These wards were ITU in Scarborough and, Ward 29 in York. The reasons were due staff being redeployed to support other wards during periods of low occupancy and dependency.

There were 3 wards where RN planned staffing levels fell below 80% on night shifts. These wards were Stroke in Scarborough, Kent, Lloyd in Bridlington. On Stroke ward this was due to RN vacancies and on Kent and Lloyd wards this was due to low bed occupancy levels; resulting in staff being redeployed to other wards.

A detailed exception breakdown is detailed below.

<u>Enhanced Supervision</u>

A number of areas show an over 100% fill rate – usually in care staff. This is due in part to the use of enhanced supervision for patients who require a higher level of observation. These areas are:

Community	**Scarborough**	**York**	
Whitecross Court	Ann Wright	AMU	Ward 11
	Beech	Ward 17	Ward 23
	Chestnut	Ward 25	Ward 26
	Stroke	Ward 32	Ward 33
		Ward 34	Ward 35
		Ward 37	Ward 39

Provision of Safe Ward Cover

The Matrons are responsible for ensuring staffing levels are as safe as possible throughout the day and night. This means that staffing is assessed throughout the day and for out of hours and weekends, effective and safe plans are implemented. This does result in staff moving from their base wards on occasions, and where necessary, increased numbers of Care Staff to support the shortfall of registered nurses. These wards are:

Bridlington	**Community**	**Scarborough**		**York**	
Johnson	Fitzwilliam	Ann Wright	Ash	G1	Ward 23
Waters	Selby	Chestnut	CCU	Ward 25	Ward 26
	St Monicas	Duke of Kent	Holly	Ward 28	Ward 29
	Whitecross Court	Maple	Oak	Ward 31	Ward 35
		Stroke		Ward 36	Ward 39

On Waters ward, it was necessary on occasions for the sister to be the Bridlington Hospital bleep holder and, on these occasions it was necessary for a second nurse to work on the ward in the event of the bleep holder being called away. This therefore shows Waters ward higher than normal staffing levels.

Across York and Scarborough sites, a number of Newly Qualified nurses have commenced in post as Pre-registered nurses whilst awaiting their NMC numbers to arrive. As a result some of the staffing ratios include these nurses working as care staff.

Bed Occupancy

Lloyd and Kent wards at Bridlington, CCU, ESA and Ward 29 in York and ITU in Scarborough changed their ratio of registered and unregistered staff according to bed occupancy, with staff being deployed to other ward areas. On occasions Kent ward was closed when there were no patients requiring overnight stay. Waters Ward has reduced its bed numbers resulting in RNs being redeployed to other wards and additional care staff being utilised. During October Ward 16 needed to increase its capacity on a weekend to help manage activity, resulting in higher than planned staffing levels.

The Surgical Assessment Unit on Lilac ward in Scarborough remained open longer than usual during October to help manage clinical activity. This resulted in a higher level of staffing.

Actions and Mitigation of risk
On a daily basis, matrons and members of the Chief Nurse team deploy staff across the Trust based on risk assessments.

5. Vacancies by Site

The vacancy information for the adult inpatient areas below, has been taken from the ward budgeted establishments and staff in post data from ESR. The vacancies pending start has been collated from central records following the introduction of centralised recruitment in HR.

	Reported vacancies		Vacancies filled pending start		Unfilled Vacancies	
	RN	**Care Staff**	**RN**	**Care Staff**	**RN**	**Care Staff**
Bridlington	7	5.6	0	4.8	7	0.8
Community	8.74	7.31	3.39	5.73	5.35	3.58
Scarborough	37.86	16.7	16.4	28.8	21.46	-12.10
York	51.90	53.07	15.4	36.39	36.5	11.8
Total	**105.5**	**75.68**	**35.19**	**75.72**	**70.31**	**4.08**

The newly registered nurses have continued to arrive during October 2016, improving our staff in post position. At the end of October 2016, there were 105.5fte RN vacant posts and, 75.68fte Care Staff positions. Of these,

35.19fte RN posts and 75.72fte Care Staff posts have been recruited and the individuals will commence in post over the coming months. The remaining RN vacancy position is 70.31fte and 4.08fte for Care Staff.

The annual turnover rate in the year to September 2016 was 10.53%. This was a reduction from 11.01% in the year to the end of August 2016. This is the first time that turnover for this staff group has been below 11% since March 2015 and is a reduction of more than 2% compared to the rate in September 2015 when annual turnover was 12.81%.

Registered nurse recruitment is on-going across the Trust and at the Recruitment Market Place held in Scarborough on 13th October 2016 over 20 people were interviewed for Nursing positions at the Trust. A number of these were final year nursing students who are seeking employment from September 2017 onwards.

The Trust will be undertaking further Care Staff interviews during November with expected start dates in early 2017.

The Trust is also commencing with its 2017 nurse recruitment campaign including attendance at recruitment fairs during November and the winter months as well as holding bespoke recruitment for post-graduate diploma nursing students on 17th November

6. Recommendation

The Board is asked to receive the exception report for information.

7. References and further reading

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

Lord Carter Report *"Operational productivity and performance in English acute hospitals:*

Unwarranted variations". 2016	
Author	**Nichola Greenwood, Nursing Workforce Projects Manager**
Owner	**Beverley Geary, Chief Nurse**
Date	**November 2016**

Appendix 1

York Teaching Hospital NHS Foundation Trust

Fill rate indicator return
Staffing:

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

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

Comments

Only complete sites your organisation is accountable for					Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
Hospital Site Details		Ward name	Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours								
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Ann Wright	430 - GERIATRIC MEDICINE		1116	924	930	1008	682	682	341	649	82.8%	108.4%	100.0%	190.3%	547	2.9	3.0	6.0
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Ash	100 - GENERAL SURGERY		930	937.5	930	975	682	682	0	0	100.8%	104.8%	100.0%	-	463	3.5	2.1	5.6
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Beech	300 - GENERAL MEDICINE		1488	1380	1302	1272	1023	1023	682	704	92.7%	97.7%	100.0%	103.2%	965	2.5	2.0	4.5
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Cherry	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	1860	1626	1488	1452	1705	1419	1364	1353	87.4%	97.6%	83.2%	99.2%	724	4.2	3.9	8.1
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Chestnut	301 - GASTROENTEROLOGY	300 - GENERAL MEDICINE	1488	1194	1116	1152	682	682	682	737	80.2%	103.2%	100.0%	108.1%	867	2.2	2.2	4.3
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Coronary Care Unit	320 - CARDIOLOGY		2325	2017.5	930	712.5	1364	1155	341	484	86.8%	76.6%	84.7%	141.9%	585	5.4	2.0	7.5
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Duke of Kent	420 - PAEDIATRICS		1627.5	1680	465	412.5	682	748	341	275	103.2%	88.7%	109.7%	80.6%	219	11.1	3.1	14.2
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Graham	430 - GERIATRIC MEDICINE		930	942	930	858	682	682	682	682	101.3%	92.3%	100.0%	100.0%	581	2.8	2.7	5.4
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Hawthorn	501 - OBSTETRICS		744	744	372	372	682	682	0	0	100.0%	100.0%	100.0%	-	380	3.8	1.0	4.7
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Holly	110 - TRAUMA & ORTHOPAEDICS		1116	954	930	978	682	682	682	682	85.5%	105.2%	100.0%	100.0%	582	2.8	2.9	5.7
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Intensive Therapy Unit	192 - CRITICAL CARE MEDICINE	100 - GENERAL SURGERY	2790	2227.5	465	465	1705	1584	0	0	79.8%	100.0%	92.9%	-	141	27.0	3.3	30.3
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Lilac	101 - UROLOGY		1860	1560	1860	1665	682	946	682	781	83.9%	89.5%	138.7%	114.5%	677	3.7	3.6	7.3
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Maple	100 - GENERAL SURGERY		2325	2040	1162.5	1237.5	1364	1243	682	660	87.7%	106.5%	91.1%	96.8%	650	5.1	2.9	8.0
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Oak	430 - GERIATRIC MEDICINE		1488	1296	2046	1956	1023	935	1023	1078	87.1%	95.6%	91.4%	105.4%	1016	2.2	3.0	5.2
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Stroke	430 - GERIATRIC MEDICINE		1116	1068	744	708	1023	803	341	550	95.7%	95.2%	78.5%	161.3%	487	3.8	2.6	6.4
	BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Johnson	430 - GERIATRIC MEDICINE		930	894	1302	1218	682	649	341	363	96.1%	93.5%	95.2%	106.5%	828	1.9	1.9	3.8
	BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Kent	110 - TRAUMA & ORTHOPAEDICS		1162.5	1005	930	862.5	682	330	0	319	86.5%	92.7%	48.4%	-	144	9.3	8.2	17.5
	BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Lloyd	100 - GENERAL SURGERY		630	630	777	382.5	187	88	0	0	100.0%	49.2%	47.1%	-	26	27.6	14.7	42.3
	BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Waters	430 - GERIATRIC MEDICINE	101 - UROLOGY	465	592.5	1162.5	1080	341	341	682	671	127.4%	92.9%	100.0%	98.4%	324	2.9	5.4	8.3
	YORK HOSPITAL - RCB55	11	100 - GENERAL SURGERY	101 - UROLOGY	1512	1434	894	822	682	671	682	770	94.8%	91.9%	98.4%	112.9%	882	2.4	1.8	4.2

	YORK HOSPITAL - RCB55	14	100 - GENERAL SURGERY	101 - UROLOGY	1674	1530	1116	942	1023	1023	682	649	91.4%	84.4%	100.0%	95.2%	748	3.4	2.1	5.5
	YORK HOSPITAL - RCB55	15	120 - ENT		1860	1755	1395	1350	1023	1012	341	341	94.4%	96.8%	98.9%	100.0%	863	3.2	2.0	5.2
	YORK HOSPITAL - RCB55	16	100 - GENERAL SURGERY		2407.5	2340	1012.5	1027.5	1254	1265	572	572	97.2%	101.5%	100.9%	100.0%	669	5.4	2.4	7.8
	YORK HOSPITAL - RCB55	17	420 - PAEDIATRICS		1488	1410	372	372	1023	1122	341	374	94.8%	100.0%	109.7%	109.7%	450	5.6	1.7	7.3
	YORK HOSPITAL - RCB55	23	430 - GERIATRIC MEDICINE		1627.5	1432.5	1395	1530	682	682	1023	1001	88.0%	109.7%	100.0%	97.8%	917	2.3	2.8	5.1
	YORK HOSPITAL - RCB55	25	430 - GERIATRIC MEDICINE		1302	1194	1116	1362	682	682	1023	1320	91.7%	122.0%	100.0%	129.0%	701	2.7	3.8	6.5
	YORK HOSPITAL - RCB55	26	430 - GERIATRIC MEDICINE		1627.5	1485	1395	1665	682	682	1023	1265	91.2%	119.4%	100.0%	123.7%	910	2.4	3.2	5.6
	YORK HOSPITAL - RCB55	28	110 - TRAUMA & ORTHOPAEDICS		1674	1368	930	1074	682	682	682	704	81.7%	115.5%	100.0%	103.2%	726	2.8	2.4	5.3
	YORK HOSPITAL - RCB55	29	110 - TRAUMA & ORTHOPAEDICS		1488	1062	744	780	682	649	341	330	71.4%	104.8%	95.2%	96.8%	374	4.6	3.0	7.5
	YORK HOSPITAL - RCB55	31	370 - MEDICAL ONCOLOGY		2092.5	1942.5	930	945	682	682	341	341	92.8%	101.6%	100.0%	100.0%	536	4.9	2.4	7.3
	YORK HOSPITAL - RCB55	32	320 - CARDIOLOGY	361 - NEPHROLOGY	1506	1428	912	1122	682	682	1023	1012	94.8%	123.0%	100.0%	98.9%	849	2.5	2.5	5.0
	YORK HOSPITAL - RCB55	33	301 - GASTROENTEROLOGY	301 - GASTROENTEROLOGY	1488	1452	1116	1074	682	682	1023	1089	97.6%	96.2%	100.0%	106.5%	908	2.4	2.4	4.7
	YORK HOSPITAL - RCB55	34	340 - RESPIRATORY MEDICINE		1488	1476	1116	1062	682	836	1023	990	99.2%	95.2%	122.6%	96.8%	901	2.6	2.3	4.8
	YORK HOSPITAL - RCB55	35	430 - GERIATRIC MEDICINE		1302	1164	1116	1278	682	682	1023	1144	89.4%	114.5%	100.0%	111.8%	906	2.0	2.7	4.7
	YORK HOSPITAL - RCB55	37	430 - GERIATRIC MEDICINE		1087.5	982.5	1935	3210	682	682	682	1705	90.3%	165.9%	100.0%	250.0%	638	2.6	7.7	10.3
	YORK HOSPITAL - RCB55	39	430 - GERIATRIC MEDICINE		1302	1074	1116	1578	682	693	682	1067	82.5%	141.4%	101.6%	156.5%	727	2.4	3.6	6.1
	YORK HOSPITAL - RCB55	36 - Acute Stroke Unit	430 - GERIATRIC MEDICINE	430 - GERIATRIC MEDICINE	1488	1548	1302	1068	1023	1023	1023	1045	104.0%	82.0%	100.0%	102.2%	620	4.1	3.4	7.6
	YORK HOSPITAL - RCB55	Acute Medical Unit	300 - GENERAL MEDICINE		4650	3971.25	3720	3483.75	2728	2508	2046	2332	85.4%	93.6%	91.9%	114.0%	838	7.7	6.9	14.7
	YORK HOSPITAL - RCB55	Coronary Care Unit	320 - CARDIOLOGY	120 - ENT	1860	1605	315	232.5	1364	1199	0	0	86.3%	73.8%	87.9%	-	202	13.9	1.2	15.0
	YORK HOSPITAL - RCB55	Extended Stay Area	100 - GENERAL SURGERY		945	975	472.5	420	374	429	0	33	103.2%	88.9%	114.7%	-	254	5.5	1.8	7.3
	YORK HOSPITAL - RCB55	G1	430 - GERIATRIC MEDICINE		1488	1224	744	786	682	682	682	682	82.3%	105.6%	100.0%	100.0%	632	3.0	2.3	5.3
	YORK HOSPITAL - RCB55	G2	501 - OBSTETRICS		1116	1056	558	546	682	682	341	341	94.6%	97.8%	100.0%	100.0%	641	2.7	1.4	4.1
	YORK HOSPITAL - RCB55	G3	501 - OBSTETRICS		744	702	372	336	682	572	0	0	94.4%	90.3%	83.9%	-	177	7.2	1.9	9.1
	YORK HOSPITAL - RCB55	Intensive Care Unit	192 - CRITICAL CARE MEDICINE		5580	5145	465	427.5	4092	3817	341	341	92.2%	91.9%	93.3%	100.0%	364	24.6	2.1	26.7
	ARCHWAYS INTERMEDIATE CARE UNIT	Archways	925 - COMMUNITY CARE SERVICES		744	714	930	858	682	671	341	341	96.0%	92.3%	98.4%	100.0%	478	2.9	2.5	5.4
	MALTON COMMUNITY HOSPITAL - RCBL8	Fitzwilliam	925 - COMMUNITY CARE SERVICES		1162.5	930	1627.5	1830	682	682	682	682	80.0%	112.4%	100.0%	100.0%	760	2.1	3.3	5.4
	SELBY AND DISTRICT WAR MEMORIAL HOSPITAL - RCB07	Inpatient Unit	925 - COMMUNITY CARE SERVICES		1162.5	1102.5	1162.5	1207.5	682	627	341	396	94.8%	103.9%	91.9%	116.1%	498	3.5	3.2	6.7
	ST HELENS REHABILITATION HOSPITAL - RCBTV	St Helens	430 - GERIATRIC MEDICINE		930	915	1162.5	1087.5	682	660	341	341	98.4%	93.5%	96.8%	100.0%	573	2.7	2.5	5.2
	ST MONICAS HOSPITAL - RCB05	St Monicas	925 - COMMUNITY CARE SERVICES		622.5	585	795	855	341	341	341	341	94.0%	107.5%	100.0%	100.0%	296	3.1	4.0	7.2
	WHITE CROSS REHABILITATION HOSPITAL - RCBP9	Whitecross Court	430 - GERIATRIC MEDICINE		930	982.5	1162.5	1095	682	649	341	352	105.6%	94.2%	95.2%	103.2%	641	2.5	2.3	4.8
		Total			76740	69696.75	53241	54192.75	45122	43307	28193	31889					29885			

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 November 2016

Workforce Report – November 2016

Action requested/recommendation

The Board of Directors is asked to read the report and discuss.

Summary

The attached document provides information up to October 2016, relating to key Human Resources indicators including; sickness and recruitment and retention.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

Outcomes 12, 13 & 14

Progress of report	Workforce and Organisational Development Committee
Risk	No risk

Resource implications	There are Human Resources implications identified throughout this report.
Owner	Patrick Crowley, Chief Executive
Author	Polly McMeekin, Deputy Director of Workforce
Date of paper	November 2016
Version number	Version 1

Board of Directors – 30 November 2016

Workforce Report – November 2016

1. Introduction and background

This paper presents key workforce metrics up to October 2016 (where available). The narrative will detail trends and any actions which are being taken to address specific issues. Of particular note:

- The monthly sickness absence rate in September was 3.82% up from 3.72% in August. A small increase in monthly absence between August and September is an expected seasonal variation. Cumulative annual absence rates have remained static at 4.14% in each of the last four months.
- The turnover rate in the year to the end of October 2016 (based on headcount) was 11.01%. This was a reduction from a rate of 11.07% in the year to the end of September 2016.
- Work is on-going locally to support the transition of junior doctors to the new contract from December 2016.
- Demand for temporary nurse staffing continues to be high with requests totalling the equivalent of 394 FTE staff in October 2016.

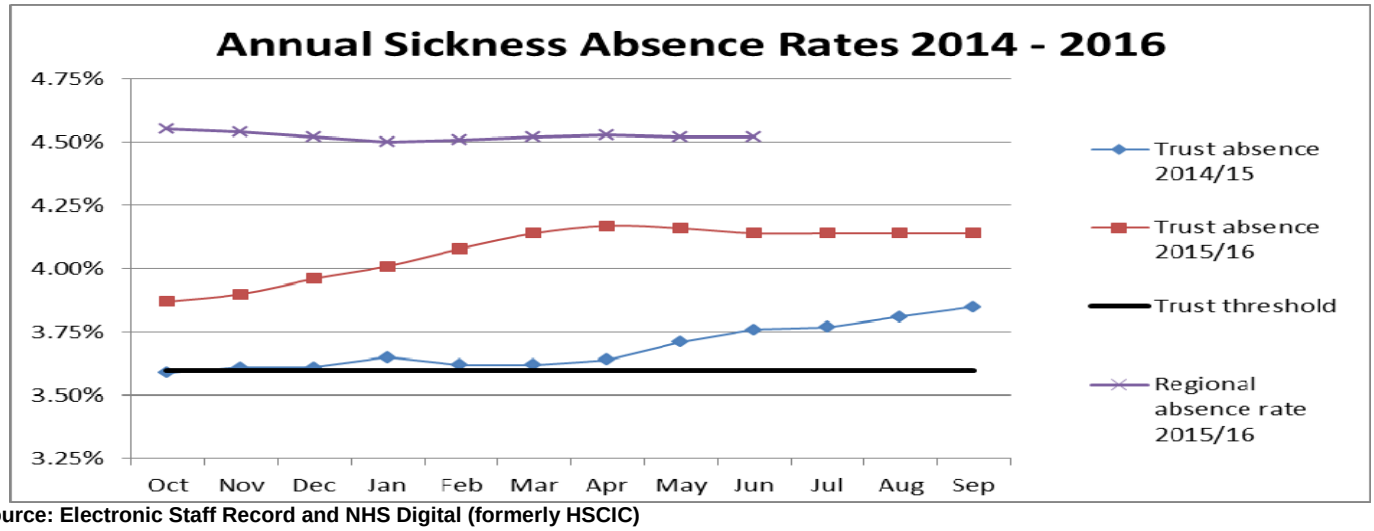
1.1 Sickness Absence

Sickness absence rates

The graph below compares the rolling 12 month absence rates to the Trust's locally agreed threshold and to the regional (Yorkshire and Humber) sickness absence rates. The Trust's cumulative annual absence rate increased in each month between April 2015 and April 2016. There were reductions in May and June 2016 and since then the annual absence rate has remained static at 4.14%.

The Trust absence rate continues to compare favourably with the regional absence rate. There is a delay in the publication of the regional data and currently only data up to June 2016 is available. In the year to June 2016, the regional annual absence rate was 4.52% compared to a Trust rate of 4.14%.

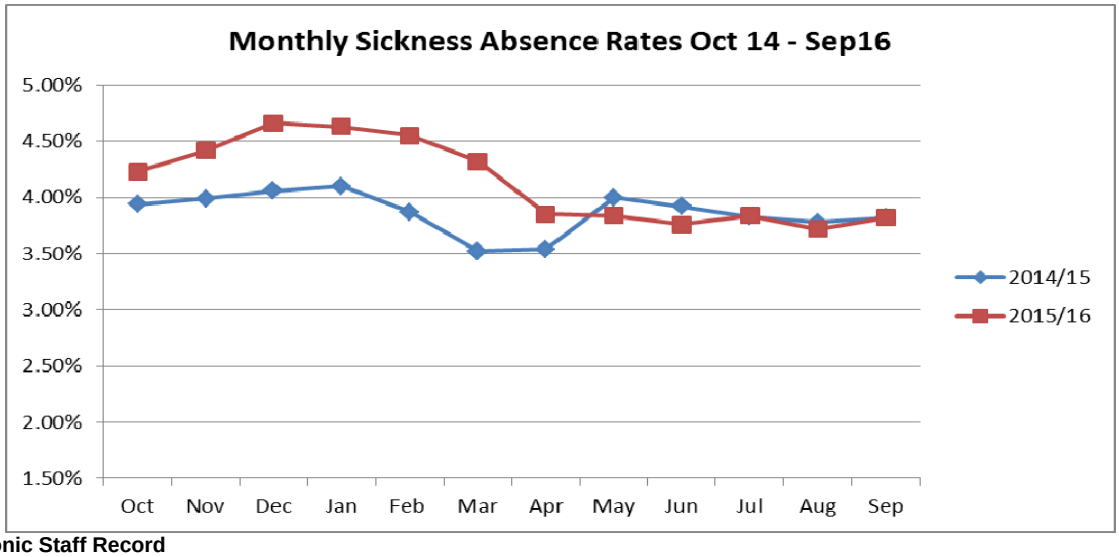
Graph 1 – Annual sickness absence rates



Source: Electronic Staff Record and NHS Digital (formerly HSCIC)

The graph below shows the monthly absence rates from October 2014 to September 2016. The monthly absence rate in September 2016 of 3.82% has increased slightly from 3.72% in August 2016 but was the same as the absence rate in the same month of the previous year.

Graph 2 – Monthly sickness absence rates



Source: Electronic Staff Record

Sickness absence reasons

The top three reasons for sickness absence in the year ending September 2016, based on both days lost (as FTE) and number of episodes are shown in the table below:

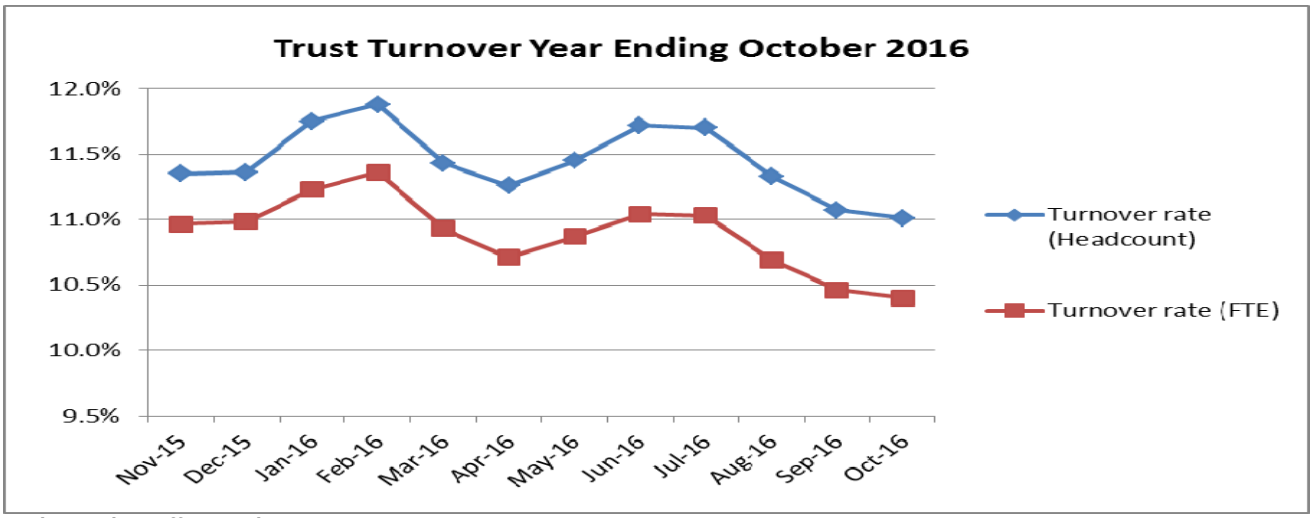
Top three reasons (days/FTE lost)	Top three reasons (episodes of absence
MSK problems, inc. back problems – 20.18% of all absence days lost	Gastrointestinal – 20.08% of all absence episodes
Anxiety/stress/depression – 19.96% of all absence days lost	Cold, cough, flu – 15.99% of all absence episodes
Gastrointestinal – 9.27% of all absence days lost	MSK problems, inc. back problems – 11.80% of all absence episodes

For the first time since the end of 2013, Anxiety/Stress/Depression has been replaced by Musculoskeletal problems / Back Problems as the highest sickness reason based on days lost (as FTE). These two sickness reasons have consistently been the two main sickness reasons across the Trust (combined they have made up, on average, 40% of all FTE days lost to sickness absence in the last 6 months). The Healthy Workforce Programme established earlier this year is overseeing the implementation of targeted interventions into these two areas.

1.2 Turnover

Turnover in the year to the end of October 2016 was 11.01% based on headcount. Turnover calculated based on full time equivalent leavers for the same period was 10.40%. This is a reduction from 11.07% and 10.46% respectively in the year to the end of September 2016. The turnover rate in the year to the end of October 2016 represented 842 leavers from the organisation and is the lowest rate it has been in the last 12 months.

Graph 3 – Overall Turnover Rates



Source: Electronic Staff Record

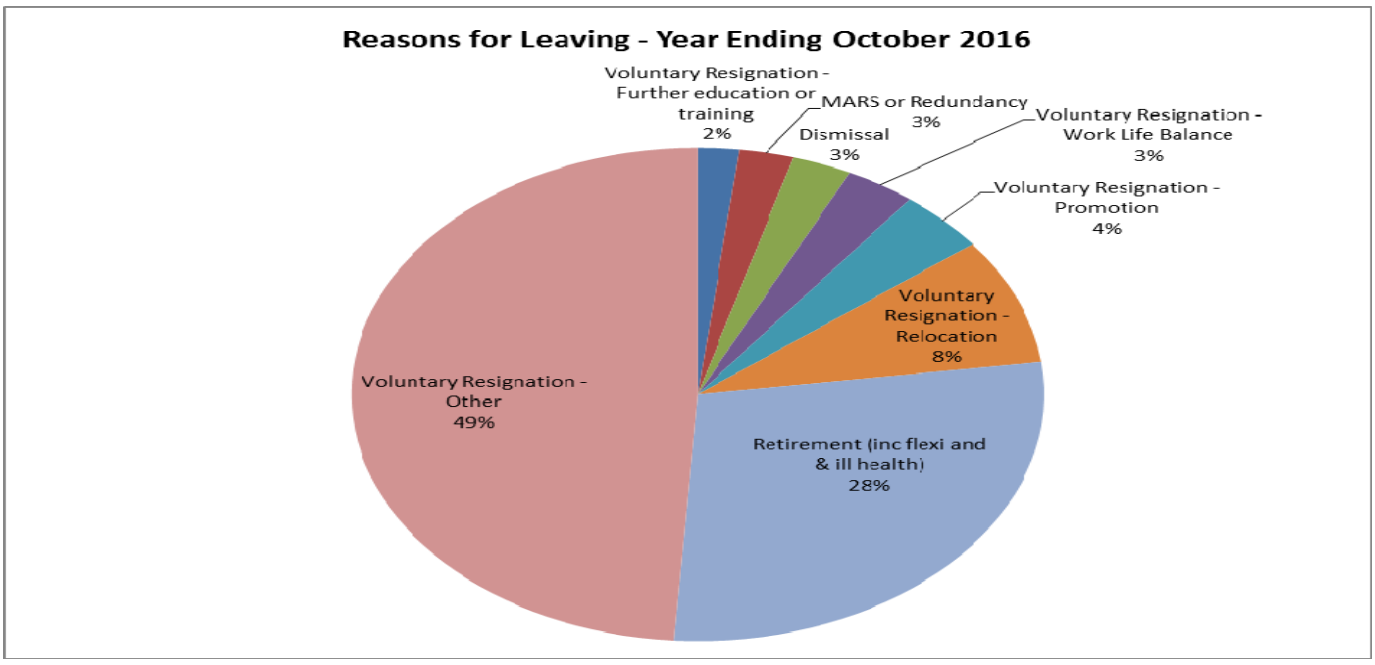
The turnover rates shown above and below exclude all staff on fixed term contracts, including all junior doctors on rotational contracts. This is a common convention used across the NHS for calculating turnover. The figures also exclude staff subject to TUPE.

The graph below shows a breakdown of reason for leaving.

In total, 66% of leavers voluntarily resigned. The 'Voluntary Resignation – Other' category shown below includes those who did not state a specific reason for leaving as well as a small number of staff who stated their leaving reason as one of the following; having adult or child dependents, better reward package, health, incompatible working relationships or lack of opportunities.

28% of staff left due to retirement, including those taking flexible retirement options and therefore may have later returned to work in some capacity.

Graph 4 – Reasons for Leaving



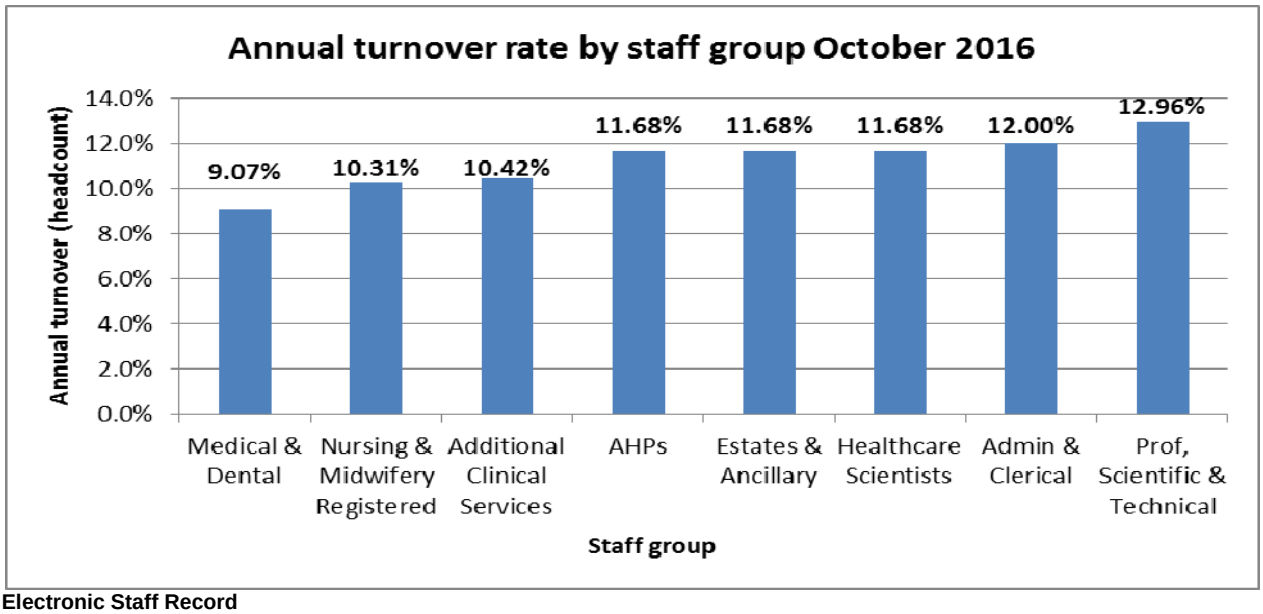
The graph below shows turnover by staff group. The two staff groups with the highest annual rate of turnover are Professional, Scientific & Technical and Admin & Clerical.
The Professional, Scientific & Technical staff group is one of the smallest staff groups within the

Trust and the turnover rate accounted for 32 leavers within this staff group.

The turnover rate for the Admin & Clerical staff group accounted for 200 leavers and this is the first time this staff group has appeared, within the last 12 months, as one of the staff groups with the highest rate of turnover. This appears to be a combination of a steady increase in turnover over the last 12 months (the turnover rate for the staff group was 10.08% in October 2015) and an improvement in turnover rates within other previously high turnover staff groups.

Of the leavers within the Admin & Clerical staff group, 70.85% voluntarily resigned which was higher than the equivalent proportion for the Trust overall. Proportionately, more Admin & Clerical staff resigned voluntarily due to either promotion, work life balance or under the category of voluntary resignation – other, than the respective equivalents for the Trust overall. MARS/Redundancy accounted for 5.03% of Admin & Clerical staff leavers; double that of the overall Trust which had an equivalent figure of 2.53%.

Graph 5 – Turnover by Staff Group



Source: Electronic Staff Record

1.3 Medical Workforce

Junior Doctor Contract

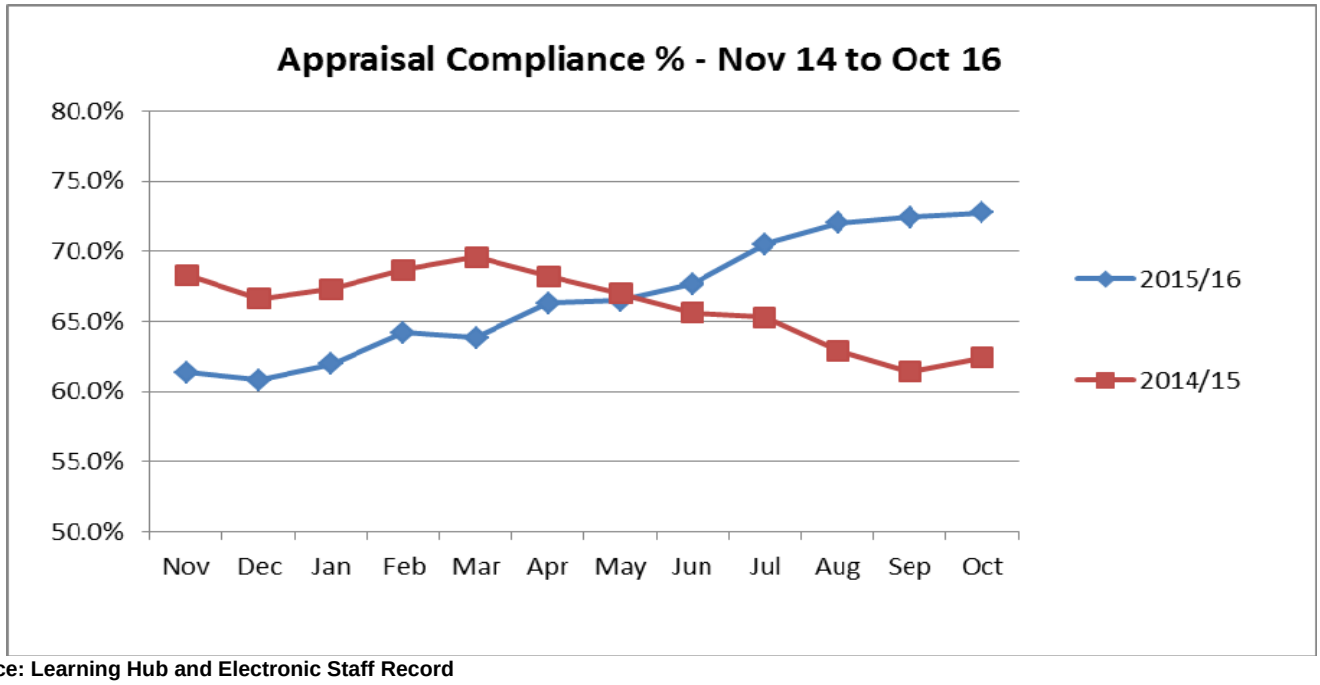
The generic work schedules have been issued for trainees due to transition onto the new contract on 7 December. Very little feedback has been received from the trainees in relation to their individual contracts.

Educational and Clinical Supervisors Update Workshops have been held in Scarborough and further sessions are planned in York. Medical Staffing provided an overview of the new contract to the Payroll Team on 2 November and the team will continue to hold drop in sessions for trainees and directorates. However, these have been very poorly attended by the junior doctors to date. The Trust's Medical Staffing Team has co-ordinated and chaired regional forum meetings for medical staffing managers to share good practice and ensure consistency. The Junior Doctors Forum has also been established with the inaugural meeting scheduled for 30 November 2016.

1.4 Appraisals

The graph below shows appraisal completion compliance from November 2014 to October 2016. From 5 September staff appraisals are recorded and inputted directly into the Learning Hub by the line manager or Directorate Management Teams via the new e-appraisal functionality.

Graph 6 – Appraisal Compliance %



Source: Learning Hub and Electronic Staff Record

Appraisal activity for Medical and Dental Staff was incorporated into the overall Trust appraisal report in December 2015. From December 2015 the overall Trust appraisal activity rate has been steadily increasing and the overall Trust rate for October 2016 stands at its highest rate over the last two years at 72.77%.

The Trust's Pay Progression Policy which was implemented in April 2016 for all staff on Agenda for Change terms and conditions will be contributing to this increased compliance. For staff to receive their pay uplift it is a requisite they have received an annual appraisal amongst other requirements.

1.5 New Approval Process for temporary VSM appointments

From 31 October 2016, new rules have come into force regarding the appointment, via an agency, of temporary Very Senior Managers (VSMs) in the NHS.

NHS Improvement has published details of the approval process which should now be followed in advance of the appointment of agency VSMs in order to help tackle the problem of agency spend generally in the NHS. VSMs are defined as all non-clinical, non-medical posts on local terms and conditions above Band 9 of Agenda for Change.

The rules will apply:

- to all NHS Trusts and to Foundation Trusts which are either receiving interim support from the Department of Health, or which are in breach of their licence for financial reasons (although other Foundation Trusts are also "strongly encouraged" to comply with the process);
- where the daily rate exceeds £750 (including on-costs); and
- to all interim contracts made (or extended) on or after 31 October 2016, including where

negotiations are in progress on that date

The guidance states that appointments should not exceed one year.

The process will involve completion of a business case approval form which will be reviewed by NHS Improvement. The guidance lists evidence which should be included in the business case such as:

- why an interim appointment is being made rather than a substantive appointment;
- steps the Trust will take to make a substantive appointment;
- steps that were taken to fill the role before engaging an agency VSM; and
- details of how the remuneration package has been calculated.

NHS Improvement seek to ensure business cases clearly demonstrate maximum value for money and failure to do so may result in the Trust being refused permission to appoint.

Following the end of the assignment, NHS Trusts are required to submit a report detailing the benefits of the work and the value which it has added. NHS Trusts are warned that non-compliance with this process may be evidence that they are not achieving value for money, which may lead to regulatory action.

1.6 Temporary staffing

Temporary nurse staffing

Demand for temporary nurse staffing (Registered Nurses (RNs) and Health Care Assistants (HCAs)) in the last year has on average equated to around 356 Full Time Equivalent (FTE) staff per month. However, demand over the past four months has been much higher than this with demand in October being 394.13 FTE. This was 33% higher than demand in the same month of the previous year (demand in October 2015 was 295.38 FTE).

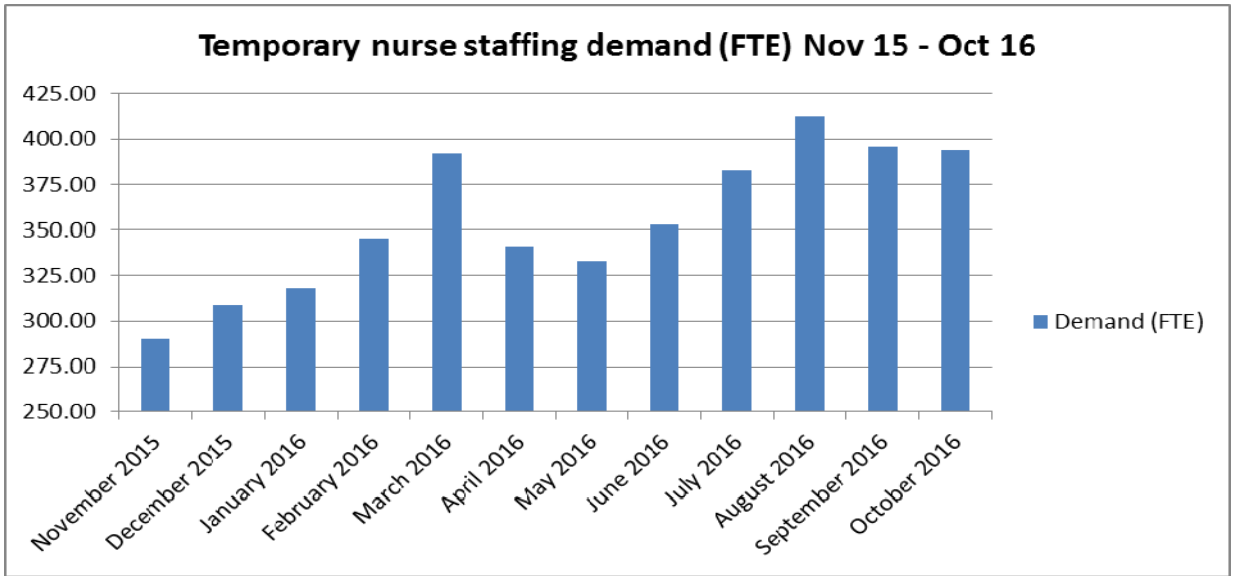
RNs and HCAs currently make up equal proportions of temporary nurse staffing demand. However, the rate at which demand has grown for RNs and HCAs over the last year is different. In October 2015 demand for RNs was 181.12 FTE; this had risen by 10% to 199.53 FTE in October 2016. In October 2015 demand for HCAs was 114.25 FTE; this had risen by 70% to 194.60 FTE in October 2016.

The most predominant reasons for making requests for temporary nurse staffing in September 2016 were:

- Vacancies – accounting for 56.9% of requests
- Sickness – accounting for 16.9% of requests
- Enhanced patient supervision (1:1 specialing) – accounting for 12.7% of requests

The increase in demand is, at least in part, a result of increases to bed numbers and additional RN posts. This includes an increasing in ED staffing to 11 RNs on each shift, staffing numbers have been increased on both AMUs and Graham Ward at Scarborough is also open. There have also been other smaller increases across the Trust as a result of requests via business cases.

Graph 7 – Temporary nurse staffing demand

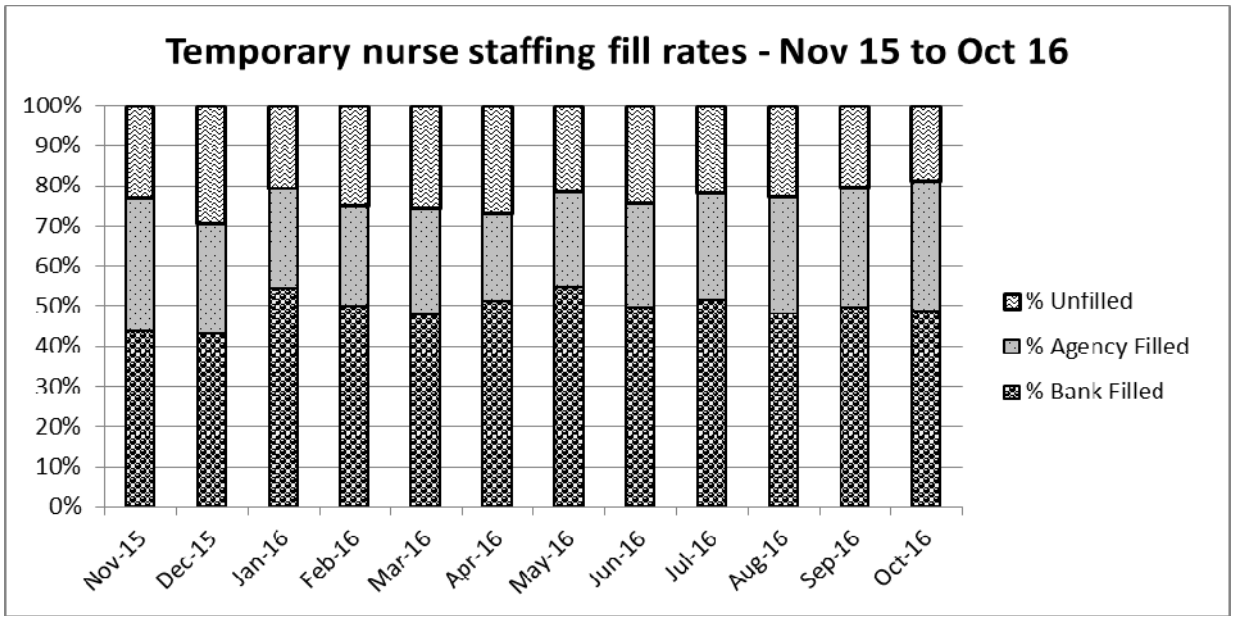


Source: HealthRoster

Graph 8 below shows the proportion of all shifts requested that were either filled by bank or agency or remained unfilled. Overall, bank fill rates reduced slightly in October compared to September (from 49.71% to 48.78%) whereas agency fill rates increased from 30.15% in September to 32.55% in October.

Bank fill at the Scarborough site (60.67%) remains higher than at the York site (43.28%) whereas the agency fill rate at York site (40.23%) remains higher than at the Scarborough site (15.94%). The agency fill rate at both sites had increased from the previous month (in September 2016 the agency fill rate was 13.04% at Scarborough and 37.76% at York).

Graph 8 – Nursing Temporary Staffing Fill Rates



Source: HealthRoster

The Trust is offering incentives to staff undertaking work on the Bank over the coming winter period from 1 December 2016 to 31 March 2017. This is based on the positive impact on bank fill rates after incentives were offered for the first time during Winter 2015/16.

For the 2016/17 winter period, substantive staff will be paid a15% uplift on their basic bank rate. As basic bank rates are already 5% above the basic AfC rate, this equates to an overall 20% uplift on the basic substantive pay rate.

Bank only staff will be paid an enhanced rate of 10% above their basic bank rate in one block payment after they have worked 187.5 hours (equivalent to 25 standard shifts) which will be paid in arrears. This equates to an overall 15% uplift on the basic AfC pay rate. Bank only staff will subsequently have the opportunity to receive these payments after each additional block of 187.5 hours worked. Bank only staff are being advised in the communications what they would receive should they become a substantive member of staff to encourage further substantive recruitment.

Online Payslips

From 5 December 2016, all nurse bank staff will start to receive their payslips online via ESR Employee Self Service (Limited Access) and will no longer receive printed paper payslips. This will be effective for both bank weekly payslips as well as for monthly substantive payslips where applicable. Staff can log into Self Service from a Trust PC or can register for internet access to Self Service which will enable staff to log in and view their payslips remotely from home at a time more convenient to them. Online payslips for other staff will be rolled out during 2017.

1.7 Reporting of Agency Use to NHS Improvement

There continues to be a requirement to report on a weekly basis to NHS Improvement all agency usage which is not compliant with the rules that have been introduced in phases since November 2015. These rules relate to use of off framework agencies, price caps (the total hourly rate paid) and wage rates (the hourly rate paid to the worker) for agency use for all staff groups. The aim of both the maximum wage rates and the overall price cap is to ensure that agency workers are paid in line with standard NHS terms and conditions.

Trusts must report in their weekly submissions, any breaches of the regulations under one of the following categories:

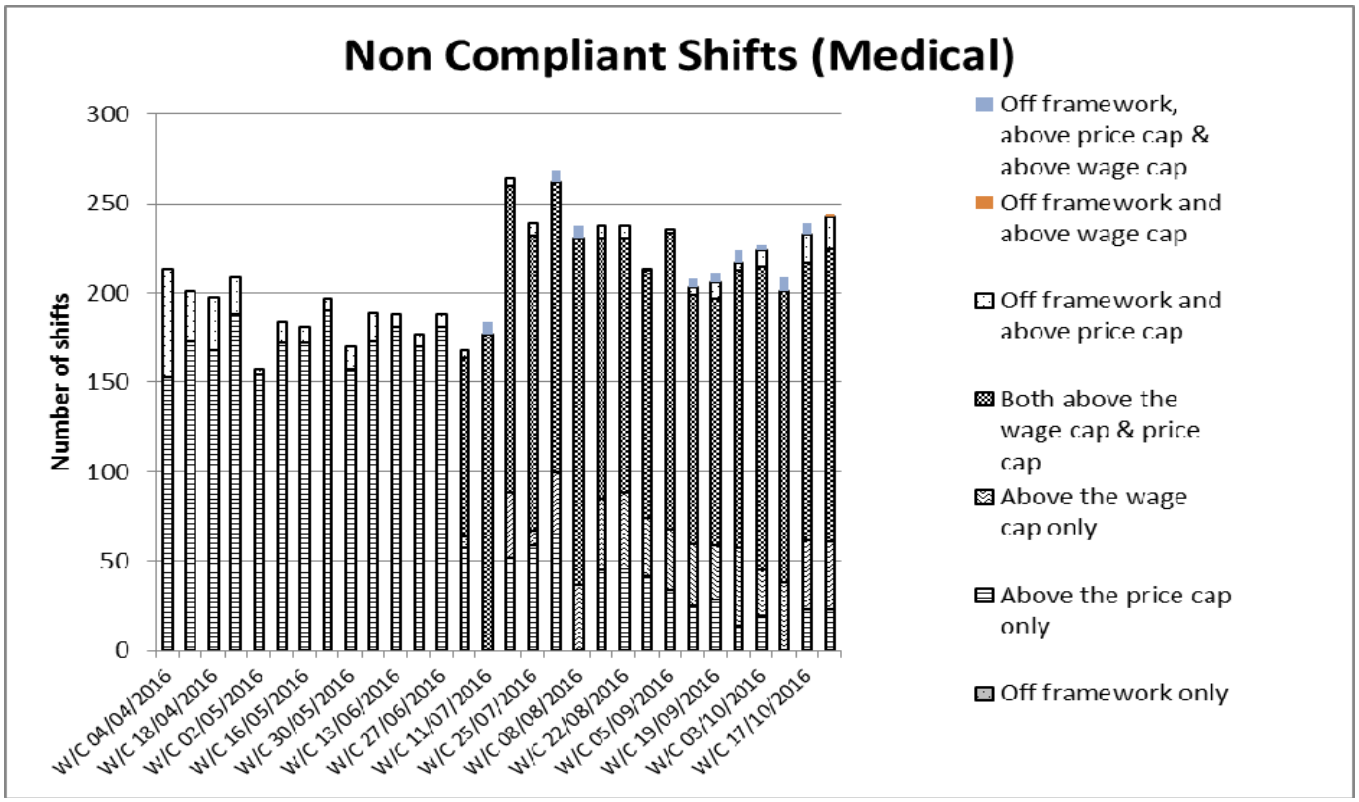
- Off framework only – shifts booked via an off framework agency but within both the price and wage caps
- Price cap only – shifts which are above the price cap but within the wage cap and via a framework agency
- Wage cap only - shifts which are above the wage cap but within the price cap and via a framework agency
- Price cap and wage cap - shifts which are above both the price cap and the wage cap and via a framework agency
- Off framework and above price cap – shifts via an off framework agency and above the price cap but within the wage cap
- Off framework and above wage cap – shifts via an off framework agency and above the wage cap but within the price cap
- Off framework, above the price and the wage cap – shifts that breach all regulations, are via an off framework agency and above both the price cap and the wage cap.

All shifts and bookings which are required to be reported to NHS Improvement are subject to senior level scrutiny and are only approved where there would be a patient safety implication of leaving the shift unfilled in line with the ‘break glass’ clause included in the rules. Retrospective review of all the shifts breaching the new regulations are considered weekly by the Executive Team.

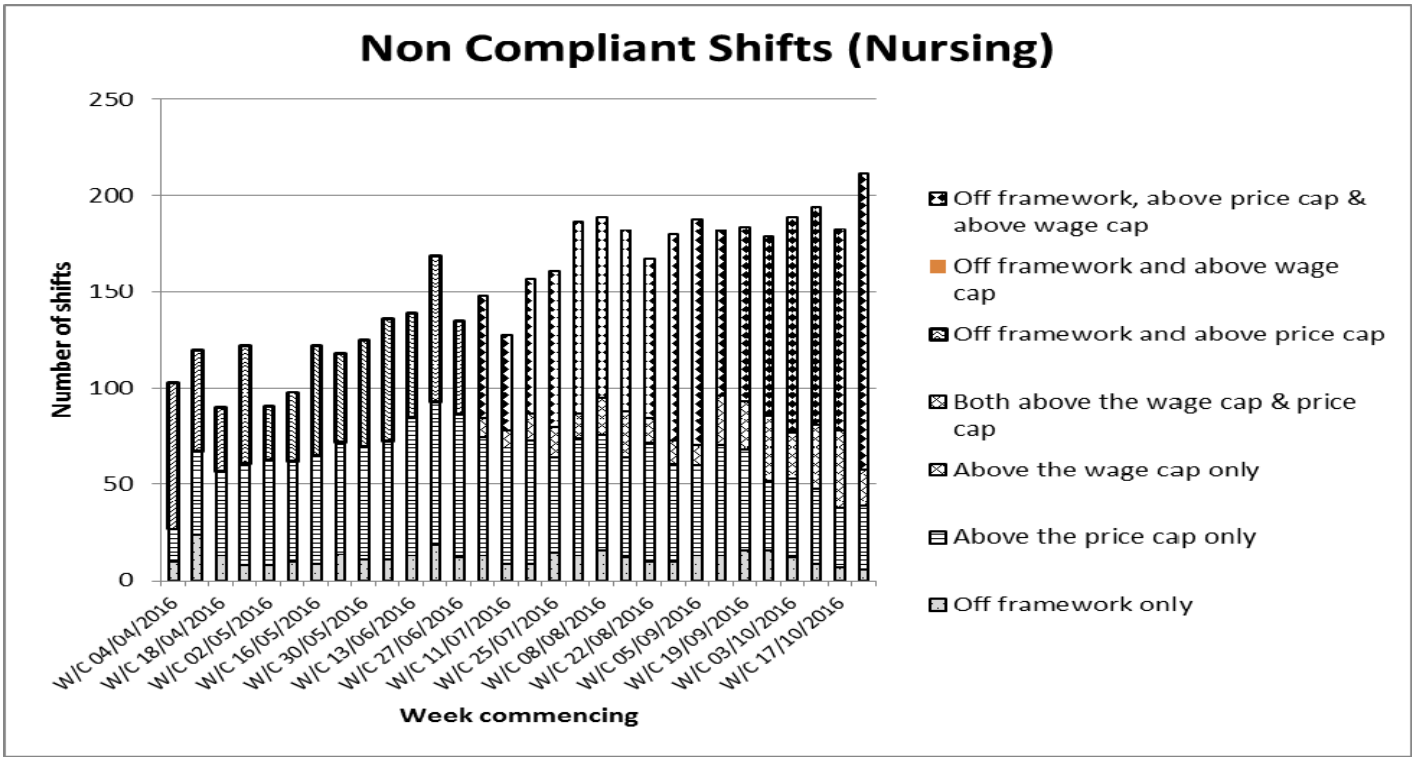
The graphs below show the number of shifts that have been reported as breaches to NHS Improvement each week since the beginning of April.

On average, the Trust is reporting just over 220 breaches relating to agency use for medics and almost 190 breaches relating to agency use for nurses each week.

Graph 9



Graph 10



At the start of this financial year, NHS Improvement set ceiling caps for agency expenditure for Trusts. This Trust's ceiling cap is £17.2 million (for spend across all staff groups). The Trust's expenditure in the financial year to date (£9.9 million between April and September 2016) is above the trajectory to meet the ceiling cap.

NHS Improvement wrote to Trusts in October requesting the submission of information in addition to that included within the usual weekly return (as detailed above). The additional information requested was:

- Monthly agency spending broken down by cost centre/service line. This was submitted on 24 October 2016.
- An anonymised list of the Trust's 20 highest earning agency staff and an anonymised list of agency staff that have been employed for more than six consecutive months. These lists were submitted on 31 October 2016.
- To complete an agency self-certification checklist. This is to be completed and submitted by 30 November 2016.
- Chief Executives to personally sign off on all shifts costing more than £120 per hour and all framework overrides above price cap. This action is to be embedded in all Trusts but for Trusts with year to date spending higher than the ceiling cap (including this Trust) there is a requirement that this data is submitted with the weekly return from 23 November 2016.

The letter also detailed the requirements for Trusts in relation to the appointment of VSMs (as detailed in section 2.5 above).

1.8 Employee Relations Activity

The table below describes the number and type of employee relations activity in each of the last three months.

Employee Relations Activity	**Jul 2016**	**Aug 2016**	**Sep 2016**	**Oct 2016**
Number of Disciplinaries (including investigations)*	14	15	13	13
Number of Grievances	18	20	23	16
Number of Formal Performance Management Cases (Stage 2 and 3)*	5	5	3	0
Number of Employment Tribunal Cases*	1	0	0	0
Number of active Organisational Change cases in consultation (including TUPE)	2	13	18	12
Number of long term sick cases ongoing	176	158	176	178
Number of short term sick cases (Stage 2 and 3)	178	183	188	127

*denotes staff on medical and dental terms and conditions are excluded from the figures as these are reported by the Professional Standards Team (MHPS).

1.9 Flu Campaign 2016

Phase 1 and 2 of the organisation's flu campaign ended on 31 October 2016. This included super vaccination clinics held in York, Scarborough & Bridlington condensed over a four week period and primarily ring fenced to frontline healthcare workers. A two week period of vaccination centres held in community areas was also incorporated within this timescale. Phase 3 of the campaign commenced on 1 November 2016 offering the vaccine to all Trust staff at 'drop in' clinic sessions.

The organisations agreed flu plan outlined a time limited period for staff to access the vaccine; the end of November concludes the programme.

During November:

- All unvaccinated frontline staff will receive an email to remind them to attend for vaccine.
- The reminder will include a request for all staff vaccinated elsewhere to inform the OH&WBS

via an email link.

- ‘Drop in’ clinic sessions planned for November in York, Scarborough & Bridlington.
- Continuation of peer vaccinator directorate visits in accordance with a planned schedule.
- The OH&WBS to maintain an ‘all contacts count’ approach for staff to access the vaccine.

Statistics:

- Frontline staff vaccinated up to & including 04/11/16 = **3,028**
- This equates to an uptake of **49%** against the CQUIN target of 75%.
- To reach the 75% target we must vaccinate a further **1,579** of Frontline staff.

For comparison, at the same time last year 26% of frontline staff were vaccinated.

2. Conclusion

This report has detailed key workforce metrics highlighting any issues or trends. In those areas where there are issues, actions which have already been identified have been detailed. The impact of actions will become apparent in subsequent reports.

3. Recommendation

The Board of Directors is asked to read the report and discuss.

Author	**Polly McMeekin, Deputy Director of Workforce**
Owner	**Patrick Crowley, Chief Executive**
Date	**November 2016**

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Finance and Performance Committee – 22 November 2016 – Neurosciences Resource Room, York Hospital

Attendance: Mike Keaney (Chairman), Mike Sweet, Steven Kitching, Andy Bertram, Lynda Provins, Juliet Walters, Sarah Barrow, Sue Rushbrook

Apologies: Gordon Cooney, Graham Lamb

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
1.	**Last Meeting Notes 18 October 2016**	The agenda covered the following AFW and CRR items AFW DoF COO CRR DoF 1-4, 8 & 9 COO 2, 3 & 6	The minutes of the meeting held on the 18 October 2016 were agreed.		
2.	**Matters arising**		The following matters arising were discussed: **Matters Arising – Agency Spend Risks** – MS asked whether an NHS locum had been secured for the Frailty Unit. AB stated that he was not aware of any developments as yet. **Finance** – Loans for Endoscopy and VIU – AB stated that there is no news as yet, but contact with the ITFF is maintained. **Efficiency –** Apprenticeship Levy – AB confirmed that this was an annual levy.		
3	**TAP – Key Priorities: Emergency Care Standard Delivery**		**Operational Performance** **Emergency Care Standard** - JW stated that performance was incredibly challenged in the Trust in both October and the beginning of November. The sustainability funding target was 90%, but unfortunately the Trust had only achieved 85.64%. The problem continues to be around high bed occupancy, which was well over 90% in October and November which is impacted by significant increases in non-elective admissions.	The Committee were assured that the Trust was operating safely and that mitigating actions to improve performance were being put in place.	JW to highlight the current challenges being experienced in relation to RTT and ECS, but that the hospital was operating

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
	Finance Control Total Delivery		JW highlighted the unplanned care diagram at the top of page 45, which showed the significant impact that non-elective work is having on the Trust. She noted that the Trust has had 440 more attendances non-elective admissions in October than in October last year and about 100 of which had needed to be admitted. It was noted this increase was being absorbed within existing capacity as a result of working more efficiently. It was reported the increase was having a detrimental impact on elective pathways. JW highlighted page 48 which showed the increases with the specialities; medical 18%, General Surgery & Urology 13%, Paediatrics 4% and a 26% increase in GP admissions which was also something of a concern. She noted the Trust was starting to feel the strain, but she stressed all the work being done and that it was absolutely the right actions to take. JW stated that the first phase of the acute medical model had started in November at Scarborough, which was tough for the Emergency Department to manage especially due to the issues with staffing and the lack of capacity in the rest of the hospital. JW stated that the time out with the acute physicians was looking at changes to the rota, but resources were incredibly tight and progress was being made. In relation to York, JW stated that the assessment unit on ward 24 would provide 18 trolleys, 12 elderly and 6 acute and there are plans to increase the resource and operating times. MS asked how long patients would be on trolleys and AB stated that the trolleys were designed to accommodate a patient for no more than 10 hours and this would be part of the operational policy. However, it was stressed this was an assessment unit and patients would not be bedded in this area.		safely which was the priority.

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			JW stated that there are plans to extend opening times of the assessment unit at York and ambulatory care at Scarborough. However she stressed that the Trust were also working with partners to look at the whole system approach and one of the priorities was to look at the reason for the increase in GP admissions. SR stated that this was a typical November where people are sick and discharges become complex and difficult. MK asked whether the plans were enough and whether the Trust should be exploring larger options to meet capacity. JW stated that everything was being done to mitigate the 11% increase. She highlighted the work to move to day cases for elective activity and the bigger strategic move in relation to the use of Bridlington. JW also noted that work needs to be done outside of the hospitals, but that this was a national picture in light of reduction of social care packages and support. This was also linked to the increase of 26% in GP admissions and SR noted the lack of GP cover provision over Christmas and New Year in Scarborough. AB stated that concerns are being raised with system partners at the A & E Delivery Board. MK asked if the plans were enough against the sustained increase in admissions. JW noted that the development of Bridlington was key along with the Acute Medical Model and the discussions being held on 4 hour metrics in relation to Scarborough, but that the real issue was outside the hospital. MK asked if the Trust was operating safely as in essence it was about patient safety not targets. The Committee discussed the difference the ACPs were making in Scarborough and it had been noted that they were identifying sick patients earlier in the		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			pathway. JW stated that the CQC meetings had been positive and the Trust was being very open, but that it is still about the lack of capacity in the community. JW stated that there is also oversight nationally and that the acute medical model will be used for other small hospitals. JW noted that the Director of Out of Hospital Care is also focused on working with the community teams to extend provision and that S & R CCG will be spot purchasing. AB stated that S & R CCG have not yet responded to the request to fund the extension of the community response team and the Trust are not in a position to staff any more beds currently at Bridlington, but that it is vital that elements are put in place to care for patients in their own home. MS asked whether YAS were performing better and JS noted that the concordat is in place, but there is more that can be done including self-handover. AB stated that the ED performance for the country was a 'sea of red' and was getting worse. He stated that JW and the team had done great work pulling everyone like ECIST and NHSI in and not one external organisation had been able to identify something extra that should be done. MS recognised the work being put in by the teams MK stated that essentially it was about making sure that the service is safe. AB stated that the primary focus was the safety of patients and it was agreed that this would be brought to the Board to provide assurance that even if targets are not achieved, the Trust is operating safely. **Cancer** - JW stated that the Trust had met 5 out of the 7 cancer targets for quarter 2. The 2 targets failed were the 14 day fast		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			track and pressures were predominately in relation to skin which dermatology were working towards getting enough capacity to get back on track and 62 day waits. The Trust is still within the tolerance of 1% for the STP funding for 62 day waits so will not be penalised for September. The Trust will need to resubmit trajectories for getting back on track. JW stated that cancer was a significant challenge, but this was also a national picture. **18 weeks** - JW stated that theatres had done well with recruitment and that this had led to a reduction in the number of list losses, however, there were still some staff shortfalls. 40 of the 100 elective cancellations were due to beds and that this week non-urgent operations were being cancelled. The plan was to make better use of day cases and theatres to reduce the backlog along with extra external capacity. She noted that the national position was similar and that it was vital that the Bridlington work went ahead. JW highlighted that work was in progress to extend theatre sessions and get the workforce recruited to ensure greater capacity. **Finance –** AB stated that the Trust achieved a £3.5m surplus against a planned surplus of £3m. He noted the loss of half of the surplus buffer in October and this was due to loosing £396k from the sustainability funding due to ECS, RTT and Cancer targets not being achieved. For October ECT and RTT both lost £140k each and Cancer lost £50k for September and October. However, AB hoped that this could be recouped by the end of the year due to the plans in place. AB stated that all the indicators are that this picture will continue for a number of months with the exception of cancer, but the Trust would still achieve the £10m surplus at the end of the year. AB stated that in relation to ECS the Trust has to achieve	The Committee noted the risks around the control total and agency spend.	AB to update Board on the risks around agency spend and achievement of the control total

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			91.5% by March 2017 so the assumption is that if 91.5% is achieved in March the full funding will be given to the Trust. He did note that RTT was different to this and must be achieved every month. AB did state that if the targets for both quarter 3 and 4 are missed then the Trust will not hit the control total due to the loss of £1.8m. If the Trust does not hit the control total then the Trust will lose the full two quarter's sustainability funding of £6.8m. Although, AB stressed there was nothing to suggest that the Trust will not finish in a surplus and the position is being closely monitored. AB stated that agency spend had also gone up and the Trust is now forecasting a £20m spend, which does not affect the metrics as the Single Oversight Framework states the tolerance from the cap can be between 0-25% before further impacting the Trust's KPI. MK stated that the positions with 18 weeks, ECS and agency spend were becoming quite critical and that this was a key emerging risk for the Board to be made aware of. The Committee discussed the inability of the CCG to pay for activity and AB thought that it was unlikely that this would happen. MS asked about the local price modification submission and AB stated that the Trust still intended to withdraw the application if an agreement was received on the loss of the acquisition support. He also noted that the application was waiting for investigation by NHSI. MK asked about the impact on next year if the Trust failed to		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			achieve the control total. AB stated that the rules have not yet been released, but it is likely to be linked to CQUINs. MK asked about the consequences of failing to meet the control total due to ECS and 18 week penalties and AB stated that the appeal process would be explored, but it would compromise cash flow next year if the full quarter 3 and 4 payments were lost. It was agreed to update the Board on the issues discussed. **Efficiency Report (inc. Carter Progress)** – SK stated that £16.4m had been achieved to date which was 63% of the £24m target and slightly behind the same position at the same time last year. The Trust is currently £1.5m behind its NHSI profile and the in-month achievement has been a little disappointing. SK noted that there is still a £1.6m planning gap that has moved marginally this month, but the really positive news was the £12m recurrent CIPs that had been achieved which he hoped to stretch to £15m by the end of the year. SK noted the key risks as the recurrent profile and planning gap. Although he was reasonably pleased with the position. MK asked if he was confident that the £26.4m for the year will be achieved and SK responded yes. **Review of Poorly Performing Directorates as part of the CIP Review -** SK gave a brief overview of the paper and stated that the intensity of contact with directorates had been increased. Efficiency panels were now up and running and were overseen by the Chief Executive and Director of Finance. A number of workshops have also been introduced to get to more staff and generate new ideas. MS stated that the table had changed in the report and	The Committee were assured that the CIP target will be achieved by year end.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			requested the key detail. SK stated that there were still currently 14 high risk schemes which were being looked at by the Clinical Lead as he believed the self-assessments were too high.		
4.	**TAP – Other Performance Issues: CQUIN Delivery**		**CQUIN Delivery** JW stated that Nicky Slater was continuing to do the CQUIN report until Lucy Turner's replacement started and that she and SR were providing monitoring and oversight. The quarter 2 report had been submitted. Sepsis - JW stated that the sepsis position had not changed significantly, but this did not recognise the significant amount of work that had been progressed. SR noted that the electronic screening tool which had been developed was being displayed as a National Conference this week. However, it was noted that the CQUIN been red at the previous meeting. Flu - JW noted that approximately 50% of frontline staff have been vaccinated and the staff that had not been vaccinated were being contacted to highlight the need for a vaccination, but also to try to capture those staff who have had it through their GP Surgeries or at pharmacies. N3A Antimicrobial Reduction – JW stated that the Trust were one of the lowest users so making a reduction was difficult. SR noted that the to achieve the sepsis the Trust had to identify and treat patients with antibiotics quicker, but the antimicrobial CQUIN required a reduction in the use of antibiotics. SR also raised that a national campaign is being planned regarding reducing antibiotics in children over winter, but this will most likely drive attendances to A & E up.		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			JW highlighted that Lucy Turner's replacement, Lynette Smith starts next week and that as part of her remit, she will pick up the weekly ECS reporting.		
5.	**Outstanding CIP Review Recommendations Progress**		SK stated that the report provided the national context and highlighted the rise in NHS deficit from £421m in 2013/14 to £2.6bn in 2 years and that the 5 Year Forward View required £22bn of efficiencies across the NHS. The report also provided a breakdown of performance of the Trust over the last 6 years. SK highlighted the good progress and the regular reviews from NHSI. SK stated that the Single Oversight Framework had placed the Trust in category 2 with targeted support, which was 1 category below the best. SK also noted that a submission had been made in October regarding Carter and STP information, but no feedback had been received to date.		
6.	**Service Line Reporting Update**		SK provided an overview of the report and noted that the draft index score had gone down by 4% to 96. He stated that the Trust was materially compliant with the external audit report and that the data was now a key part of the challenge at the efficiency panels and there are some clinicians interested in using it. SK stated that there were varying degrees of usage currently from the Directorates, but that this was being raised at the panels. MK noted that there were a number of discrepancies in the data between sites and SK stated that validation of data was still being carried out. MS stated that the report provided a lot of assurance, but was concerned about the time spent preparing returns. SR stated that the time spent on returns was a huge frustration to teams.	The Committee were assured by the information and the on-going work to ensure greater use of the data.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			She noted the wealth of information held by the Trust and that there was still a lot of work to do which could really influence patient care. The Committee discussed the issues of fixed costs in relation to loss making directorates. MK noted the amount of data and it was key that the directorates used it as part of their armoury. SK stated that the directorates were starting to use the information, but it was clinical discussions that were now required. MK and MS commended the system and the information it provided.		
7.	**Tenders**		SB provided an overview of the report which will be provided to the Committee on a quarterly basis. She noted the tender stages including identification of opportunities, weighting methodology being developed and the involvement of Corporate Directors. SB stated that a log of previous tenders also provides timely identification of future opportunities. SB stated that the Trust has submitted a joint tender for the East Riding Communities Services with City Healthcare and final notification of the outcome is awaited. The Trust's bid for cytology has been unsuccessful and work is being prepared to question the decision. SB attended the Scarborough and Ryedale CCG marketplace on the 21 November, but it is still not clear if and when the service will be tendered. MS stated that this was a really good report with a systematic documented approach. In future it was requested that the first page contained a little more detail. He noted the STP footprint	The Committee were assured by the information on tenders.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			and the Committee discussed how this aligned with the cytology tender decision. It was noted the Corporate Team are providing strategic guidance to ensure the right tenders are explored and submitted. MK commended the paper and thanked SB for attending.		
8.	**Risk Registers**		JW stated that her risks had been updated and one for maternity added. AB stated that he had reviewed his risks and had not made any changes. MS asked whether risk 4 (Commissioner resources) warranted a higher score. AB stated that 15 was a high score and to his knowledge a Commissioner had never defaulted on a payment. MS asked whether risk 8 (sustainability funding) should be heading towards 20. AB responded that the severity had been scored at 5 and the likelihood 3 as the Trust is expecting to recoup some of the monies at the end of the year.		
9.	**Any other business**		No other business was discussed.		
10.	**Next Meeting**		The next meeting is arranged for the 17 January 2017 in the Boardroom, York Hospital The Committee agreed that a December meeting will only be called if the situation warrants it. A brief update will be provided at the December Board.		

F1

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 November 2016

Finance Report

Action requested/recommendation

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

Summary

This report details the financial position for York Teaching Hospital NHS Foundation Trust for the period ended 30 November 2016.

At the end of November the Trust is reporting an Income and Expenditure (I&E) surplus of £3.5m against a planned surplus of £3.0m for the period. The Income & Expenditure position places the Trust ahead of its Operational plan.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	Finance & Performance Committee
Risk	There are financial risk implications identified in the report.
Resource implications	There are financial resource implications identified in the report.
Owner	Andrew Bertram, Finance Director
Author	Graham Lamb, Deputy Finance Director
Date of paper	November 2016
Version number	Version 1

Briefing Note for the Finance & Performance Committee Meeting 22 November 2016
Briefing Note for the Board of Directors Meeting 30 November 2016

Subject: November 2016 (Month 7) Financial Position

From: Andrew Bertram, Finance Director

Summary Reported Position for October 2016

The Trust's I&E account shows a month7 surplus of £3.5m against a planned surplus of £3.0m. The Trust is therefore currently reported as £0.5m ahead of plan and has maintained the favourable variance reported in all previous months, although the size of the variance has reduced from consistently around £1m down to £0.5m. This continues to be encouraging given the current and well documented risks to our plan and known pressures in the system.

The month 7 CIP position is also encouraging with £16.4m of our £26.4m target (62%) removed from budget. Of note is some £12m has been removed recurrently. This continues to be the highest recurrent delivery proportion the Trust has ever delivered. There is a planning gap for the year of £1.6m and this raises some concern but work continues to identify additional directorate schemes and corporate schemes.

Cash levels are behind plan but the main variance relates to the receipt of the Q2 sustainability funding assumed in October but not being paid until November/December. There are no cash issues causing any concern for escalation to the Board.

Sustainability Funding

The Board are aware that the business rules associated with the Sustainability Funding have now been published and the Trust has received its Q1 payment.

The current reported I&E position assumes continuation of payment in full for Q2 but not for month 7. We have adjusted down the in-month sustainability funding by £396k recognising the reported failures against the ECS trajectory, 18-weeks and cancer 62-day targets. Despite this failing the Trust is presently managing to its control total. The Board are aware that this is a compliance gateway for access to any sustainability funding and that, assuming the control total is met; a payment of 70% of the sustainability funding is made. The balance relates to delivery of the ECS trajectory (12.5%), delivery of 18-weeks (12.5%) and delivery of cancer access standards (5%).

The payment timetable has been published for Q2 sustainability funding and a split payment is expected. Payment of 70%, relating to meeting the financial control total, is expected on 22 November and payment of the remaining 30%, relating to performance, is expected in the Trust's bank account on 1 December.

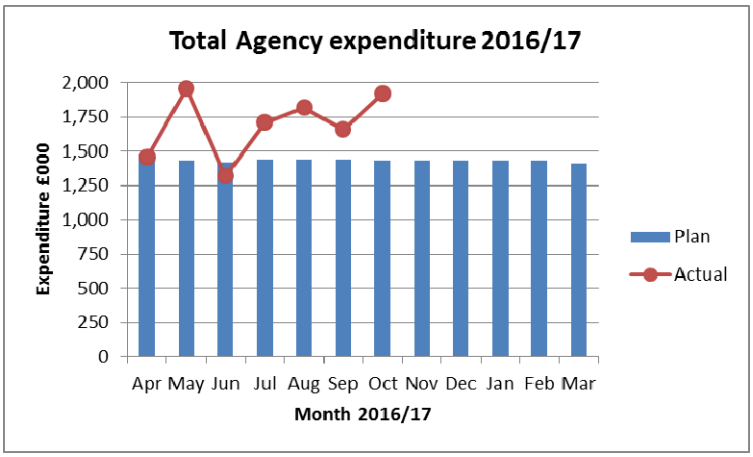
Publication of the Q3 and Q4 timetable for sustainability payments is expected imminently.

Enhanced Agency Expenditure Analysis

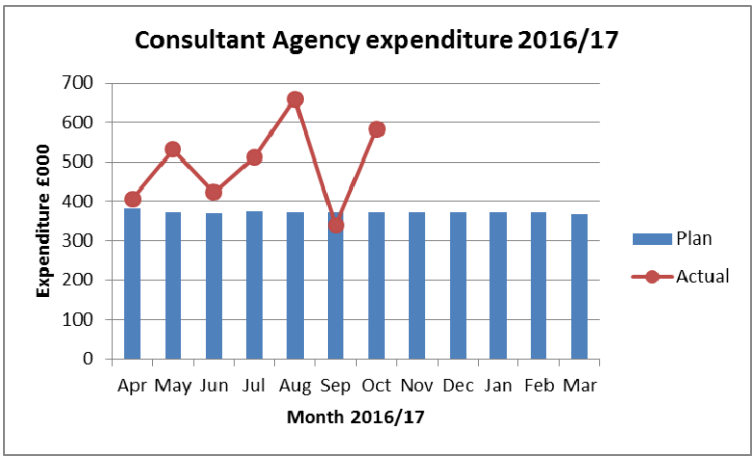
As discussed previously at the Board we have developed our agency staff cost reporting to ensure full visibility against the Trust's overall improvement trajectory. The Board are aware that NHSI has set the Trust an upper cap limit of £17.2m for its 2016/17 agency expenditure. As a reminder the agency spend for 2015/16 totalled £24m.

We have developed a suite of charts that set indicative targets for agency expenditure in the categories of Consultant, Other Medical, Nursing and Other Staff. The sum of each of these targets reconciles back to our capped plan of £17.2m.

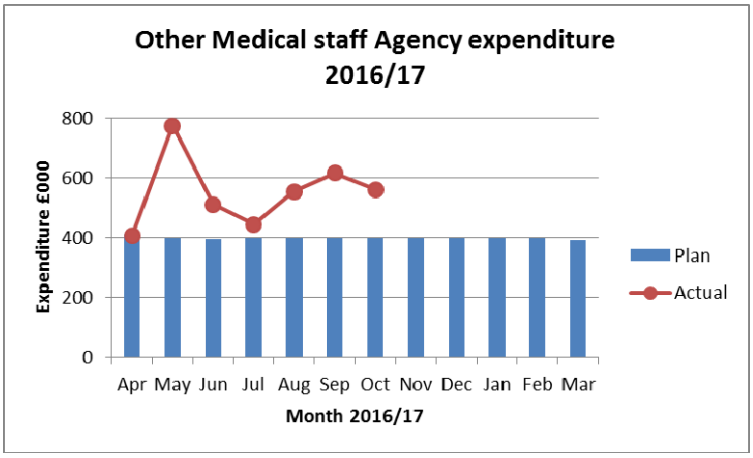
Expenditure is above trajectory but remains significantly below the pro-rata position based on the 2015/16 spend. Corrective action continues to be necessary.



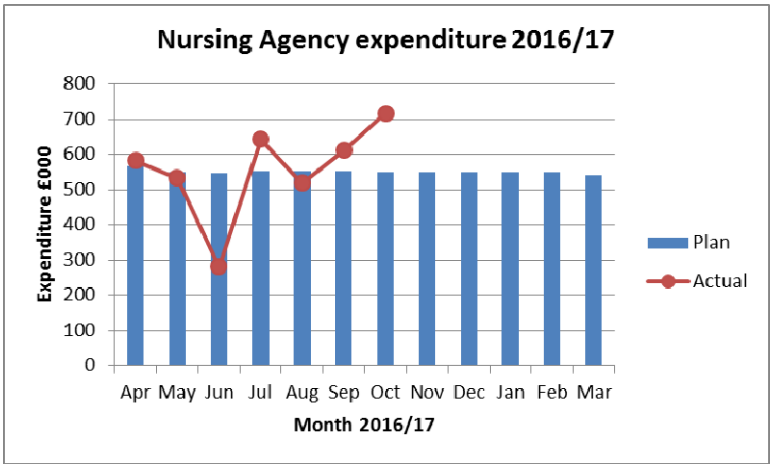
This first chart shows the monthly overall agency target; set at approximately £1.4m per month. October has been a high spending month at £1.9m. The forecast outturn now stands at £20.3m (18% cap breach). October was some £0.2m above the average for the year.



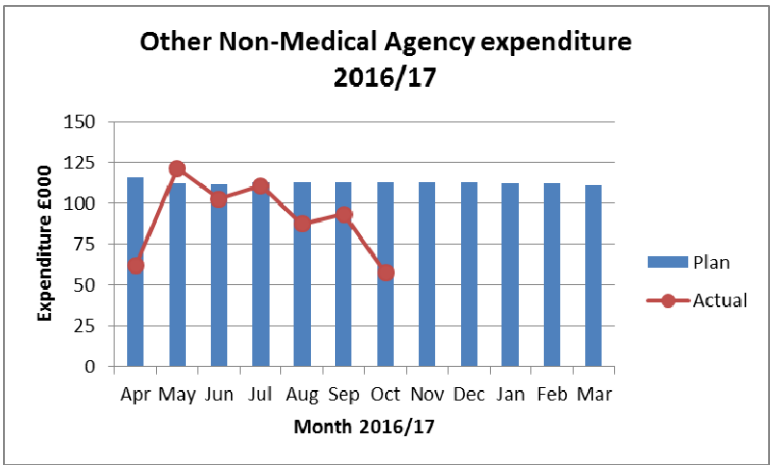
Consultant medical staff agency expenditure is a significant pressure area. October spend has been high again and we are now forecasting a 33% breach against the indicative cap rate.



Other medical staff (junior staff) agency expenditure also continues to be a main pressure area. October spend has been high again and we are now forecasting a 38% breach against the indicative cap rate.



Nursing staff agency expenditure remains under overall control with the forecast outturn matching almost exactly the indicative cap. However, October has been significantly higher than plan and if this continues then we will see nursing agency costs significantly exceed the indicative cap.



The final chart shows non-medical and non-nursing agency staff expenditure. In relative terms this is low level agency usage and there are no issues I would wish to bring to the Board's attention.

2016/17 Contract Issues

We continue to manage a small number of CCG challenges to our charging data relating to increases in the numbers of zero length of stay patients, patients undergoing in-patient rehabilitation and an increase in the coding and admission of patients with sepsis. On the basis of the investigative work done to date and presentations and discussions of the data with the CCGs, appropriate adjustments have been made to the reported income position.

There is evidence of an improving understanding of the reported position and discussions are moving towards requests for the Trust to reduce its charges on the grounds of CCG affordability. It is clear from our reported position that scope to work with commissioners in this way, without compromising delivery of our control total, is extremely limited.

2017/18 and 2018/19 Contract Issues

We have started discussions with all commissioners in relation to preparing and agreeing contracts for 2017/18 and 2018/19. Contract offers (or statements of overall maximum contract envelopes) have been received from all commissioners. Without exception these offers are all below current year forecast outturn activity levels and are significantly below Trust predicted activity levels for 2017/18 and 2018/19. These initial offers have been made on the grounds of affordability and not on the grounds of likely activity levels. The Trust has rejected these initial offers. We continue discussions with commissioners with the aim of completing contracts by the nationally mandated deadline of 23 December.

Finance Performance Report

November 2016

Our ultimate objective: To be trusted to deliver safe, effective and sustainable healthcare within our communities.

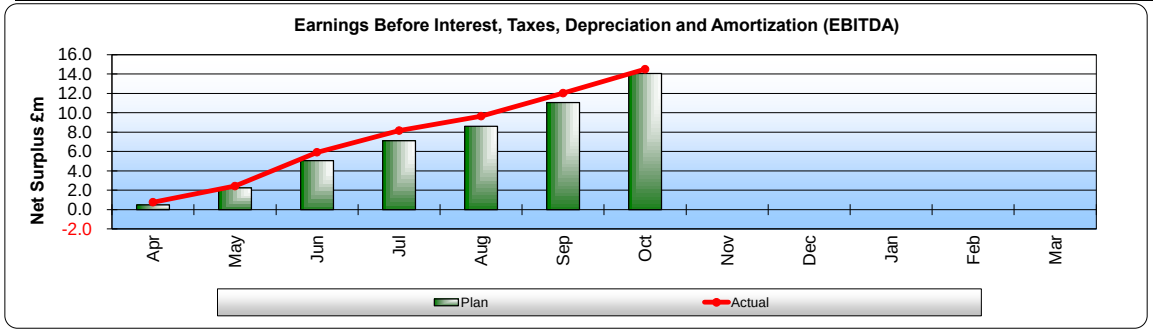
Finance Report
Chapter Index

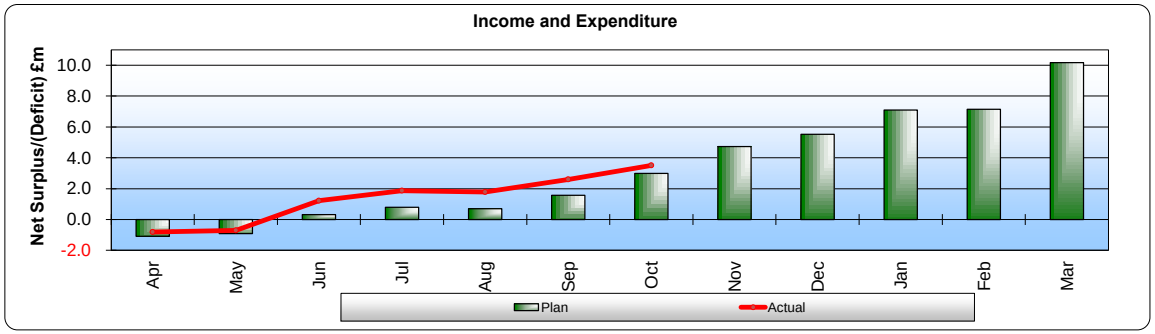
Summary Income and Expenditure Position
Month 7 - The Period 1st April 2016 to 31st October 2016

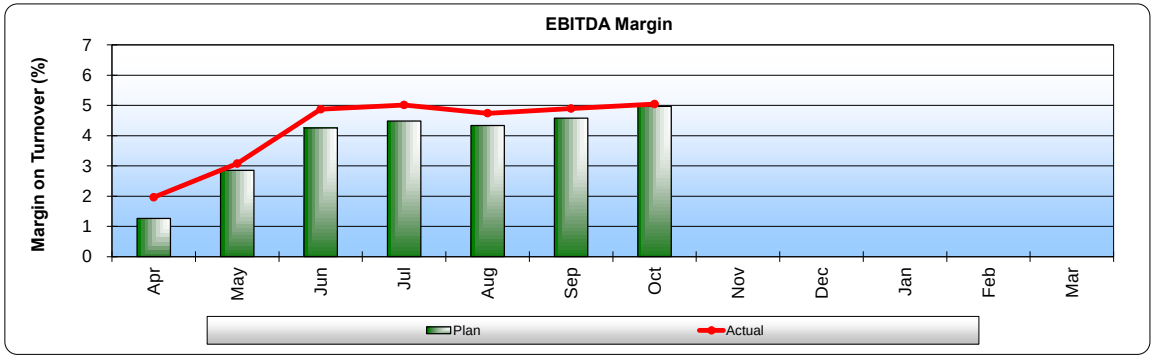
York Teaching Hospital NHS Foundation Trust

Summary Position:

* The Trust is reporting an I&E surplus of £3.5m, placing it £0.5m ahead of the operational plan.
* Income is £4.3m ahead of plan, with clinical income being £2.9m ahead of plan and non-clinical income being £1.4m ahead of plan.
* Operational expenditure is ahead of plan by £3.9m, with further explanation given on the 'Expenditure' sheet.
* The Trust's 'Earnings before Interest, Depreciation and Amortisation' (EBITDA) is £14.5m (5.04%) compared to plan of £14.1m (4.97%), and is reflective of the reported net I&E performance.







	Annual Plan	Plan for Year to Date	Actual for Year to Date	Variance for Year to Date	Forecast Outturn	Annual Plan Variance
	£000	£000	£000	£000	£000	£000
NHS Clinical Income						
Elective Income	26,596	15,372	14,986	-386	26,596	0
Planned same day (Day cases)	39,052	22,555	22,593	38	39,052	0
Non-Elective Income	111,616	65,407	66,130	723	111,616	0
Outpatients	65,508	37,507	38,042	535	65,508	0
A&E	13,800	8,116	8,381	265	13,800	0
Community	30,667	17,728	17,789	61	30,667	0
Other	151,147	87,461	89,041	1,580	151,147	0
	438,386	**254,146**	**256,962**	**2,816**	**438,386**	**0**
Non-NHS Clinical Income						
Private Patient Income	1,005	586	537	-49	1,005	0
Other Non-protected Clinical Income	1,827	1,066	1,109	43	1,827	0
	2,832	**1,652**	**1,646**	**-6**	**2,832**	**0**
Other Income						
Education & Training	15,049	8,778	8,397	-382	15,049	0
Research & Development	3,167	1,848	2,058	210	3,167	0
Donations & Grants received (Assets)	0	0	0	0	0	0
Donations & Grants received (cash to buy Assets)	739	431	459	28	739	0
Other Income	18,270	10,562	12,231	1,669	18,270	0
Transition support	10,045	5,860	5,860	0	10,045	0
	47,270	**27,479**	**29,004**	**1,525**	**47,270**	**0**
Total Income	**488,488**	**283,277**	**287,612**	**4,335**	**488,488**	**0**
Expenditure						
Pay costs	-324,062	-186,410	-185,704	706	-324,062	0
Drug costs	-50,879	-29,662	-32,271	-2,609	-50,879	0
Clinical Supplies & Services	-45,916	-26,655	-26,332	323	-45,916	0
Other costs (excluding Depreciation)	-48,133	-27,988	-28,689	-701	-48,133	0
Restructuring Costs	0	0	-109	-109	0	0
CIP	9,986	1,504	0	-1,504	9,986	0
Total Expenditure	**-459,004**	**-269,211**	**-273,105**	**-3,894**	**-459,004**	**0**
Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA)	**29,484**	**14,066**	**14,507**	**441**	**29,484**	**0**
Profit/ Loss on Asset Disposals	0	0	27	27	0	0
Fixed Asset Impairments	-300	0	0	0	-300	0
Depreciation	-12,000	-7,000	-7,000	0	-12,000	0
Interest Receivable/ Payable	100	58	100	41	100	0
Interest Expense on Overdrafts and WCF	0	0	0	0	0	0
Interest Expense on Bridging loans	0	0	0	0	0	0
Interest Expense on Non-commercial borrowings	0	0	0	0	0	0
Interest Expense on Commercial borrowings	-487	-269	-255	13	-487	0
Interest Expense on Finance leases (non-PFI)	0	0	0	0	0	0
Other Finance costs	0	0	0	0	0	0
PDC Dividend	-6,627	-3,866	-3,866	0	-6,627	0
Taxation Payable	0	0	0	0	0	0
NET SURPLUS/ DEFICIT	**10,170**	**2,990**	**3,512**	**522**	**10,170**	**0**

Contract Performance
Month 7 - The Period 1st April 2016 to 31st October 2016

York Teaching Hospital NHS
NHS Foundation Trust

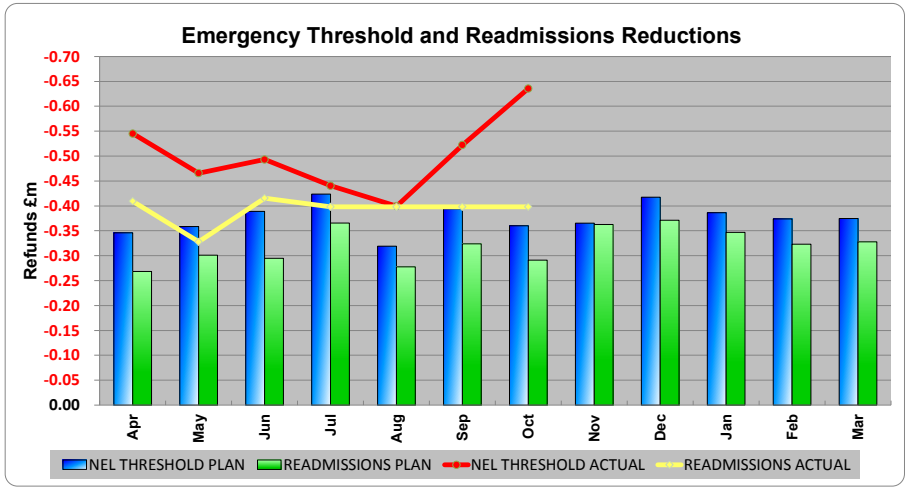
Contract	Annual Contract Value	Contract Year to Date	Actual Year to Date	Variance
	£000	£000	£000	£000
Vale of York CCG	206,033	119,199	123,852	4,653
Scarborough & Ryedale CCG	78,061	45,359	47,636	2,277
East Riding CCG	42,000	24,662	24,508	-154
Other Contracted CCGs	17,332	10,142	10,211	69
NHSE - Specialised Commissioning	37,475	21,912	23,307	1,395
NHSE - Public Health	14,190	8,289	8,657	368
Local Authorities	4,740	2,810	2,779	-31
Total NHS Contract Clinical Income	**399,831**	**232,373**	**240,950**	**8,577**

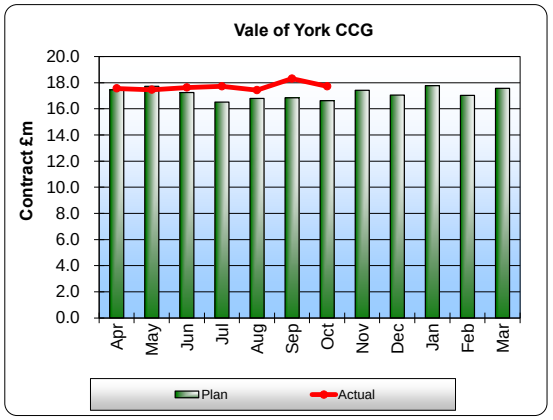
Plan	Annual Plan	Plan Year to Date	Actual Year to Date	Variance Year to Date
	£000	£000	£000	£000
Non-Contract Activity	15,511	9,079	8,821	-258
Risk Income	23,044	12,694	7,843	-4,851
Total Other NHS Clinical Income	**38,555**	**21,773**	**16,664**	**-5,109**

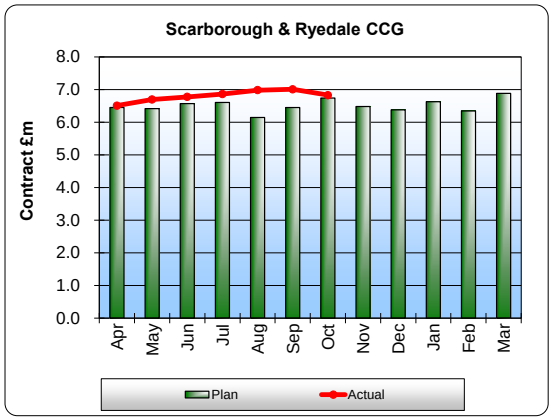
Specialist registrar income moved to other income non clinical	-744
Winter resilience monies in addition to contract	92

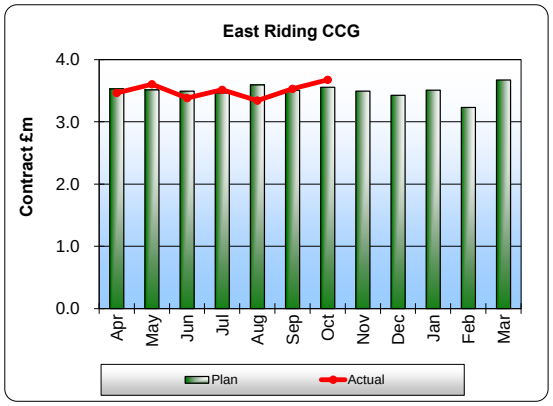
Total NHS Clinical Income	**438,386**	**254,146**	**256,962**	**2,816**

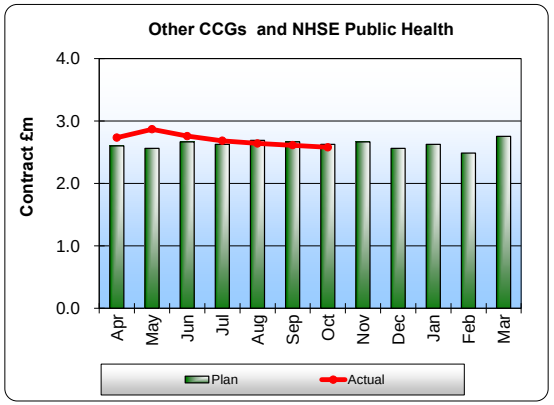
Activity data for October is partially coded (48.34%) and September is 90.89% coded. There is therefore some element of income estimate involved for the uncoded portion of activity.

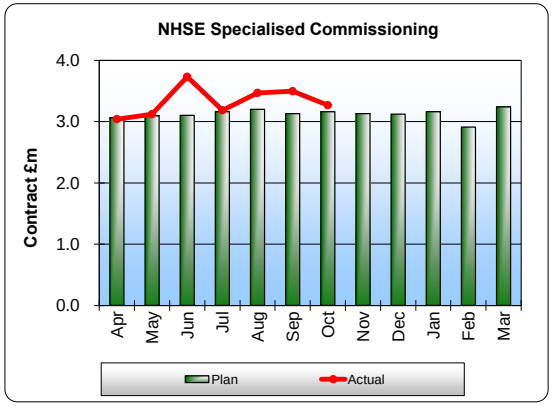


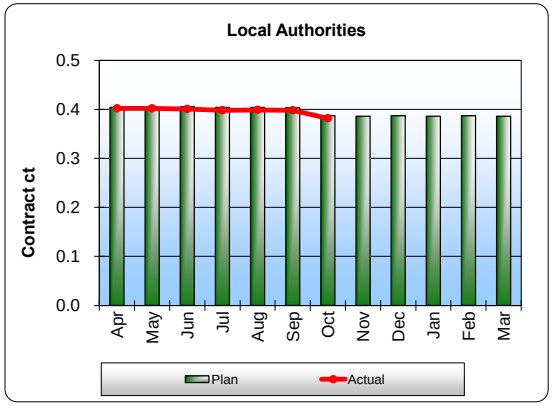












Expenditure Analysis
Month 7 - The Period 1st April 2016 to 31st October 2016

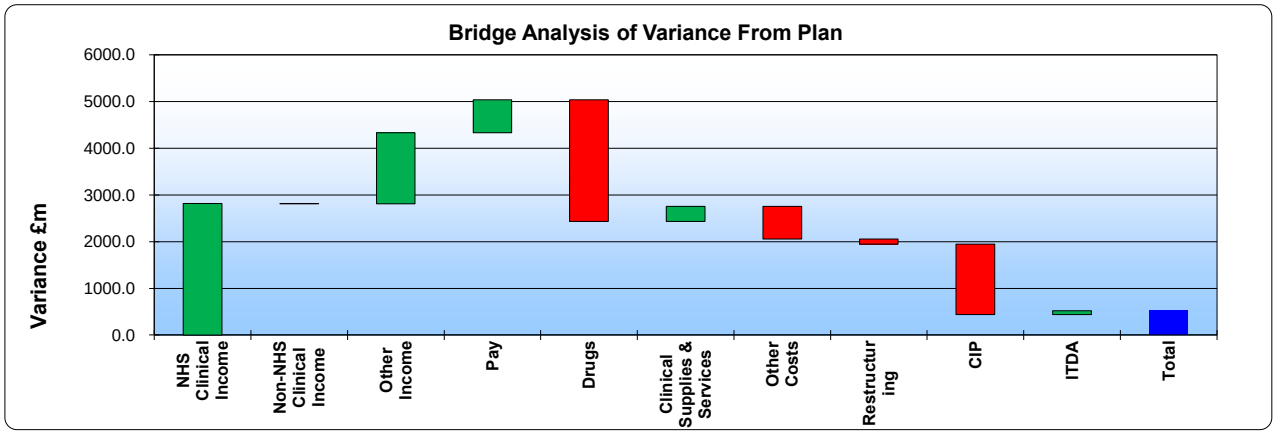
York Teaching Hospital NHS
NHS Foundation Trust

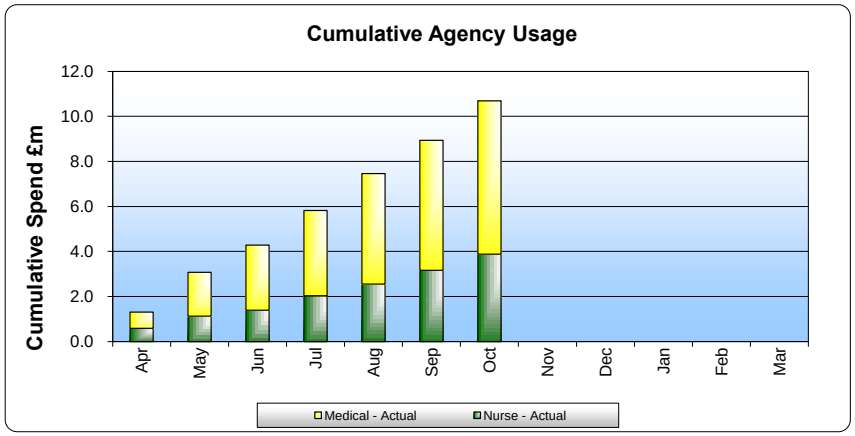
Key Messages:

There is an adverse expenditure variance of £3.9m at the end of October 2016. This comprises:

* Pay budgets are £0.7m favourable, linked to vacant posts.
* Drugs budgets are £2.6m adverse, mainly due to pass through costs for drugs excluded from tariff.
* CIP achievement is £1.5m behind plan.
* Other budgets are £0.5m adverse.

Staff Group	Annual	Year to Date								Previous	Comments
	Plan	Plan	Contract	Overtime	WLI	Bank	Agency	Total	Variance	Variance	
Consultants	58,513	33,740	29,213	0	859	0	3,107	33,180	561	435	
Medical and Dental	30,090	17,460	15,428	0	144	0	3,700	19,273	-1,813	-1,518	
Nursing	96,688	56,243	45,689	314	248	3,896	3,884	54,030	2,213	1,996	
Healthcare Scientists	11,048	6,372	5,314	129	133	-1	109	5,684	689	1,062	
Scientific, Therapeutic and technical	15,363	8,892	8,127	39	0	2	130	8,299	594	445	
Allied Health Professionals	25,251	14,644	13,040	55	171	6	123	13,395	1,249	1,154	
HCAs and Support Staff	44,346	25,851	23,483	402	77	47	107	24,116	1,735	1,429	
Chairman and Non Executives	163	95	95	0	0	0	0	95	-1	-1	
Exec Board and Senior managers	12,310	7,106	7,884	2	0	0	0	7,886	-780	-706	
Admin & Clerical	37,199	21,494	19,254	168	65	95	165	19,746	1,748	1,493	
Agency Premium Provision	5,597	3,258	0	0	0	0	0	0	3,258	2,790	
Vacancy Factor	-12,504	-8,745	0	0	0	0	0	0	-8,745	-8,164	
TOTAL	**324,062**	**186,410**	**167,528**	**1,107**	**1,698**	**4,044**	**11,326**	**185,703**	**707**	**416**	



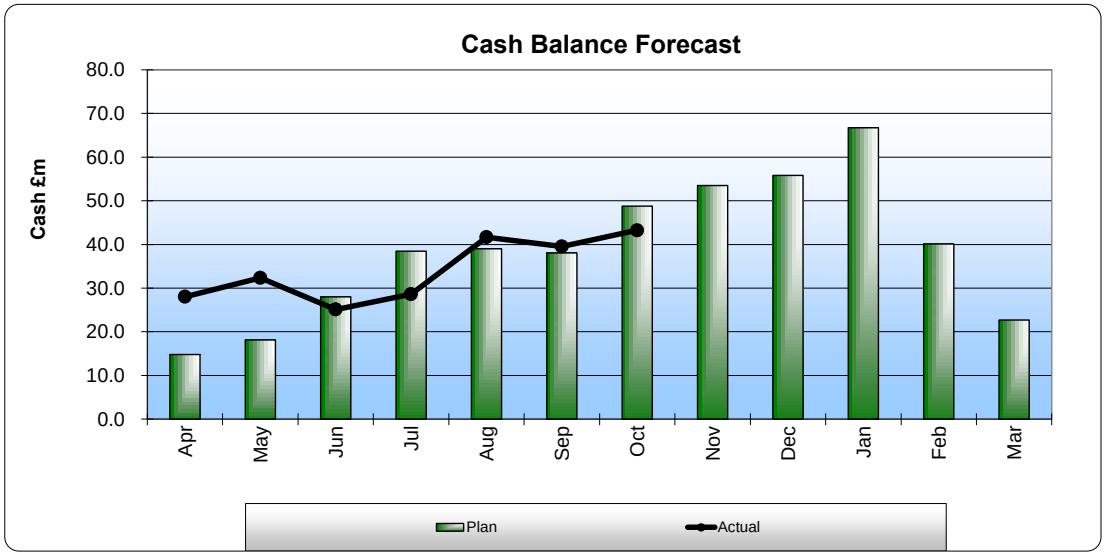


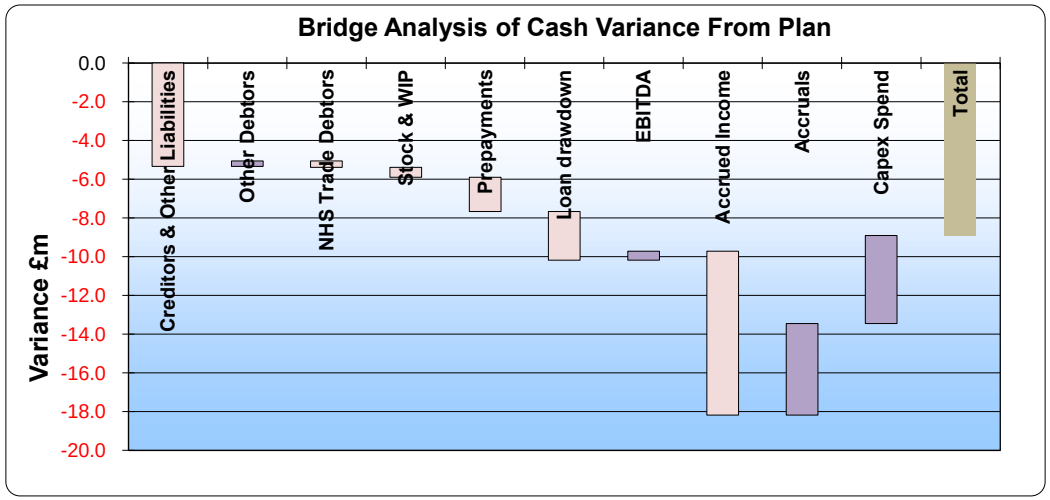
Cash Flow Management
Month 7 - The Period 1st April 2016 to 31st October 2016

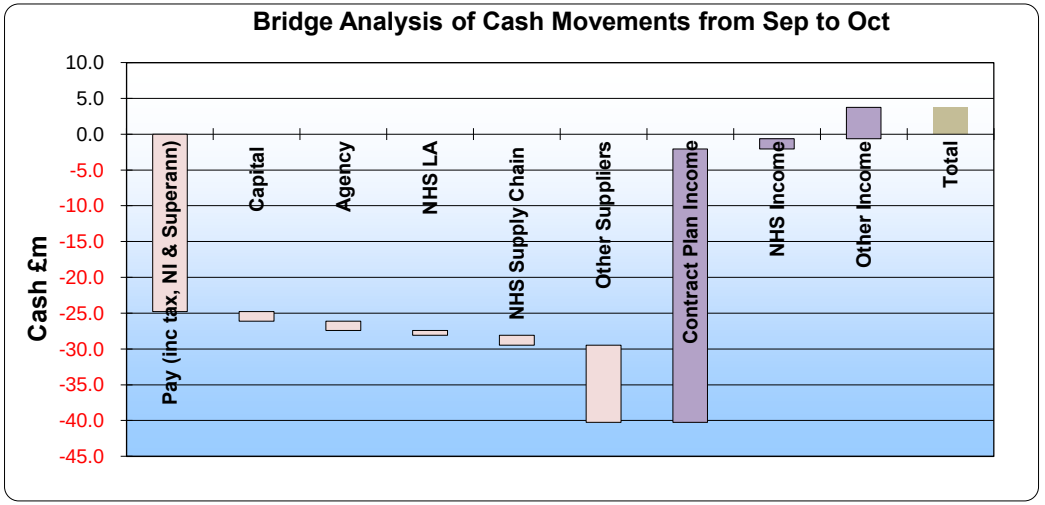
York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

* The cash position at the end of October was £43.2m, which is behind plan. The key factors influencing cash are:
* Negative impact due to delays in the receipt of £3.4m S&T funding. This was originally planned in October, but now revised to November/December.
* Negative impact due to expenditure incurred with the level of overtrade activity of approx £4m.
* Positive impact due to delays in the Capital Programme.







Cash Flow Management
Month 7 - The Period 1st April 2016 to 31st October 2016

York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

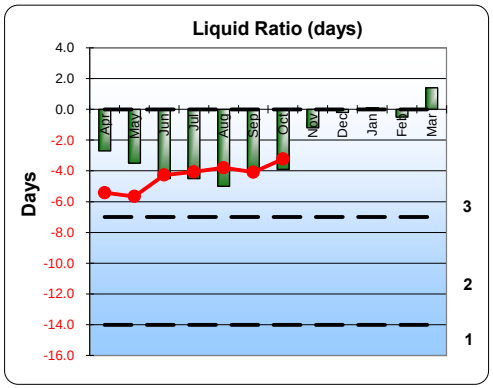
* The receivables balance at the end of October was £8.3m, which is below plan.
* The payables balance at the end of October was £8.5m, which is below plan.
* The Financial Sustainability Risk Rating (FSRR), which is assessed as a score of 4 in October, and is reflective of the I&E position.

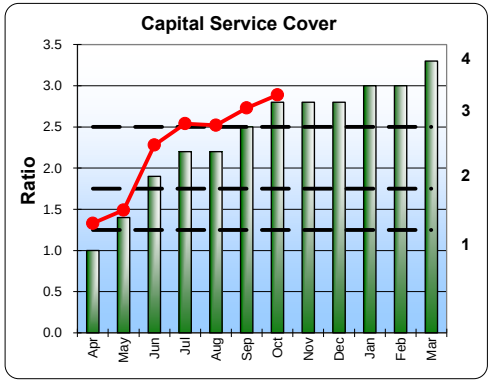
Significant Aged Debtors (+6mths)

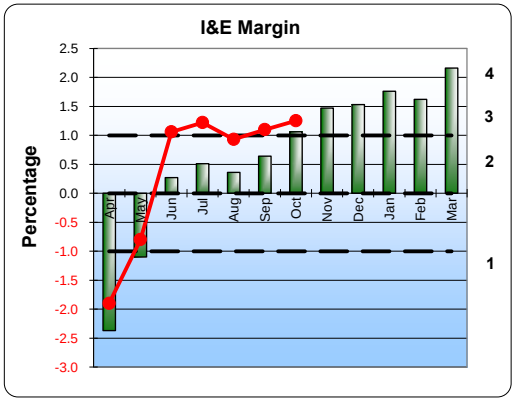
Leeds & York Partnership NHS FT	**£372K**
NHS Property Services	**£213K**
Depuy Ireland	**£193K**

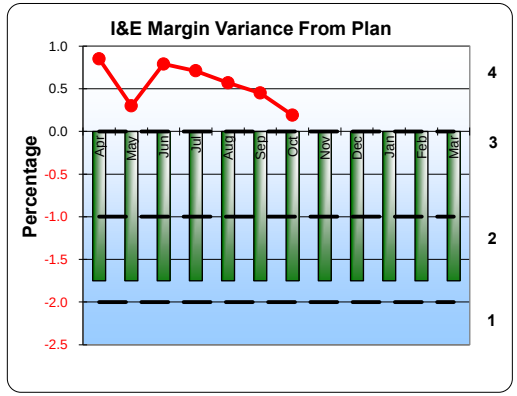
	Under 3 mths	3-6 mths	6-12 mths	12 mths +	Total
	£m	£m	£m	£m	£m
Payables	5.76	1.27	0.77	0.67	8.47
Receivables	5.71	0.94	1.12	0.57	8.34

FSRR Area of Review	Plan for Year	Plan for Year-to-date	Actual Year-to-date	Forecast for Year
Liquidity (25%)	4	3	3	4
Capital Service Cover (25%)	4	4	4	4
I&E Margin (25%)	4	4	4	4
I&E Margin Variance From Plan (25%)	2	2	4	4
Overall Financial Sustainability Risk Rating	4	3	4	4







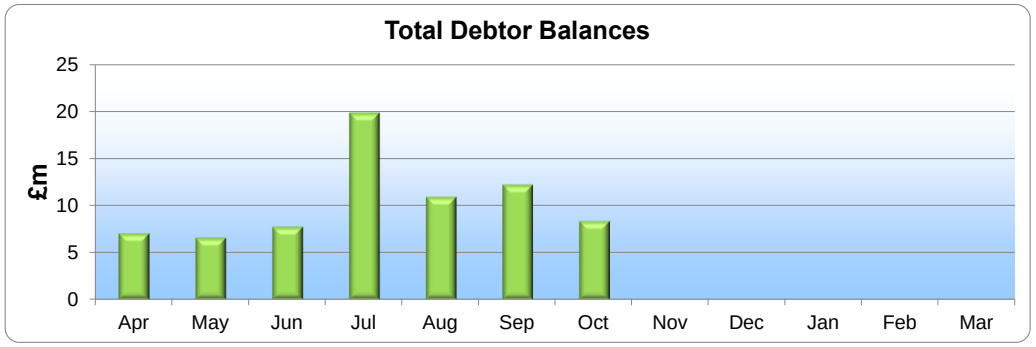


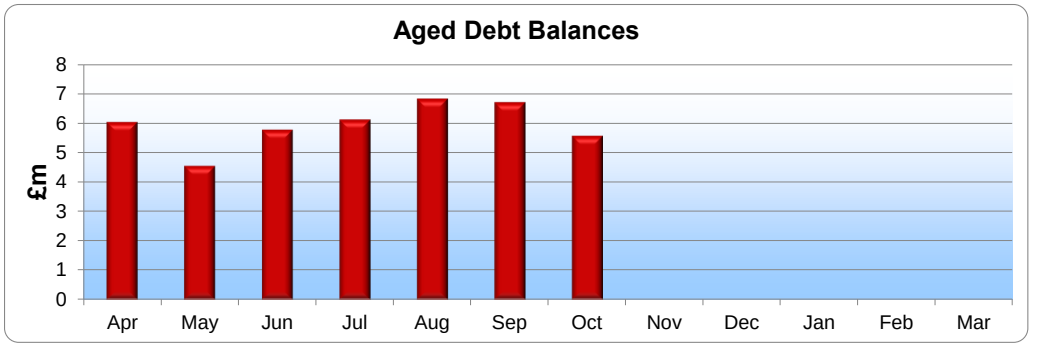
Debtor Analysis
Month 7 - The Period 1st April 2016 to 31st October 2016

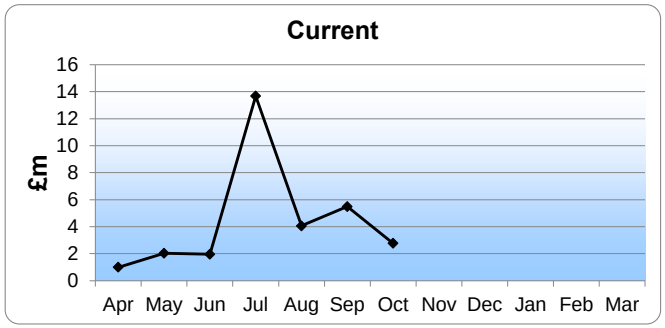
York Teaching Hospital NHS
NHS Foundation Trust

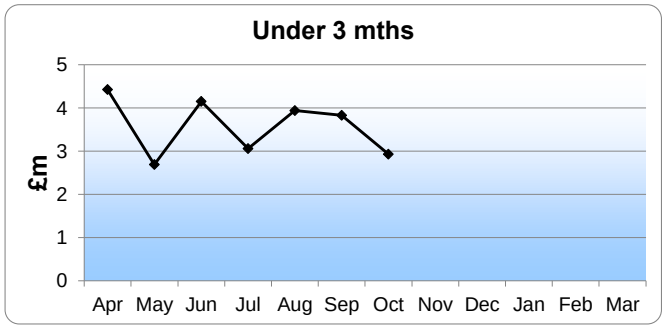
Key Messages:

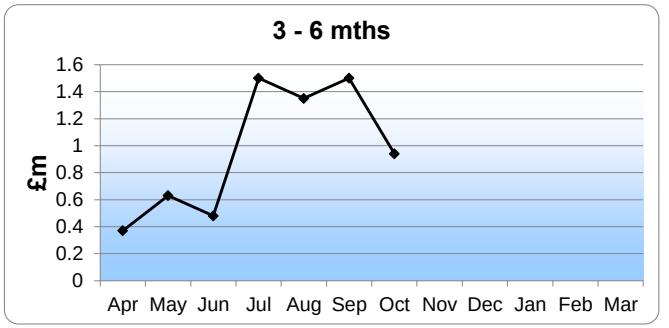
* At the end of October, the total debtor balance was £8.3m, with £2.8m relating to 'current' invoices not due.
* Aged Debt was £5.6m, however £2.9m of this is under 3 months old.
* Short terms debtors have reduced significantly from the September position.

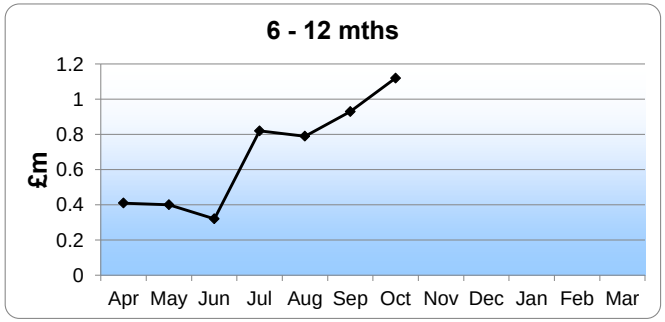


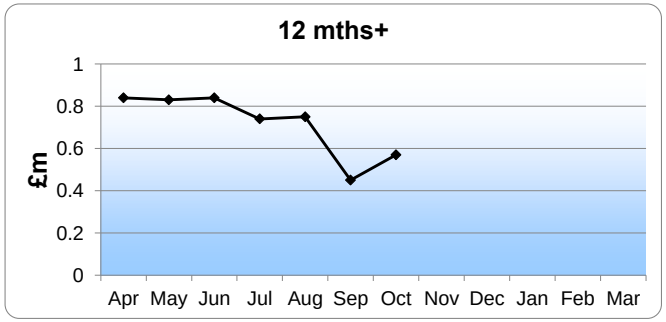












Capital Programme
Month 7 - The Period 1st April 2016 to 31st October 2016

York Teaching Hospital NHS
NHS Foundation Trust

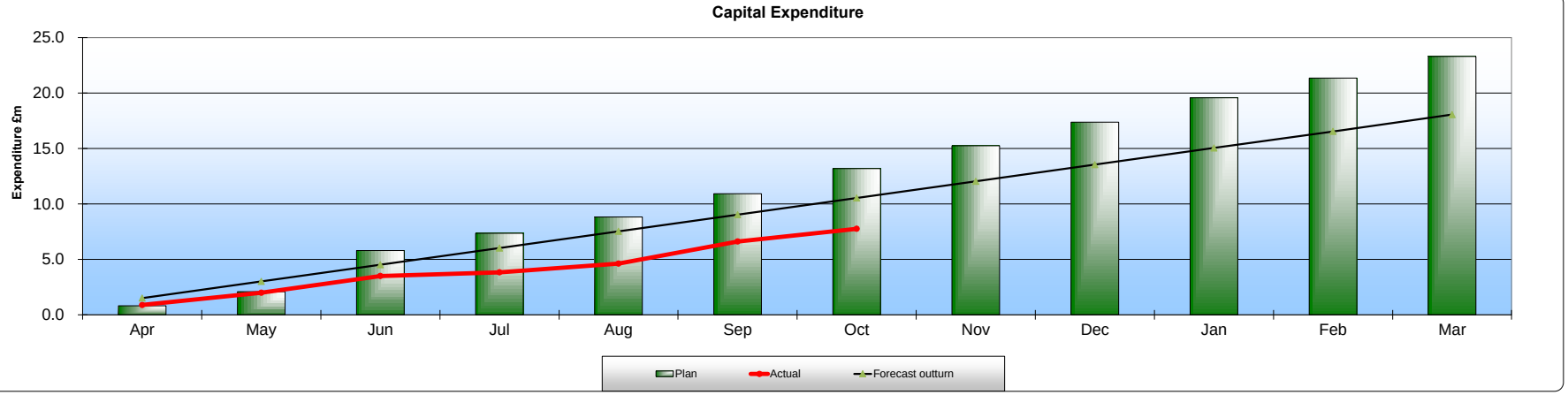
Key Messages:

*The capital plan is underspent by £5.4m at the end of October. The Trust outturn position has reduced to £18.055m which is shown in the forecast outturn line in the graph.

* The Endoscopy scheme loan has been approved by the ITFF however the Trust is waiting for confirmation from Treasury as to when the funds will be released. This has impacted on the Trust Capital outturn position reducing it by approx £2.5m.

* The radiology schemes have been delayed whilst work on the master plan has completed and there have been delays on the start of the Radiology lift replacement scheme in SGH and the fire alarm scheme.

* The purchase of Tanpit Lodge was completed on the 29th September 2016.



Scheme	Approved in-year Expenditure	Year-to-date Expenditure	Forecast Outturn Expenditure	Variance	Comments
	£000	£000	£000	£000	
Urology Facilities Malton	1,600	1,214	1,600	0	
Purchase of Tanpit Lodge Easingwold	1,000	1,000	1,000	0	
Theatre 10 to cardiac/vascular	1,100	75	1,000	100	
Radiology Replacement	5,730	43	2,275	3,455	Slipped to 2017/18
Radiology Lift Replacement SGH	640	21	293	347	Slipped to 2017/18
Fire Alarm System SGH	640	141	445	195	Slipped to 2017/18
Other Capital Schemes	2,719	1,957	3,546	-827	York Admin Block plus Breast imaging PACS
SGH Estates Backlog Maintenance	750	432	1,210	-460	Roof repairs-Malton & Scarborough
York Estates Backlog Maintenance - York	750	157	750	0	
Surgical Assesment Unit/ Ward 14	-	5	590	-590	
Medical Equipment	450	196	450	0	
IT Capital Programme	1,600	861	1,600	0	
Capital Programme Management	1,350	990	1,350	0	
Star Appeal	243	12	191	52	
SGH replacement of estates portakabins	732	17	755	-23	
Endoscopy Development	3,500	642	1,000	2,500	Waiting for loan approval
Contingency	500	-	-	500	
TOTAL CAPITAL PROGRAMME	**23,304**	**7,763**	**18,055**	**5,249**	A level of capital creditors is included in the total spend figure.

This Years Capital Programme Funding is made up of:-	Approved in-year Funding	Year-to-date Funding	Forecast Outturn	Variance	Comments
	£	£	£	£	
Depreciation	12,000	7,276	12,000	-	
Loan Funding b/fwd	-	-	-	-	
Loan Funding	7,950	-	3,000	4,950	
Charitable Funding	787	302	758	29	
Strategic Capital Funding	2,567	185	2,297	270	
TOTAL FUNDING	**23,304**	**7,763**	**18,055**	**5,249**	

Efficiency Programme

Month 7 - The Period 1st April 2016 to 31st October 2016

York Teaching Hospital NHS
NHS Foundation Trust

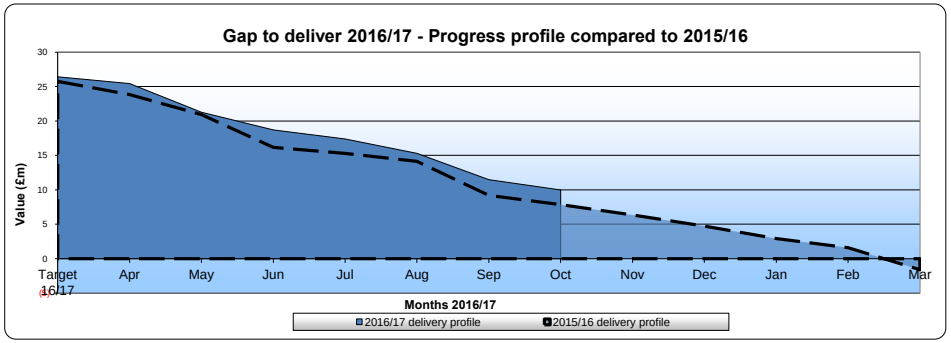
Key Messages:

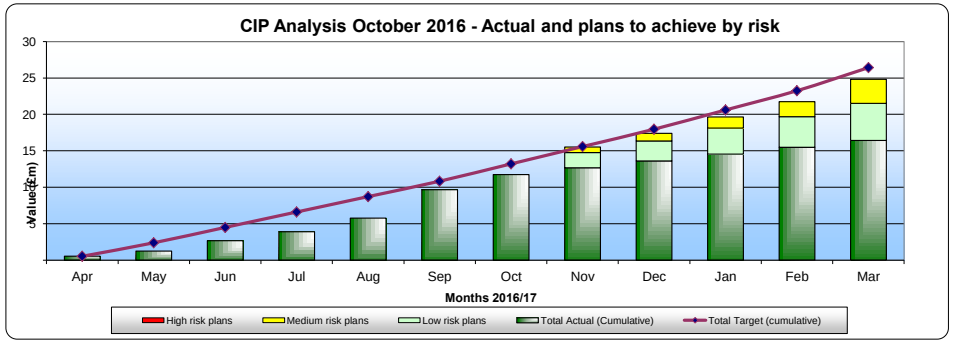
* Delivery - £16.4m has been delivered against the Trust annual target of £26.4m, giving a shortfall of (£10m)
* Part year NHSI variance - The part year NHSI variance is (£1.5m).
* In year planning - The 2016/17 planning gap is currently (£1.6m), High Risk Plans have now been excluded from the planning position.
* Four year planning - The four year planning gap is (£12.9m).
* Recurrent delivery - Recurrent delivery is £12m, which is 46% of the 2016/17 CIP target.

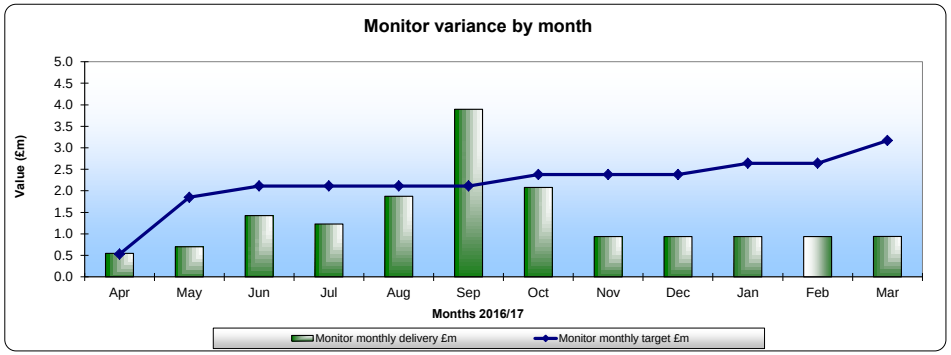
Executive Summary - October 2016	Total £m
TARGET	
In year target	26.4
DELIVERY	
In year delivery	16.4
In year delivery (shortfall)/Surplus	-10.0
Part year delivery (shortfall)/surplus - NHSI variance	-1.5
PLANNING	
In year planning surplus/(gap)	-1.6
FINANCIAL RISK SCORE	
Overall trust financial risk score	(2 - RED/AMBER)

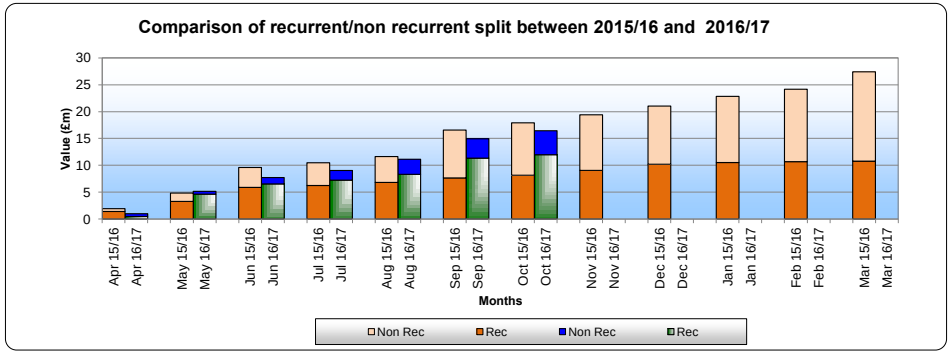
4 Year Efficiency Plan - October 2016					
Year	2016/17	2017/18	2018/19	2019/20	**Total**
	£m	£m	£m	£m	**£m**
Base Target	26.4	15.5	15.5	15.5	**73.0**
Plans	24.8	18.2	9.5	7.6	**60.1**
Variance	-1.6	2.7	-6.0	-8.0	**-12.9**
%	**94%**	**117%**	**61%**	**49%**	**82%**

Risk Ratings			
Financial			
Score	September	October	Trend
1	7	10	↑
2	5	4	↓
3	7	5	↓
4	6	4	↑
5	2	4	↑
Governance			
Score	September	October	Trend
Red	0	0	→
Green	26	26	→







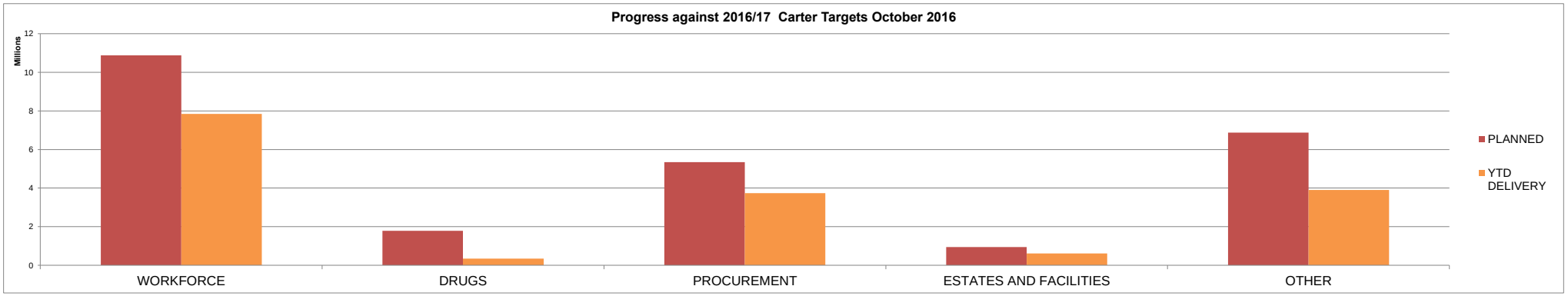


Key Messages:

Work ongoing with Carter Leads to identify key workstreams.
As from November 2016 each Carter Workstream Lead will report into the Carter Steering Group with progress against the relevant workstream.

EFFICIENCY PROGRAM - CARTER WORKSTREAM PERFORMANCE OCTOBER 2016

CATEGORY	WORKFORCE	DRUGS	PROCUREMENT	ESTATES AND FACILITIES	OTHER	TOTAL
	£000	£000	£000	£000	£000	£000
2016/17 OVERALL TARGET						26,416
PLANNED	10,889	1,791	5,342	949	6,882	25,852
YTD TARGET						13,208
YTD DELIVERY	7,845	345	3,732	608	3,899	16,430
YTD VARIANCE	-637	-994	2,279	-574	3,147	3,221
4 YEAR TARGET						0
4 YEAR PLANS	19,452	8,021	8,283	3,486	21,918	61,161
4 YEAR VARIANCE	0	0	0	0	0	0



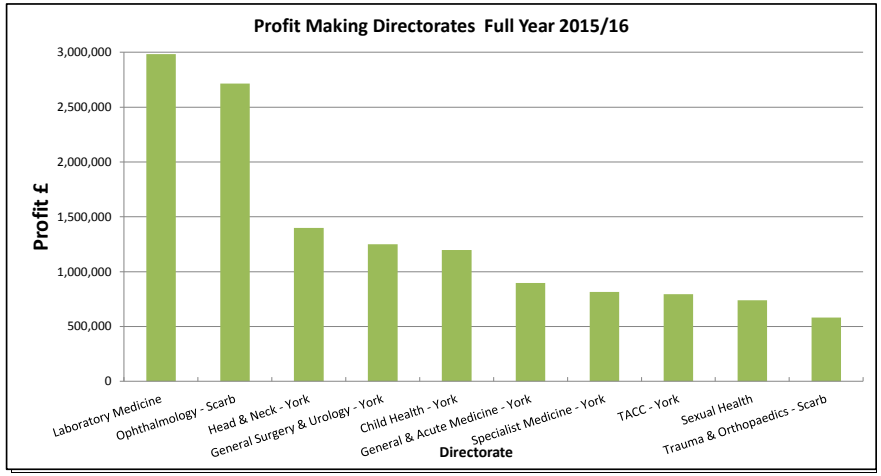
WORKFORCE	DRUGS
1. Draft Internal Dashboard set up and is being reviewed by the Workforce Lead. 2. Work ongoing with Improvement Director and Deputy Director of Workforce lead to identify and refine key schemes.	1. Draft Internal Dashboard set up and is being reviewed by the Pharmacy Lead. 2. NHSI updated Model Hospital Portal with National Pharmacy Dashboard August 16. Meeting to be scheduled with Pharmacy Lead to review.
PROCUREMENT	**ESTATES AND FACILITIES**
1. Procurement Steering Group set up and monthly meetings are being held to drive the programme forward. 2. Internal Dashboard set up and in use and reported in to the Carter Steering Group. 3. Workshop held with Procurement and a follow-up held in September with schemes being identified and updated on a monthly basis.	1. Work progressing on Internal Dashboard. 2. National Dashboard now live on Model Hospital and being reviewed.

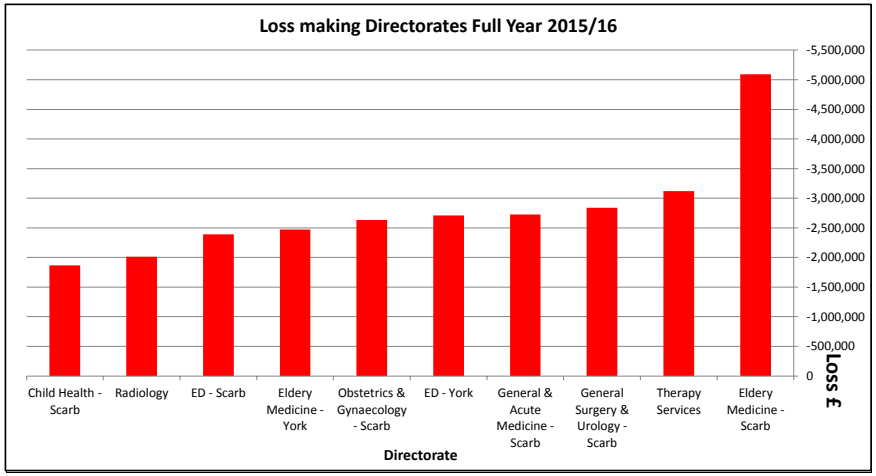
Service Line Reporting
Month 7 - The Period 1st April 2016 to 31st October 2016

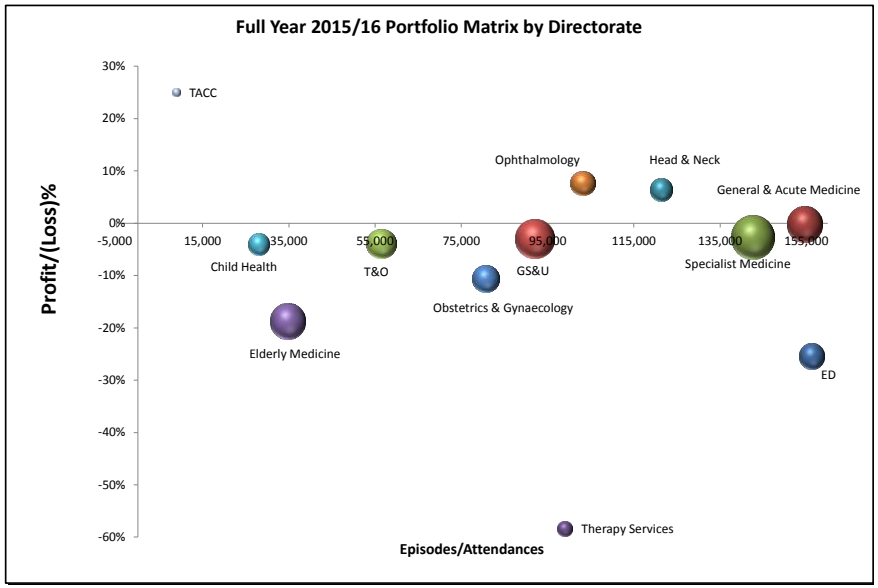
York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

* Current data is based on full year 2015/16
* It is expected that Q1 2016/17 will be completed towards the middle / end of November 2016
* Our annual mandatory Reference Cost calculation was successfully submitted and signed-off on 28th July 2016
* Our annual mandatory Education and Training cost calculation was successfully submitted and signed-off on 13th September 2016







DATA PERIOD	Full Year 2015/16
CURRENT WORK	* Q1 2016/17 SLR reports are now the key focus for the team * Work with Directorate teams is currently on-going to improve the quality of consultant PA allocations used within the SLR system for each quarterly reporting period * The SLR team are continuing to work with Directorate teams to improve the quality of outpatient staffing group costs within SLR
FUTURE WORK	* Work on the Q2 2016/17 SLR data will commence once the Q1 data is published * Future work around junior doctor PA allocations will improve the quality of the SLR data and also inform the annual mandatory Education & Training cost collection exercise * Planning for the NHSI Costing Transformation Programme will soon begin to ensure that we are prepared for future mandatory reporting requirements

FINANCIAL BENEFITS TAKEN SINCE SYSTEM INTRODUCTION	**£2.7m**

Use Of Resource Metric for York Teaching Hospital NHS Foundation Trust

	units	Plan YTD ending 31-Oct-16	Actual YTD ending 31-Oct-16	Variance YTD ending 31-Oct-16	Plan Year ending 31-Mar-17	Adjusted Forecast Year ending 31-Mar-17	Forecast Variance Year ending 31-Mar-17
Capital Service Cover							
Capital service metric	0.0x	2.772	2.888	0.116	3.304	3.330	0.027
Capital service rating	Rating	1	1		1	1	
Liquidity							
Liquidity metric	£m	(3.872)	(3.228)	0.644	1.363	4.158	2.795
Liquidity rating	Rating	2	2		1	1	
I&E Margin							
I&E Margin metric	%	0.98%	1.12%	0.14%	2.08%	2.03%	(0.10%)
I&E Margin rating	Rating	2	1		1	1	
I&E Variance From Plan							
I&E Variance from plan metric	%		0.14%			(0.05%)	
I&E Variance from plan rating	Rating		1			2	
Agency							
Agency metric	%	(0.00%)	17.60%	17.60%	0.00%	14.48%	14.48%
Agency rating	Rating	1	2		1	2	
Use Of Resources Rating							
Overall rating unrounded	Rating		1.40			1.40	
If unrounded score ends in 0.5	Rating		-			-	
Rounded score	Rating		1			1	
Use Of Resources Rating before overrides	Rating		1			1	
4 Rating Trigger for Use Of Resources Rating	Text		NO TRIGGER			NO TRIGGER	
Use Of Resources Rating after 4 rating override	Rating		1			1	
Control total override - Control total accepted	Text		Yes			Yes	
Control total override - Planned or Forecast deficit	Text						
Control total override - Maximum score	Rating						
Is the provider in Financial Special Measures?	Text		No			No	
Use Of Resources Rating after overrides	Rating		1			1	

Threshold	1	2	3	4
Capital Service Cover	2.5	1.75	1.25	<1.25
Liquidity	0	-7	-14	<-14
I&E Margin	1.00%	0.00%	-1.00%	<=-1%
Variance from plan	0.00%	-1.00%	-2.00%	<=-2%
Agency	0.00%	25.00%	50.00%	>=50%

Metric	Weighting
Capital Service Cover rating	20.00%
Liquidity rating	20.00%
I&E Margin rating	20.00%
I&E Margin Variance From Plan rating	20.00%
Agency Spend	20.00%

F2

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 November 2016

Efficiency Programme Update – October 2016

Action requested/recommendation

The Board is asked to note the October 2016 position.

Executive Summary

This report provides a detailed overview of progress to date regarding delivery of the Trust's Efficiency Programme. The 2016/17 target is £26.4m and delivery, as at October 2016 is £16.4m.

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

Implications for equality and diversity

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

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

Reference to CQC regulations

There are no references to CQC regulations

Progress of report	Finance & Performance Committee
Risk	The Efficiency Programme presents a significant

	financial risk to the organisation.
Resource implications	The aim of this work stream is to ensure the most effective use of the Trust resources.
Owner	Andrew Bertram, Finance Director
Author	Steven Kitching, Head of Corporate Finance & Resource Management
Date of paper	November 2016
Version number	Version 1

York Teaching Hospital NHS
NHS Foundation Trust

Briefing note for the Finance & Performance Committee Meeting
22 November 2016 and Board of Directors Meeting 30 November 2016

Subject: October 2016 - Efficiency and Carter update

From: Steve Kitching, Head of Corporate Finance & Resource Management

Summary reported position for October 2016

Current position – highlights

Delivery - Overall delivery is £16.4m in October 2016 which is (63%) of the £26.4m annual target. This position compares to a delivery position of £17.9m (69%) in October 2015.

Part year delivery is (£1.5m) behind the profiled plan submitted to NHSI.

The relative Directorate positions are shown in ***appendix 1&2*** attached.

In year planning – There is an in year planning gap of (£1.6m) at October 2016, the comparative position in October 2015 was a gap of £2.6m.

Four year planning – The four year planning gap is (£12.9m). The position in October 2015 was a gap of (£15.8m). We have a strong planning position for years 1&2 of the plan with £43m (103%) worth of plans identified.

Recurrent vs. Non recurrent – Of the £16.4m delivery, £12m (74%) has been delivered recurrently. Recurrent delivery is £3.9m ahead of the same position in October 2015. The work continues to identify recurrent schemes.

Quality Impact Assessments (QIA) – All schemes have been sent out to Directorate teams and self-assessments have been completed. A review of schemes is currently underway with Richard Khafagy, Clinical Lead for the QIA process.

Overview

The October 2016 position is encouraging with recurrent delivery at £12m (46%) of the annual target; the highest recurrent delivery over the past 5 years. The in-year planning position has also moved on in the month from a (£1.7m) gap in September to a (£1.6m) gap in October, a £0.1m improvement.

Carter

The Trust has just completed a back office financial return to NHSI and we await feedback on the next stage of this project.

Risk

The key risks in the programme:

- There is an overall planning gap of (£1.6m) in year and a (£12.9m) 4 year planning gap.
- Recurrent delivery to date is £12m of the overall target (£26.4m) and this remains a key focus.
- There are 14 schemes which have been rated as high risk following the self-assessment process; however the Clinical Lead and senior nursing review continues.

Poorly Performing Directorates

To support poorly performing directorates, both in terms of planning and delivery the following have been put in place:

- The intensity of directorate contact has been increased significantly, regular CIP meetings continue with the efficiency team, in addition to this finance, efficiency and workforce has become the sole focus of the Operational Performance Assurance Meetings (OPAM's).
- In addition to the above all directorates meet with the Chief Executive and Finance Director, at least once a year at the efficiency panels, which have recently started for 2016/17 and the Senior Finance Team have bi-annual meetings with all Finance Managers to go through each Directorates finance & efficiency position in detail.
- The Corporate Efficiency Team have held a number of workshops with Directorates to focus on planning, with more workshops in the pipeline.

DIRECTORATE	FINANCE						GOVERNANCE	
	R	RA	A	AG	G	Trend	R	G
COMMUNITY						→		
RADIOLOGY						→		
WOMENS HEALTH						→		
EMERGENCY MEDICINE						→		
TACC						→		
SEXUAL HEALTH						→		
SPECIALIST MEDICINE						↓		
AHP & PSYCHOLOGICAL MEDICINE DIRECTORATE						↓		
GS&U						↓		
CHILD HEALTH						↓		
MEDICINE FOR THE ELDERLY						↓		
GEN MED YORK						↓		
GEN MED SCARBOROUGH						→		
HEAD AND NECK						→		
LAB MED						→		
PHARMACY						↓		
OPHTHALMOLOGY						↑		
ORTHOPAEDICS						→		
CORPORATE								
ESTATES AND FACILITIES						↓		
MEDICAL GOVERNANCE						↓		
CHIEF NURSE TEAM DIRECTORATE						→		
FINANCE						→		
SNS						→		
OPS MANAGEMENT YORK						↑		
CHAIRMAN & CHIEF EXECUTIVES OFFICE						→		
HR						↑		
LEARNING ORGANISATIONAL DEVELOPMENT & RESEARCH						↑		
TRUST SCORE						↓		

DIRECTORATE	Yr1 Target (£000)	4Yr Target (£000)	Yr 1 Plan v Target		Yr 1 Delivery v Target		Y1 Recurrent Delivery v target		4 Yr Plan v Target		Risk Score	
			%	Score	%	Score	%	Score	%	Score	Total Score	Monitor Rating
COMMUNITY	1,099	2,281	11%	1	21%	1	17%	1	62%	1	4	1
RADIOLOGY	1,693	3,295	30%	1	23%	1	17%	1	28%	1	4	1
WOMENS HEALTH	1,683	3,430	40%	1	28%	1	27%	1	56%	1	4	1
EMERGENCY MEDICINE	522	1,930	40%	1	31%	1	31%	1	50%	1	4	1
TACC	2,248	6,274	52%	1	39%	1	22%	1	68%	1	4	1
SEXUAL HEALTH	635	1,329	48%	1	40%	1	0%	1	83%	1	4	1
SPECIALIST MEDICINE	3,172	7,189	64%	1	44%	1	42%	2	58%	1	5	1
AHP & PSYCHOLOGICAL MEDICINE DIRECTORATE	1,280	3,462	59%	1	51%	1	46%	3	43%	1	6	1
GS&U	1,964	5,109	91%	2	66%	3	39%	2	87%	1	8	2
CHILD HEALTH	1,072	2,374	89%	1	69%	3	58%	5	87%	1	10	2
MEDICINE FOR THE ELDERLY	1,513	3,774	92%	2	77%	4	55%	4	64%	1	11	2
GEN MED YORK	1,846	5,686	98%	2	57%	2	48%	3	121%	5	12	3
GEN MED SCARBOROUGH	871	2,311	107%	3	70%	3	62%	5	70%	1	12	3
HEAD AND NECK	850	2,050	146%	5	79%	4	59%	5	87%	1	15	3
LAB MED	794	2,881	127%	5	125%	5	105%	5	76%	1	16	4
PHARMACY	374	1,065	130%	5	71%	3	71%	5	121%	5	18	4
OPHTHALMOLOGY	763	2,795	126%	5	84%	5	75%	5	113%	4	19	5
ORTHOPAEDICS	1,228	3,521	156%	5	146%	5	91%	5	130%	5	20	5
CORPORATE												
ESTATES AND FACILITIES	2,701	7,099	74%	1	51%	1	44%	3	82%	1	6	1
MEDICAL GOVERNANCE	195	533	66%	1	66%	3	5%	1	24%	1	6	1
CHIEF NURSE TEAM DIRECTORATE	389	730	136%	5	58%	2	33%	1	72%	1	9	2
FINANCE	417	1,203	119%	4	119%	5	55%	4	41%	1	14	3
SNS	750	1,772	119%	4	87%	5	81%	5	72%	1	15	3
OPS MANAGEMENT YORK	205	568	124%	5	105%	5	85%	5	61%	1	16	4
CHAIRMAN & CHIEF EXECUTIVES OFFICE	74	186	227%	5	227%	5	105%	5	90%	2	17	4
HR	376	1,007	124%	5	122%	5	78%	5	129%	5	20	5
LEARNING ORGANISATIONAL DEVELOPMENT & RESEARCH	217	627	140%	5	133%	5	70%	5	120%	5	20	5
TRUST SCORE	**28,929**	**74,481**	**94%**	**2**	**62%**	**2**	**45%**	**3**	**84%**	**1**	**8**	**2**

F3

Providing care together in York, Scarborough, Bridlington, Malton, Whitby, Selby and Easingwold communities.

York Teaching Hospital NHS
NHS Foundation Trust

Public Performance Report

November 2016

Our ultimate objective

To be trusted to deliver safe, effective and sustainable healthcare within our communities.

Access Targets: 18 Weeks

Indicator	Consequence of Breach (Monthly)	Threshold	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Aug	Sep	Oct
Incomplete Pathway: Percentage of patients on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	Not applicable for 2016/17 - part of NHS England Sustainability and Transformation Fund (STF)	**92%**	94.0%	93.0%	92.5%	90.8%	91.6%	90.8%	90.9%
Zero tolerance RTT waits over 52 weeks for incomplete pathways	Not applicable for 2016/17 - part of NHS England Sustainability and Transformation Fund (STF)	**0**	0	0	0	0	0	0	0
Admitted Pathway: Percentage of admitted patients starting treatment within a maximum of 18 weeks from Referral	Not applicable	**Not applicable**	77.8%	74.2%	70.6%	68.6%	68.1%	65.8%	64.5%
Non Admitted Pathway: Percentage of non-admitted patients starting treatment within a maximum of 18 weeks from Referral	Not applicable	**Not applicable**	95.3%	95.3%	95.5%	94.4%	94.6%	94.2%	93.2%

Access Targets: Cancer

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

Indicator	Consequence of Breach	Threshold	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Jul	Aug	Sep
14 Day Fast Track	Not applicable	**93%**	95.2%	93.5%	92.8%	89.9%	89.6%	88.7%	92.7%
14 Day Breast Symptomatic	Not applicable	**93%**	94.8%	95.1%	95.6%	93.3%	90.0%	94.0%	95.8%
31 Day 1st Treatment	Not applicable	**96%**	99.5%	98.6%	99.4%	99.0%	99.2%	99.6%	98.0%
31 Day Subsequent Treatment (surgery)	Not applicable	**94%**	95.5%	96.2%	96.5%	97.0%	100.0%	100.0%	92.7%
31 Day Subsequent Treatment (anti cancer drug)	Not applicable	**98%**	100.0%	99.2%	100.0%	100.0%	100.0%	100.0%	100.0%
62 day 1st Treatment	Not applicable for 2016/17 - part of NHS England Sustainability and Transformation Fund (STF)	**85%**	84.5%	85.8%	86.4%	84.3%	85.2%	88.8%	77.1%
62 day Screening	Not applicable	**90%**	97.0%	90.4%	91.0%	92.5%	91.7%	93.2%	92.6%
62 Day Consultant Upgrade	Not applicable	**85%**	50.0%	-	-	-	-	-	-

Emergency Department

Indicator	Consequence of Breach (Monthly)	Threshold	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Aug	Sep	Oct
Percentage of A & E attendances where the Patient was admitted, transferred or discharged within 4 hours of their arrival at an A&E department	Not applicable for 2016/17 - part of NHS England Sustainability and Transformation Fund (STF)	**95%**	87.1%	85.0%	87.3%	91.4%	90.5%	90.9%	85.5%
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 30 minutes	Not applicable for 2016/17 - part of NHS England Sustainability and Transformation Fund (STF)	**0 > 30min**	336	640	592	559	205	168	245
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 60 minutes	Not applicable for 2016/17 - part of NHS England Sustainability and Transformation Fund (STF)	**0 > 60min**	190	525	591	425	181	119	184
Ambulance Handovers over 30 and 60 Minutes by CCG	**Ambulance Handovers over 30 and 60 Minutes by CCG**	**Breach Category**	**Q3 15/16**	**Q4 15/16**	**Q1 16/17**	**Q2 16/17**	**Aug**	**Sep**	**Oct**
	NHS VALE OF YORK CCG	30mins - 1hr	91	183	226	116	38	35	86
		1hr 2 hours	74	122	232	75	24	24	55
		2 hours +	18	69	62	12	1	2	6
	NHS SCARBOROUGH AND RYEDALE CCG	30mins - 1hr	127	184	165	215	78	64	70
		1hr 2 hours	42	128	101	131	59	35	44
		2 hours +	7	40	29	42	20	12	9
	NHS EAST RIDING OF YORKSHIRE CCG	30mins - 1hr	86	135	117	146	50	51	60
		1hr 2 hours	36	96	89	90	37	32	35
		2 hours +	4	35	22	23	14	4	10
	NHS HAMBLETON, RICHMONDSHIRE AND WHITBY CCG	30mins - 1hr	10	19	28	25	9	7	8
		1hr 2 hours	2	21	12	10	6	1	6
		2 hours +	0	9	1	3	1	1	1
	NHS HARROGATE AND RURAL CCG	30mins - 1hr	0	2	3	4	3	1	0
		1hr 2 hours	0	2	1	0	0	0	4
		2 hours +	0	1	0	1	0	1	0
	OTHER	30mins - 1hr	22	25	53	53	27	10	21
		1hr 2 hours	6	20	33	34	16	7	14
		2 hours +	1	12	9	4	3	0	0
Total number of patients waiting over 8hrs in A&E	General Condition 9	Q1 - Establish baseline	1060	1656	1045	591	269	175	479
Trolley waits in A&E not longer than 12 hours	Not applicable for 2016/17 - part of NHS England Sustainability and Transformation Fund (STF)	**0 > 12 hrs**	18	32	7	0	0	0	4
Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	**95%**	98.4%	99.0%	98.8%	To follow	98.6%	To follow	To follow

Mortality

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Oct 13 - Sep 14	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15	Jan 15 - Dec 15	Apr 15 - Mar 16
Mortality – SHMI (YORK)	**Quarterly:** General Condition 9	**A banding of "Significantly higher that expected" in SHMI using the "Extract Poisson Distribution" method for deriving upper and lower confidence limits, applied to each sub-group reported**	99	97	96	95	93	94	95
Mortality – SHMI (SCARBOROUGH)	**Quarterly:** General Condition 9		109	107	108	107	107	108	107

Infection Prevention

Indicator	Consequence of Breach (Monthly)	Threshold	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Aug	Sep	Oct
Minimise rates of Clostridium difficile	*Schedule 4 part G* **Quarterly:** 1 Monitor point tbc	**48**	15	15	7	6	2	1	3
Number of Clostridium difficile due to "lapse in care"	Establish baseline and set trajectory	**TBC**	TBC	TBC	TBC	TBC	TBC	TBC	TBC
Number of E-Coli cases	**Quarterly:** General Condition 9	**(TBC)**	23	33	17	32	14	10	4
Number of Methicillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia cases	**Quarterly:** General Condition 9	**30**	10	7	13	7	5	0	8
Zero tolerance MRSA	£10,000 in respect of each incidence in the relevant month	**0**	0	2	2	2	2	0	2
Confirmed cases of MRSA Bacteraemia to be notified to commissioner by next working day	General Condition 9	**100%**	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Post Infection Review (PIR) of MRSA bacteraemia/SI report to be provided to the commissioner within 21 working days of the case being identified in line with national data capture system	General Condition 9	**100%**	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Post Infection Review (PIR) completed	TBC	**TBC**	n/a	n/a	n/a	n/a	n/a	n/a	n/a
All High Risk (non-day case) Elective admissions are screened for MRSA prior to admission	**Quarterly:** General Condition 9	**95%**	83.1%	74.0%	84.5%	86.2%	83.7%	85.0%	88.7%
Emergency admissions are screened for MRSA within 24 hours of admission	**Quarterly:** General Condition 9	**95%**	74.5%	75.0%	83.4%	86.5%	86.7%	86.4%	82.9%

Quality and Safety

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Aug	Sep	Oct
Percentage of Patients waiting less than 6 weeks from Referral for a diagnostic test	Not applicable for 2016/17 - part of NHS England Sustainability and Transformation Fund (STF)	**99%**	99.1%	99.6%	99.3%	99.4%	99.2%	99.4%	99.2%
Sleeping Accommodation Breach	£250 per day per Service User affected	**0**	0	3	0	0	0	0	0
All Patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days	Non-payment of costs associated with cancellation and non- payment or reimbursement (as applicable) of re-scheduled episode of care	**0**	8	4	13	2	1	1	1
No urgent operation should be cancelled for a second time	£5,000 per incidence in the relevant month	**0**	0	0	0	0	0	0	0
Cancelled operations within 48 Hours of the TCI due to lack of beds	General Condition 9	**65 per month**	182	210	61	22	12	3	48
VTE risk assessment: all inpatient undergoing risk assessment for VTE, as defined in Contract Technical Guidance	General Condition 9	**95%**	97.9%	98.4%	98.7%	98.5%	98.3%	98.5%	98.7%
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	**99%**	99.8%	99.9%	99.9%	To follow	99.8%	To follow	To follow
All ELECTIVE patients to have an Expected Discharge Date (EDD) recorded in the patient case notes or patient management system within 24 hours of admission	General Condition 9	**Q1 - 91% Q2 - 91% Q3 - 93% Q4 - 93%**	89%	92%	87%	88%	88%	88%	88%
Delayed Transfer of Care – All patients medically fit for discharge and issued a 'notification notice' as per joint protocol for the transfer of care	As set out in General Condition 9 - Trust only to be accountable for Health delays.	**Set baseline in Q1 and agree trajectory**	Monthly Provider Report						
Trust waiting time for Rapid Access Chest Pain Clinic	General Condition 9	**99%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
No patient cancelled more than twice by the Trust for non-clinical reasons. All new dates to be arranged within 6 weeks of the cancelled appointment	General Condition 9	**90%**	Annual statement of assurance						
Outpatient clinics cancelled with less than 14 days notice	General Condition 9	**180 per month**	448	482	519	531	137	222	218
Reduction in number of hospital cancelled first and follow up outpatient appointments for non-clinical reasons where there is a delay in the patient treatment	General Condition 9	**Not applicable**	2492	2599	2760	2504	757	909	828
% Compliance with WHO safer surgery checklist	General Condition 9	**100%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Readmissions within 30 days – Elective	The CCG will apply a % penalty following Flex and Freeze validation. (ER)	**08/09 outturn awaiting figure from CCG**	489	499	535	2 month coding lag	166	2 month coding lag	2 month coding lag
Readmissions within 30 days – Non-elective	The CCG will apply a % penalty following Flex and Freeze validation. (ER)	**08/09 outturn awaiting figure from CCG**	1551	1660	1622	2 month coding lag	536	2 month coding lag	2 month coding lag
Reduction in avoidable transfers within the Trust after 10pm. Excludes transfers for clinical reasons or for patients transferred to a more appropriate ward	General Condition 9	**300 per Quarter**	308	317	235	239	62	93	98
Number/Percentage women who have seen a midwife by 12 weeks and 6 days (as per IPMR definition)	General Condition 9	**90%**	99.7%	99.2%	99.8%	n/a	99.8%	99.8%	99.5%
Stroke Performance against Sentinel Stroke National Audit Programme (SSNAP)	General Condition 9	**Best Practice Standards**	Quarterly summary of performance against SSNAP indicators as submitted to RCP. Stroke service exception action plan to be produced quarterly .						
All Red Drugs to be prescribed by provider effective from 01/04/2016	Recovery of costs for any breach to be agreed via medicines management committee	**100% list to be agreed**	CCG to audit for breaches						
All Amber Drugs to be prescribed by provider effective from 01/04/2016	Recovery of costs for any breach to be agreed via medicines management committee	**100% list to be agreed**	CCG to audit for breaches						
NEWS within 1 hour of prescribed time	None - Monitoring Only	**None**	86.9%	85.9%	87.3%	87.9%	87.8%	88.1%	87.8%

Never Events

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Aug	Sep	Oct
Never Events	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure or episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	**>0**	0	1	2	2	1	0	0

District Nursing Activity Summary

Indicator	Source	Threshold	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Aug	Sep	Oct
Community Adult Nursing Referrals (excluding Allied Health Professionals)	GP	-	3748	3309	3325	3427	1175	1176	1212
	Community nurse/service	-	1141	1315	1459	1465	501	510	519
	Acute services	-	1328	1311	1315	1403	482	444	418
	Self / Carer/family	-	965	879	864	1031	371	321	328
	Other	-	441	423	507	432	135	137	136
	Grand Total	-	7623	7237	7470	7758	2664	2588	2613
Community Adult Nursing Contacts	First	-	5068	5089	5620	6018	2091	1946	2123
	Follow up	-	55322	61791	74408	84084	28592	27959	27890
	Total	-	60390	66880	80028	90102	30683	29905	30013
	First to Follow Up Ratio	-	10.9	12.1	13.2	14.0	13.7	14.4	13.1
Community Hospitals average length of stay (days)	Archways	-	21.2	21.1	21.7	26.2	25.1	33.2	22.0
	Malton Community Hospital	-	19.1	18.2	18.8	18.5	18.9	17.1	14.6
	St Monicas Hospital	-	16.7	18.9	16.4	22.7	24.4	26.8	14.5
	The New Selby War Memorial Hospital	-	19.9	19.5	14.1	23.0	25.4	27.0	19.3
	Whitby Community Hospital	-	12.8	0.0	0.0	0.0	0.0	0.0	0.0
	Total	-	22.6	22.8	20.6	23.7	21.5	26.6	20.1
Community Hospitals admissions. Please note: Patients admitted to Community Hospitals following a spell of care in an Acute Hospital have the original admission method applied, i.e. if patient is admitted as a non-elective their spell in the Community Hospital is also non-elective.	Archways	Elective	12	15	10	4	0	1	2
		Emergency	77	73	71	64	20	18	24
	Malton Community Hospital	Elective	41	44	34	39	13	14	13
		Emergency	84	82	84	93	32	29	23
	St Monicas Hospital	Elective	23	23	17	14	5	4	8
		Emergency	30	28	37	23	8	6	11
	The New Selby War Memorial	Elective	27	22	22	24	6	3	4
		Emergency	69	72	75	66	22	24	30
	Total	Elective	103	104	83	81	24	22	27
		Emergency	260	255	267	246	82	77	88

Monthly Quantitative Information Report

York Teaching Hospital NHS
NHS Foundation Trust

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Complaints and PALS												
New complaints this month	38	28	25	40	46	36	30	33	33	50	44	36
Number of cases requiring deadline extension this month	33	30	47	35	20	26	18	35	12	20	20	40
Top 3 complaint subjects												
All aspects of Clinical Treatment	30	24	21	39	49	21	26	18	17	26	71	40
Communications/information to patients (written and oral)	7	9	13	24	21	14	6	12	10	26	72	19
Patient Care	11	11	11	26	22	10	11	7	14	18	26	13
Top 3 directorates receiving complaints												
Acute & General Medicine	11	2	7	7	9	8	8	5	6	7	6	3
Emergency Medicine	2	6	4	4	8	5	3	3	6	7	6	10
General Surgery & Urology	4	7	2	7	5	4	3	1	5	6	3	3
Number of Ombudsman complaint reviews (new)[1]	2	1	0	4	0	2	3	4	2	2	0	0
Number of Ombudsman complaint reviews upheld	0	1	0	1	0	0	1	0	0	0	0	0
Number of Ombudsman complaint reviews partly upheld	0	2	0	2	1	2	1	3	0	1	2	0
New PALS queries this month	505	450	492	557	443	480	407	387	315	333	284	279
Top 3 PALS subjects												
Requests for information and advice	202	171	196	208	191	200	187	173	n/a	n/a	n/a	n/a
Any aspect of clinical care/treatment	66	53	68	89	48	59	55	47	24	34	28	23
Communication issues	50	40	42	48	48	36	25	23	60	60	51	51

Serious Incidents												
Number of SI's reported	19	13	11	28	21	19	12	31	15	17	12	9
% SI's notified within 2 working days of SI being identified*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
* this is currently under discussion via the 'exceptions log'												
Compliance with Duty of Candour for Serious Incidents:												
-Verbal Apology Given	9	6	7	7	8	9	6	20	8	6	7	2
-Written Apology Given *	1	0	0	2	1	1	1	2	1	1	1	0
-Invitation to be involved in Investigation	0	0	0	0	0	2	1	2	2	3	0	1
-Given Final Report (If Requested)	0	0	0	0	0	0	1	0	3	1	0	1

Pressure Ulcers**												
Number of Category 2	47	36	33	42	52	50	44	32	31	36	60	78
Number of Category 3	4	2	4	3	3	2	6	6	1	4	6	10
Number of Category 4	1	1	1	1	0	1	0	1	1	1	1	1
Total number developed/deteriorated while in our care (care of the organisation) - acute	49	38	37	44	57	44	53	37	28	40	59	93
Total number developed/deteriorated while in our care (care of the organisation) - community	33	20	24	25	29	25	20	25	28	25	37	36

Falls***												
Number of falls with moderate harm	4	2	3	7	4	1	4	3	3	3	4	1
Number of falls with severe harm	10	1	4	5	5	5	3	9	3	7	4	5
Number of falls resulting in death	0	1	0	0	0	0	0	0	1	1	0	0

Monthly Quantitative Information Report

York Teaching Hospital NHS
NHS Foundation Trust

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Safeguarding												
% of staff compliant with training (children)	82%	82%	82%	84%	85%	86%	86%	85%	86%	86%	86%	86%
% of staff compliant with training (adult)	82%	82%	83%	83%	84%	85%	85%	85%	85%	86%	86%	85%
% of staff working with children who have review CRB checks												

Prevent Strategy												
Attendance at the HealthWRAP training session												
Number of concerns raised via the incident reporting system												

Claims												
Number of Negligence Claims	21	15	12	12	12	18	16	17	12	10	10	13
Number of Claims settled per Month						3	6	2	5	9	5	1
Amount paid out per month **						£635,000	£66,500	£125,000	£342,500	£989,450	£262,750	£35,000
Reasons for the payment						Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability

* As not all SIs result in harm there will be instances where no written letter is required. The approach of the Trust is to bring the patient's relatives in to discuss the report and offer a summary if they require this. Meetings have been arranged with a number of relatives regarding this.
Note ** and *** - falls and pressure ulcers subject to validation. Falls resulting in deaths are investigated as Serious Incidents and the degree of harm will be confirmed upon completion of investigation.
All falls and pressure ulcer data is refreshed monthly to reflect ongoing monitoring and reporting of falls and pressure ulcers. A change on the way the Trust reports pressure ulcers was implemented on 01/09/16 resulting in a slight increase in the pressure ulcers reported as developing under our care.
* * one claim in April was settled for a lump sum payment of £450,000 (included in the data) with yearly payments of £145,000 to fund care needs, with the Claimant's life expectancy being between 3 and 5 years. The ongoing care costs are excluded from the above data as they cannot be quantified at present.

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 November 2016

2016/17-21: Laboratory Medicine Capital Programme

Action requested/recommendation

The Board is asked to approve the business case based on the preferred option.

Executive Summary

This business case outlines the plans to redevelop laboratory accommodation on the York site to accommodate a consolidated Histology, Cytology and Microbiology service and relocate Blood Sciences in Scarborough to the vacated Haldane ward to release the Pathology block for the development of the Emergency Department.

The laboratory strategic plan seeks to provide a service that is fit for purpose for the next 10 years. Re-organisation and skill mix reviews will drive efficiencies necessary to see the service compete with other providers to make York Laboratory Medicine the provider of choice for our commissioners.

The current Cervical Cytology contract brings in £1.4m income p.a. and the directorate has just submitted a response to the tender for a new 2+2 year service for our existing area (North Yorkshire, Hull & Humberside) and North East Lincolnshire & Goole due to commence in April 2017. The contract value is £2.0m p.a. and we expect to be the provider of choice when it is awarded in November. The new build will provide a larger and more suitable environment for the Cytology service necessary to provide this service as well as being in an ideal position to bid for the service in 2019-21 when larger geographic areas are tendered.

This plan will enable the directorate to become more efficient, make better use of staff, automated equipment and processes. The consolidation of Microbiology and Histology services will not only result in cost savings but also cost avoidance for replacement equipment, maintenance contracts, building backlog maintenance and staff.

The case for this service development is presented in 3 phases:

A. **The refurbishment and extension of the Histology laboratory and consultant accommodation on the 3rd floor, Laboratory Medicine (York site), that includes the Cytology service relocated from the 1st floor Laboratory Medicine (York site).**
   The Histology laboratory in York hospital is not fit for purpose and has not been updated since it was built in the 1970's. It is cramped and there are insufficient areas to accommodate all our consultant staff.

The consolidation of the Scarborough Histology service onto the York took place in January 2016 as a result of the 3 consultants leaving and inability to recruit to Biomedical Scientist posts. This has further exacerbated the poor environment and staff are becoming demoralised.

B. The refurbishment of the vacated 1st floor Cytology laboratory (York site) to accommodate the Microbiology service from Scarborough and the replacement of the existing autoclave with two units necessary to deal with increased capacity and provide a robust and continuous service.
The consolidation of microbiology services onto the York site will enable better use of technology to speed up processes e.g. Maldi-Tof for rapid bacterial identification, make better use of automation and improve efficiency.

C. Relocate the Blood Science service in Scarborough to the vacated Haldane ward.
The vacated Haldane ward is ideal as an open plan laboratory that will enable The Haematology, Biochemistry and Blood Transfusion services (Blood Sciences) to meet service needs for Scarborough as well as provide capacity for the York laboratory. Additionally, the Trust plan for an extended ED service in Scarborough utilises the existing Pathology block footprint. Moving the Blood Science, Microbiology and Histology services are therefore an enabler for the ED development.

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

Implications for equality and diversity

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

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

Reference to CQC regulations

There are no references to CQC regulations.

Progress of report	This business case has been presented to the Business Case Panel, Capital Programme Executive Group (CPEG), Corporate Directors and the Executive Board
Risk	Inability to resolve the lack of space and accommodation for the Histology service is affecting our ability to attract Consultant Histopathologists to this Trust. We currently have two vacancies that remain unfilled. This impacts upon our ability to provide a truly reactive and timely service. To mitigate this, we send work out to a private provider at additional cost. Failure to consolidate microbiology services on the York site will reduce our ability to further modernise the service, make better use of technology and automation and deliver efficiencies. Inability to consolidate microbiology services on the York site and move Blood Sciences from the Pathology block in Scarborough to Haldane ward would fail to release the Pathology block for the ED development. Failure to provide a more suitable environment for the Cytology service will directly impact on our ability to successfully tender for enlarged service areas in 2019-21.
Resource implications	Resources implication detailed in the report.
Owner	Dr Neil Todd, Clinical Director Laboratory Medicine
Author	Paul Sudworth, Directorate Manager Laboratory Medicine
Date of paper	October 2016
Version number	Version 16

APPENDIX Bi

York Teaching Hospital NHS
NHS Foundation Trust

BUSINESS CASE SUMMARY

1. Business Case Number

2016/17-21

2. Business Case Title

Laboratory Medicine Capital Programme to facilitate integration on the York hospital site of the Microbiology and Histology laboratory services, relocate Cytology services within Histology and relocate Blood Science department in Scarborough hospital to the vacated Haldane ward.

3. Management Responsibilities & Key Contact Point

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

Note: If the Business Case spans more than one Directorate/Department, there is a requirement that consideration be given to joint ownership/authorship, including Financial apportionment and monitoring.

Business Case Owner:	**Dr Neil Todd**

Business Case Author:	**Paul Sudworth**
Contact Number:	**01094 725859**

4. Issue(s) to be addressed by the Business Case

Describe the background and relevant factors giving rise to the need for change. Relevant data (e.g. BCBV data, etc.) *must be included to support the background described.*

This business case outlines the plans to redevelop laboratory accommodation on the York site to accommodate a consolidated Histology, Cytology and Microbiology service and relocate Blood Sciences in Scarborough to the vacated Haldane ward to release the Pathology block for development of the Emergency Department.

Since the acquisition of Scarborough Trust in July 2012 and the formation of a single directorate for Laboratory Medicine, a service review by discipline was undertaken. This review concluded that the Microbiology and Histology services are better delivered from a single enlarged site that makes best use of available resource and delivers efficiencies whilst maintaining a high quality service for our patients.

To accommodate the Microbiology service from Scarborough, the plan is to move the Cytology service from the 1st floor of the York laboratory into a refurbished and extended Histology laboratory on the 3rd floor. This will provide a larger Cytology laboratory necessary to maintain our existing contract for cervical screening and support our bid for a larger catchment in April 2017. The Cytology service brings in £1.4M income p.a.
The Pathology block in Scarborough requires significant investment for ongoing maintenance and is not fit for purpose. The vacated Haldane ward is ideal as an open plan laboratory that will enable The Haematology, Biochemistry and Blood Transfusion services (Blood Sciences) to meet service needs for Scarborough as well as provide capacity for the York laboratory. Additionally, the Trust plan for an extended ED service in Scarborough utilises the existing Pathology block footprint. Moving the Blood Science, Microbiology and Histology services are therefore an enabler for the ED development.

This plan will enable the directorate to become more efficient, make better use of staff, automated equipment and processes. The consolidation of Microbiology and Histology services will not only result in cost savings but also cost avoidance for replacement equipment, maintenance contracts, building backlog maintenance and staff.

The laboratory strategic plan seeks to provide a service that is fit for purpose for the next 10 years. Re-organisation and skill mix reviews will drive efficiencies necessary to see the service compete with other providers to make York Laboratory Medicine the provider of choice for our commissioners.

The case for this service development will be presented in 3 phases:

A. The refurbishment and extension of the Histology laboratory and consultant accommodation on the 3rd floor, Laboratory Medicine (York site), that includes the Cytology service relocated from the 1st floor Laboratory Medicine (York site).
B. The refurbishment of the vacated 1st floor Cytology laboratory (York site) to accommodate the Microbiology service from Scarborough and the replacement of the existing autoclave with two units necessary to deal with increased capacity and provide a robust and continuous service.
C. Relocate the Blood Science service in Scarborough to the vacated Haldane ward.

5. Options Considered

List below the alternative options considered to resolve the issue(s) presented in section 4 above. This should include consideration of alternative workforce and clinical models.
***Note**: All options must be costed.*

Description of Options Considered
1. All 3 phases (A, B & C) as described above.
2. As detailed in the 3 phases above but relocate Cytology to an off-site location
3. Phase A & B above and leave Blood Science in existing Pathology Block
4. Phase A only
5. Phase C only
6. Move Cytology off-site, refurbish the vacated laboratory area and consolidate Microbiology onto the York
7. Cytology service lost at re-tender April 2017
8. Do nothing

6. The Preferred Option

6.1 Preferred Option

Detail the preferred the option together with the reasons for its selection. This must be supported with appropriate data in demonstrating how it will address the issue(s) described in section 4 above.

The preferred option is for all 3 phases in option 1; that is:

A. *The refurbishment and extension of the Histology laboratory and consultant accommodation on the 3rd floor, Laboratory Medicine (York site), that includes the Cytology service relocated from the 1st floor Laboratory Medicine (York site).*

The existing Histology department has not been updated since it was first built in the 1970's and the size and layout fail to meet current and future requirements. The plan will be for a larger open plan laboratory that better meets service needs and makes better use of staff and equipment. This plan enables the Scarborough service to be consolidated onto the York site with substantial savings in staffing and overheads and future proofs the service for an increasing workload (currently around 4%p.a.).
The Histology department at York on the 3rd floor of Laboratory Medicine occupies half of the roof space available. By extending over the remaining half of the roof space will provide sufficient space for a refurbished and extended Histology laboratory to accommodate the Scarborough service, the Cytology service, accommodation for all Consultant Histopathologists (up to 12) and other ancillary functions.

We currently have two vacant Consultant Histopathologist posts to fill and there are a limited number of newly qualified consultants and consultants wishing to relocate in the UK. Suitable candidates can therefore choose where they wish to work. A new, high quality laboratory and accommodation will ensure we can offer the very best to prospective candidates. Recruitment of newly qualified pathologists would also generate substantial salary cost savings. Without this development, it is unlikely we will be successful in filling these vacancies and this will result in a continuation of referring work to a private provider (Backlogs). Their cost to us is approximately double the cost of our in-house service. The use of Backlogs increases our turnaround time for results and currently fails to deliver a local service to our requesting clinical teams.
Failure to appoint to the vacant Consultant Histopathologist posts may impact upon our ability to meet cancer target turnaround times. A shrinking consultant workforce would further exacerbate this risk.
This service would also be in line with the Trust strategic plans and objectives for the redevelopment of the Scarborough site i.e. the extension of ED, as well as demonstrating full integration of the Histology service. This service reconfiguration is in line with the Independent Review of NHS Pathology Services (Carter report 2008).

The poor state of the Histology department coupled with the lack of space that has been compounded with the addition of the Scarborough service is impacting on staff. The environment is not suitable for the needs of a modern day service and the volume and complexity of work undertaken. There is a significant concern that these environmental factors are having a detrimental effect upon staff morale and impacts on our ability to employ and retain staff.

B. *The refurbishment of the vacated 1st floor Cytology laboratory (York site) to accommodate the Microbiology service from Scarborough and the replacement*

of the existing autoclave with two units necessary to deal with increased capacity and provide a robust and continuous service.

The Cytology service generates £1.4M income p.a. and provides the Cervical Cytology service for North Yorkshire, East Riding and Humberside. This contract runs until April 2017 at which time a new contract will be tendered. We have been informed that this new contract will include North Lincolnshire and Goole and will increase our workload by 30%. The Cytology service is currently provided on the 1st floor of the Laboratory Medicine block in York hospital and is too small to accommodate our existing workload and any increase in workload would be difficult to manage. A new and enlarged department will significantly improve the likelihood of winning the re-tender thereby increasing income to the Trust. In future, the NHS cervical screening programme will move to a primary screening system for HPV testing and the new accommodation will support this molecular work.

The Cytology tender has just been released for the period April 2017 – March 2019 with an option to extend the service for a further 2 years. The cost ceiling for this is £2M p.a.
Apart from 5 pilot sites in the UK, laboratories are primary screening 5-10% of their workload for HPV and the remainder (90-95%) is by conventional microscopic screening. The level of HPV testing is set nationally. It is expected that in the 2019/2021 contract, the majority of primary screening will be HPV testing and this will enable the number of centres providing Cervical Cytology screening to be reduced. We have 4 years' experience of HPV testing and would be able to accommodate this change.
The space design on the 3rd floor is sufficient for an increase in Cytology screening when the change to primary HPV testing is rolled out. This will enable our service to bid for a significantly larger patch where workload rises from 94,000 a year up to 450,000 a year. This figure is based on the regional volume likely to be tendered in 2019/21.

The directorate strategic plan consolidates the Microbiology service onto the York site. This is also in line with the Independent Review of NHS Pathology Services (Carter report 2008).
Supported by a comprehensive transport service to move samples across the two sites, the consolidated service will improve quality and enable further development of the service through economies of scale. Consolidating microbiology services on the York site will support advances in automation, skill mix, turnaround times and 7 day working.

Consolidation also supports the drive to improve quality and safety. Systems of work, training and education are better delivered on one site. Rationalisation of staff and more appropriate skill mix for the new systems of work will enable an improvement to the quality of the service whilst achieving recurrent cost savings.
In October 2015, the Microbiology department in York installed a Maldi-Tof mass spectrometer. This piece of equipment shortens the time for identification of bacterial isolates from 1 to 2 days (or longer) to several hours. Appropriate antibiotics can therefore be prescribed for patients at an earlier stage than our current techniques allow and this will likely impact positively upon morbidity, mortality and length of stay. Due to the cost of this instrument, only one has been installed on the York site. Consolidating the microbiology service will enable patients in Scarborough hospital to benefit from this advancement. Duplication of other equipment is also reduced.

There will be immediate staff savings as a result of consolidation (detailed in financial proforma) and further savings as the service develops. Posts would be

lost as a result of further efficiency savings through natural wastage over a 2-5 year period. This is estimated at £137k recurrently.
The vacated Cytology accommodation (1st floor Lab Med, York site) will require a refit to meet the standards necessary for a microbiology laboratory. This option would avoid the need to spend additional money to maintain the service on two sites.

C. *Relocate the Blood Science service in Scarborough to the vacated Haldane ward.*

Blood Science in Scarborough hospital is located in the Pathology block. This building does not provide adequate form and function for modernising the services and is no longer fit for purpose. Our understanding is that significant remedial work is required to bring the building up to an acceptable standard; this comprises of:

- Electrical infrastructure £200k
- Roof £120k
- Windows and surrounds £50k
- Door access £20k

With the planned move for the Histology and Microbiology services to York hospital, the 1st floor of the building will be vacant. An open plan laboratory designed within the Haldane Nightingale ward is essential to modernise the service and this will also enable the Scarborough site to act as a capacity/overflow laboratory for the York service.

The expansion and new build for the Emergency Department (ED) in Scarborough requires the existing Pathology block footprint. For this scheme to go ahead, all 3 phases detailed above will need to proceed.

Backlog maintenance on the York site is estimated at £886,292
Backlog maintenance on the Scarborough site is estimated at £497,685

At this time, the impact of the Sustainability and Transformation Plan (STP) for our laboratory services has not been identified. However, the directorate has undertaken a significant amount of work in 2014/5 with Hull laboratories as part of the Alliance network to identify options as to how we could work collaboratively. Blood science laboratories are required on each acute site so it is highly unlikely that the STP would see a change for provision of this service. With regard to Histology and Microbiology, clinical services must be delivered across all acute sites whilst laboratory function could be further consolidated, however, this plan would take 2-5 years to implement and would require significant investment in a new build on one of the major acute hospital sites within the STP area. There is considerable risk in retaining clinical and scientific staff if only one laboratory provided Microbiology and Histology services across the STP area and this would impact upon turnaround time of results and a likely failure to meet cancer targets.

The Carter report makes note that Pathology costs for a Trust should be less that 1.6% of operating expenditure. The calculated cost for the York and Scarborough Pathology service is 1.1%. This figure has been achieved through a programme of staffing and skill mix reviews, best value of contracts and the start of a consolidation process across the York and Scarborough sites.

The option appraisal score sheet details the benefit criteria and scores these together with a weighting for each of the 7 options.
The preferred option (option 1) score highest at 220 closely followed by option 2 and option 7 that both score 200. Option 2 differs in that the Cytology service is located off-site. This option still meets all the requirements of the capital plan and whilst it reduces the cost of the 3rd floor extension, it is more costly for the off-site location lease and

associated costs over a 10 year period.
Option 7 differs in that the Cytology contract is lost for the period 2018-2022 (actual contract is for 2 years + 2 years). This option still meets all the other requirements as detailed in option1 and reduces the cost of the 3rd floor extension but there would be a loss of income to the Cytology service that is currently £1.4m but predicted to be £2m for the new contract.

All other options score significantly less (25-125) and do not provide the expected benefits to the service.

6.2 Does the Preferred Option address any Risk(s) identified on the Directorate or Department's Risk Register?

Yes	**X**
No	

Please tick

If yes, what is/are the risk(s), and to what extent are they addressed by the Preferred Option?

Risk Reg. No.	Risk	Extent		
		Minimally	Partially	Fully
100	The lack of available space within the Lab Med area on the York site, particularly in relation to 3rd floor Histology, due to a continually increasing workload and the transfer of work from the Scarborough site has resulted in unfit laboratory conditions and working environments for clinical and scientific staff in breach of ISO 15189 accreditation standards.			**X**
105	Scarborough Pathology premises not fit for purpose may result in failure to comply with legislation and accreditation standards, with particular regard to electrical safety, asbestos removal, leaking roof and walls and windows replacement.			**X**
107	The York and Scarborough sites each have one autoclave sited with their laboratory. Both require replacing as they have been in situ for >10 years and are prone to breakdown. In addition, parts for the autoclave in York are becoming difficult to obtain as the unit is obsolete. Autoclaving of microbiological waste on the laboratory site is mandatory. Breakdown of either autoclave results in a build-up of hazardous waste that must be consigned and notified to the HSE for transport off site for incineration. This can only be a short term measure and serious failure of either autoclave			**X**

	may result in a lengthy delay. This would be criticised by the HSE and could materially affect provision of a microbiology service.			

Please tick x1 per risk

6.3 Other Options

Detail the reasons for rejecting the remaining options listed under section 5, together with supporting detail.

Option 2: As detailed in option 1 but re-locating Cytology to an off-site location.

When the option to extend the 3rd floor across the remaining half of the roof was originally examined in 2014 by the capital planning team, there was a view that the existing plant on the roof would have to remain and so a horseshoe formation of build (with consultant accommodation around the edge) would be the only option. Whilst this provided an expansion and refurbishment of the existing Histology department to accommodate the service from Scarborough, it failed to provide sufficient space for the Cytology service. Sites were therefore identified in and around York for the Cytology service; plans and costs have been provided.
This plan was subsequently reviewed by our existing Capital Programme Manager at the end of 2015 and the option of a complete build with the re-siting of plant was preferred. Should this be financially viable then option 1 remains the preferred choice.

Whilst it is possible to locate this service away from the hospital, this move creates difficulties as Consultants and Senior Scientific staff would still have to work across the York and off-site location. Separate transport arrangements will be required to ensure samples are delivered throughout the day incurring significant costs.

The off-site location requires a refit to accommodate the laboratory and an agreed lease for a 10 year period. In addition to the refit cost, there are leasing and services costs as well as the decommissioning costs at the end of the lease period. Provision of the Cytology service on the York hospital site is a better option as the accommodation will be wholly owned by the Trust.

This option will deliver the directorate strategic plan should the preferred option be discounted.

Option 3: As detailed in option 1 but not moving Blood Sciences out of the Pathology block in Scarborough.

This option delivers the consolidation of services for Microbiology and Histology but fails to upgrade the Blood Science service in Scarborough. There are two compelling reasons for re-locating Blood Sciences to Haldane ward; firstly the proposed ED extension and secondly the poor state and repair of the Pathology block and inability to accommodate all laboratory areas in an open plan area.

The Trust strategic plan for Scarborough includes the extension of ED and provision of an acute medical unit. This plan extends the existing ED across the Pathology block footprint. Costs and feasibility to knock down the Pathology block for this new build have been undertaken. Failure to move the Blood Science service out of the Pathology block would prevent this scheme from going ahead. It is essential to maintain the Blood Science service on the Scarborough site to provide a safe and robust service to the acute hospital. Turnaround times for urgent samples are under 60 minutes with a mean time of 2 hours for in-patient samples. It is not possible to provide this service away from the main hospital and the provision of a 'hot lab' facility in the hospital with the bulk of the work transferred to York would create significant patient safety issues.

The Pathology block requires significant investment that includes replacement of the roof, removal of asbestos (this can only be undertaken when the building is unoccupied), electrical infrastructure, replacement windows and surrounds and general work to make the building serviceable. The design of the laboratory, whilst adequate for the service in the 1960's is unsuitable for a modern day laboratory. Many of the laboratory functions have been placed in small, separate rooms that make it extremely difficult to work across the specialities.
The directorate is developing a Blood Science department in Scarborough so that Biomedical Scientists (BMS) and support staff are multi-disciplinary trained; this makes best use of our limited staffing. This change will only see real benefits when staff are operating in an open plan laboratory. Haldane ward is the only vacant area identified that meets the service needs.

Option 4: The refurbishment and extension of the existing Histology laboratory on the 3rd floor Laboratory Medicine that includes the Cytology service relocated from the 1st floor.

This option enables the consolidation of the Histology service on the York site and an enlarged Cytology service to meet the needs of our current and future capacity. However, this fails to address the consolidation of the Microbiology service onto the York site in line with the directorate strategic plan. The vacated Cytology area would be left unused as the screening room (currently set up as an office environment) could not be used for laboratory purposes.

Maintaining two microbiology services (York & Scarborough) will require additional staffing resource and the maintenance of duplicate equipment and maintenance contracts. The Maldi-Tof mass spectrometer is sited on the York site and it would be too expensive to provide another unit in Scarborough. The results in a two-tier service where the identification of bacterial pathogens takes 24-48 hours longer than in York. This impacts upon antibiotic prescribing and may affect bed stay, morbidity and mortality. The lack of access to rapid antibiotic susceptibility testing in Scarborough as the instrument is sited in the York laboratory.

The failure to move the Scarborough Blood Science service to Haldane ward as previously detailed fails to release the site for ED expansion and requires significant investment to maintain the Pathology Block.

Option 5: Relocate the Blood Science service in Scarborough to the vacated Haldane ward only.

This option would deliver the benefits to a new Blood Science laboratory in Scarborough but would fail to deliver the further consolidation of Histology and Microbiology onto the York site with associated benefits (see earlier).

This option is not feasible as the Microbiology service and Histology equipment will still remain in the Pathology block thus preventing the demolishing of the building to accommodate the proposed ED build. The Pathology building would have around 30% occupancy only for the Microbiology service with other areas unsuitable for alternative uses.

Option 6: Move Cytology off-site, refurbish the vacated laboratory area and consolidate Microbiology onto the York

This option would address the limited space we currently have for Cytology and consolidate the Microbiology service onto the York site. However, the chronic and critical shortage of space for the Histology service would not be addressed. The ability of the directorate to fill vacant Consultant Histopathologist and BMS posts is inextricably linked to the quality of the environment, particularly as Consultant staff require their own individual accommodation as their daily duties are mostly carried out in this environment. Their daily work revolves around microscopy of sections, dictating results and MDT's. To undertake their work efficiently and safely requires a quiet and pleasant environment. It cannot be over stated that prospective candidates, particularly for Consultant posts will not apply if this is unavailable or sub-standard. We are fortunate to have a strong team of 8.5 WTE Consultant Histopathologists and the addition of an up to date laboratory and suitable accommodation will increase the likelihood of attracting high quality candidates.

Option 7: Cytology service lost at re-tender April 2017

This option deals with the loss of the Cervical Cytology contract out to tender now with a start date of April 2017. The outcome of this tender will be known late November 2017.

The loss of the service with the 17 staff currently employed would release the current laboratory and screening area for the Microbiology service as detailed in options 1 & 2. There would not be a need to provide the full roof extension on the 3rd floor of the Lab Med block, however, the existing footprint with a refurbishment would still fail to accommodate the existing Histology service and Consultant accommodation and the non-gynae Cytology laboratory. The non-gynae work is already incorporated into the preferred option.

The options are to build the full extension on the 3rd floor as detailed in the preferred option, or to build a smaller extension. The benefit of continuing the full extension on the 3rd floor is to provide additional space for other laboratory areas e.g. Biochemistry & Haematology or allow spare space to be used by other Trust services.

Option 8: Do nothing

This option fails to deliver any consolidation, updating and improvement to the service, primarily:

- Failure to recruit to two vacant consultant Histopathologists posts as there is no accommodation for them. This creates critical capacity issues, increases turnaround times, increase cost due to work being sent out to 'back logs' for diagnosis.
- Fail to update and consolidate Histology services on the York site and ensure the Histology laboratory is fit for purpose and suitable to accommodate services and staff from Scarborough. Fails to deliver cost efficiencies through consolidation.
- Fails to consolidate Microbiology services on the York site that enables further improvements to the service through automation; this is only possible with the larger single service. Fails to benefit Scarborough hospital patients with the recent introduction of the Maldi-Tof bacterial identification instrument.
- Fails to relocate the Blood Science laboratory to the vacated Haldane ward. The existing Scarborough Pathology block is not fit for purpose as a modern day laboratory and significant cost is necessary to maintain the building. The Haldane ward project would deliver an open plan, modern and reactive service that would not only provide a first class service for Scarborough hospital and our community but also as a capacity laboratory for the York site.
- Fail to release the Pathology block in Scarborough to enable the development of the planned expansion of the Emergency department.
- Fail to release savings through consolidation.

7. Trust's Strategic Objectives (*Currently Under Review*)

7.1 Alignment with the Trust's Strategic Objectives

The Trust has identified four strategic 'frames' that ensure there is a focus for its emerging priorities and objectives and assists in the communication to staff, patients and other stakeholders. The four strategic 'frames' are:

1 Improve Quality and Safety
2 Develop and enable strong partnerships
3 Create a culture of continuous improvement
4 Improve our facilities and protect the environment

In this context listed below are four principle objectives that fit to the strategic frames. Indicate using the table below to what extent the preferred option is aligned with at least one of these principle objectives.

Strategic Objective	Aligned? Yes/No	If Yes, how is it Aligned?
Improve quality and safety - To provide the safest care we can, at the same time as improving patients' experience	Yes	Consolidating Histology & Microbiology services enables the departments to deliver a seamless

of their care. To measure our provision against national indicators and to track our provision with those who experience it.		high quality service that enables patients from all hospital sites and within the community to benefit from increased automation and faster testing times due to the larger single site departments
Develop and enable strong partnerships - To be seen as a good proactive partner in our communities - demonstrating leadership and engagement in all localities.	No	
Create a culture of continuous improvement - To seek every opportunity to use our resources more effectively to improve quality, safety and productivity. Where continuous improvement is our way of doing business.	Yes	Single site services enable investment in larger capacity and newer technologies. This makes better use of our resources (staff and financial) and improves quality through greater efficiencies.
Improve our facilities and protect the environment - To provide a safe environment for staff, patients and visitors, ensuring that all resources are used as efficiently as possible.	Yes	The new extension and refurbishment for Histology and Microbiology will improve facilities for our staff and ensure best use of limited resources. The Blood Science move to Haldane ward enables the expansion of ED and improves the environment for patients and staff.

8. Benefit(s) of the Business Case

8.1 Benefit(s)

The identification at the outset of the benefit(s) that arise from the business case is crucial to ensuring that a robust evaluating of the progress and delivery of the business case objectives is possible during the post implementation reviews.

*Clearly detail and **quantify** the expected benefits that will accrue to the Trust from the preferred option in each of the three domains of service improvement. The benefits identified must be tangible, and capable of being evidenced ideally through some form of measurement.*

Quality and Safety						
Description of Benefit	**Metric**	**Quantity Before**	**Quantity After**	**At 3m**	**At 6m**	**At 12m**
Rapid identification of bacteria causing infections for samples submitted to Scarborough (use of	Time	24-72 hours	<3 hours	<3 hours	<3 hours	<3 hours

Maldi-Tof only available in York)						
Improved turnaround time for Histology samples currently referred to Backlogs	Days	14 days	7 days	7 days	7 days	7 days
Resilience of the microbiology service on a single site. Two autoclaves to ensure compliance with HSE.	Available	No	Yes	Yes	Yes	Yes
How will information be collected to demonstrate that the benefit has been achieved? Audit						

Access and Flow						
Description of Benefit	**Metric**	**Quantity Before**	**Quantity After**	**At 3m**	**At 6m**	**At 12m**
Release of Pathology block for ED development	Availability	No	Yes	Yes	Yes	yes
Formation of a capacity Blood Science laboratory to support York GP workload	Availability	No	Yes	Planned implementation	Yes	Yes
Improved turnaround times for identification of bacterial pathogens for microbiological work previously undertaken in Scarborough. This makes use of the Maldi-Tof instrument.	Availability	No	Yes	Yes	Yes	Yes
How will information be collected to demonstrate that the benefit has been achieved? Progression of the ED build. Ability to move work from York GP's to Scarborough laboratory in the event of capacity issues in the York laboratory. Identification of bacterial pathogens – time taken for identification of organisms from patient samples previously investigated in the Scarborough laboratory.						

Finance and Efficiency						
Description of Benefit	**Metric**	**Quantity Before**	**Quantity After**	**At 3m**	**At 6m**	**At 12m**
Maintaining Cytology contract in next round of bidding	Contract in place	Contract to be renewed in 2017	Contract retained	Contract retained	Contract retained	Contract retained
Reduced cost of Consultant staff in Histology	WTE/£	11.5 WTE/£208k	10.5 WTE/£0k	10.5 WTE/£0k	10.5 WTE/£0k	10.5 WTE/£0k
Reduced cost of BMS and MLA staff in Histology CIP already achieved.	WTE/£	28.30wte/£845k	26.30wte/£786k	26.30wte/£786k	26.30wte/£786k	26.30wte/£786k

Reduced cost of BMS and MLA staff in Microbiology (Scarborough Staff)	WTE/£	17.36wte/ £542k	12.10wte/ £405k	As natural wastage occurs		
Reduction in equipment costs – Histology	£	£320k	£297k	£297k	£297k	£297k
Reduction in equipment costs – Microbiology	£	£590k	£550k	£570k	£550k	£550k
Reduced cost of services e.g. NEQAS, CPA accreditation	£	£35k	£23k	£30k	£23k	£23k
Cost avoidance – reduced costs for Histology reporting by Backlogs costs reduction above cost of substantive consultant posts	£	£80,000	£0k	£0k	£0k	£0k
Reduction of on-going backlog maintenance and cost avoidance (Estates & Facilities) for the York laboratory.	£	£886,292	£0k	£0k	£0k	£0k
Reduction of on-going backlog maintenance and cost avoidance (Estates & Facilities) for the Scarborough laboratory.	£	£497,685	£0k	£0k	£0k	£0k
Additional staff for the microbiology service should this remain in Scarborough (1.0 wte Band 7)	£	£45,324	£0k	£0k	£0k	£0k
Reduction in use of hermetically sealed containers and staff time for transport of unautoclaved waste off-site for incineration in the event of an autoclave breakdown.	£	£15k	£0k	£0k	£0k	£0k
How will information be collected to demonstrate that the benefit has been achieved? Cost benefit analysis						

8.2 Corporate Improvement Team Review

The Corporate Improvement Team must review all business cases across the three quality domains. The date that the business case was reviewed by the CIT together with any comments which were made must be provided below. It is insufficient to confirm merely that the document has been circulated or that a discussion has taken place.

Date of Review	18/07/16 reviewed by Louise Parker
Comments by CIT	**Measurement suite comprehensive and represent potential benefits to be realised from this BC**

9. Summary Project Plan

Detail below the specific actions, individuals responsible for their delivery, and timescales that must be done in order to realise the intended benefits of the preferred option of this business case. For example, these may include acquisition of key space requirements, or equipment, IT software/ hardware; the recruitment of key personnel, training, implementation of systems, change in business and/or clinical processes, etc. ***All fields must be completed****.*

Description of Action	Timescale	Actioned By
Submit business case to CPEG, BC panel and Corporate Directors	July 2016	Paul Sudworth
As agreed by Board of Directors	ASAP	Paul Sudworth

10. Risk Analysis:

Identify the key risks to the Trust of proceeding with the preferred option, and what actions can be taken to mitigate them should they arise.

Identified Risk	Proposed Mitigation
Loss of the Cytology contract in 2017/18	Outcome of tender will be known before the end of March 2017. Consider a smaller extension to the 3rd floor Histology department.
Failure of the Scarborough ED build going ahead	May still be cost effective and improve quality of service to move out of the Pathology block in Scarborough.
Effect of re-organisation of laboratory services within the STP project	There is a need for Blood Science laboratories on all acute sites. With regard to Histology and Microbiology a single site service across the STP area could only be delivered with a brand new laboratory sited on one of the acute sites. Significant cost and logistics would question whether this option would deliver any benefits.
Lack of rapid identification of bacterial pathogens using the Madi-Tof mass spectrometer that is sited in York.	None, unless a second instrument is obtained for the Scarborough lab (approx. £160k purchase + £5k p.a.).
Inability to obtain rapid antibiotic susceptibility tests on the Scarborough site because of the lack of a Vitek instrument	None, unless a second instrument is obtained for the Scarborough lab (approx. £60k purchase + £15k p.a.).

11. Risk of Not Proceeding:

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

Should we fail to secure funding for option 1 or 2 the risks to the service would be:

- Inability to release savings and meet our efficiency target year on year. The CIP schedule already details schemes that will release savings.

- Inability for the ED expansion scheme in Scarborough to go ahead as the Pathology block would still house the Blood Science and Microbiology services and Histology equipment that cannot be accommodated on the York site.
- Potential risk of not being awarded the tender for the Cervical Cytology tender for North Yorkshire, Humberside and North Lincolnshire. The current income to the Trust is £1.4M p.a. and this will increase with the new tender with the addition of the North Lincolnshire patch for the first time.
- Reduce the likelihood of replacing two Consultant Histopathologist posts due to the lack of suitable consultant accommodation and laboratory environment.
- Cost avoidance schemes would create additional expenditure e.g. new autoclave in Scarborough (c£100k), additional BMS staff in Microbiology Scarborough (c£70k), equipment maintenance, NEQAS & Accreditation fees (c£30k).
- Inability to attract suitable candidates for the Consultant Histopathologist posts due to the poor and inadequate environment.
    - Continuing additional cost associated with sending Histology work to Backlogs.
    - Increased turnaround time for results that may impact upon patient care.
- Inability to fully establish a Blood Science department in Scarborough to make best use of staffing resources. This would slow down potential savings associated with skill mix changes following this introduction.
- Failure for the Scarborough patients to benefit from the introduction of the Maldi-Tof mass spectrometry bacterial identification assay that reduces time to identification. This currently creates a two tier service to our patients.
- Failure for Scarborough patients to benefit from rapid antibiotic susceptibility tests using the Vitek instrument sited in York.

12. Is there a requirement to apply for MSSE funding via the MSSE Committee, linked to this Business Case?

Yes	
No	X

13. Consultant, and other Non-Training Grade Doctor Impact

(Only to be completed where the preferred option increases the level of Consultant/ non-Training Grade input)

13.1 Impact on Consultant/ Non-Training Grade Doctor Workload:

The Trust is committed to reduce the number of Programmed Activities (PAs) being worked by any Consultant/ Non-Training Grade Doctor to a maximum of 11. This section should illustrate the impact that the additional Consultant/ Non-Training Grade input created will have on the average number of PAs worked in the specialty, the frequency of the on-call rota, and the PA profile across the whole specialty team. Information is also required of each Consultant's/ Non-Training Grade Doctor's actual annual working weeks against the 41 week requirement.

The information below must be accompanied by the Trust's Capacity Planning Tool, and the Job Plan, which should be appended to, and submitted with the business case.

	Before	After
Average number of PAs		
On-call frequency (1 in)		

Consultant/ Non-Training Grade Doctor Team Work Profile				
Name of Consultant/ Non-Training Grade Doctor	**Working Weeks v 41 Week Requirement**		**PA Commitment**	
	Before	**After**	**Before**	**After**

13.2 Executive Job Planning Committee:

The Medical Director/Executive Job Planning Committee must review all proposed job plans for new consultant posts, as well as any job plans for existing consultants where the proposed new post would have an impact on current working practices. The date that the job plans were approved by the Committee and any comments which were made must be provided below.

Date of Approval	
Comments by the Committee	

14. Stakeholder Consultation and Involvement:

Identify the key stakeholders (both internal and external to the Trust) essential to the successful implementation of the business case; the extent to which each support the proposal, and where appropriate, ownership for the delivery of the benefits identified above. Where external stakeholder support is vital to the success of the business case (e.g. commitment to commission a service), append documentation (letter, e-mail, etc.) evidencing their commitment. If the Business Case spans more than one Directorate or Department the expected/required close collaboration in such circumstances must be evidenced, and if necessary, joint authorship selected.

Examples of stakeholders include Lead Clinicians, support services (e.g. Systems & Network Services, Capital Planning re: accommodation), commissioners (e.g. Vale of York CCG, Scarborough & Ryedale CCG, etc), patients & public, etc. ***Please bear in mind that most business cases do have an impact on Facilities & Estates services.***

Stakeholder	**Details of consultation, support, etc.**
Mandatory Consultation	
Corporate Improvement Team	
Radiology Directorate	
Laboratory Medicine	
Pharmacy	
AHP & Psychological Medicine	
Theatres, Anaesthetics and Critical Care	
Community Services	
Other Consultation	
Clinical service users in Scarborough	

15. Sustainability

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

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

Will this Business Case:	Yes/No	If Yes, Explain How
Reduce or minimise the use of energy, especially from fossil fuels?	Yes	Running Histology and Microbiology services from one site reduces duplication and so energy usage.
Reduce or minimise Carbon Dioxide equivalent emissions from NHS activity?	Yes	As above
Reduce business miles?	No	
Reduce or minimise the production of waste, and/or increase the re-use and recycling of materials?	Yes	Deliveries to one site only for Microbiology
Encourage the careful use of natural resources, such as water?	Yes	Less use when operating from one site for Histology and Microbiology

16. Alliance Working

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

Building centralised services on the York site makes any future collaboration with Hull and/or Harrogate possible as each of our services will have increased capacity.

17. Impact on the Ambulance Service:

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

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

18. Market Analysis:

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

New tender for Cervical Cytology services expected April 2017. This could see increased income due to a larger contracting area. Current workload is 72,000 specimens per annum with an expected increase of 22,000 specimens per annum from North Lincolnshire and Goole (+30%). Currently £1.4M p.a., estimate new contract could be up to c£1.82M p.a.

19. Financial Summary

19.1 Commissioning Team Review:

The Commissioning Team must review all business cases for consistency with PbR and other national commissioning guidance, and with regard to consistency with CCG, NHS England, and Local Authorities commissioning intentions. The date that the business case was reviewed by the CT together with any comments which were made must be provided below.

Date of Review	25th July 2016
Comments by CT	The business case does not present any significant concerns to the commissioning team other than the potential risk to our income through the re-tendering of the Cytology service in 16/17. This risk is clearly identified in the case.

19.2 Estimated Full Year Impact on Income & Expenditure:

Summarise the full year impact on income & expenditure for the specialty as a result of this business case. The figures should cross reference to the more detailed analysis on the accompanying 'Financial Pro Forma'.

	£000	£000	£000
Capital Expenditure		4,883	4,883
Income	15,695	16,115	420
Direct Operational Expenditure	18,485	18,697	212
EBITDA	-2,790	-2,582	208
Other Expenditure		188	188
I&E Surplus/ (Deficit)	-2,790	-2,770	20
Existing Provisions	n/a		0
Net I&E Surplus/ (Deficit)	-2,790	-2,770	20
Contribution (%)	-17.8%	-17.2%	4.8%
Gross I&E Surplus/(Deficit)			397
Non-recurring Expenditure	n/a	140	140

Supporting financial commentary:

Income
The additional income within this case is based on the successful tendering for our current Cytology Screening contract, from 2017/18 this will include the North Lincolnshire and Goole (NLAG) portion of the screening programme an additional 30% on top of current screening levels, we assume this will provide an additional £420k of income.

Pay
The pay reduction of 5.26wte within Microbiology will take place over a number of years, the directorates plan for this is to remove these posts by natural wastage and by using staff moving over to York to fill current vacancies. Given current vacancy levels within the directorate we would expect all posts to be removed within 5 years of scheme completion.

Additional staffing of 2x B4 Screeners and 1x B2 MLA will be required for the additional Cytology Screening workload, these will be required from the start of the new contract in April 2017.

Direct Expenditure
£40k reduction in clinical supplies and services is due to the amalgamation of the York and Scarborough Microbiology labs and relates to £28k consumables and £12k maintenance contract reductions.

3 additional transport runs are required for this scheme, the cost of these additional runs is included in this case in total despite the requirement for these runs being for services other than Laboratory Medicine.

Non Recurrent Expenditure
The costs included in here include £89k of Redundancy costs based on the staff that have indicated they would not be willing to relocate to the York site.

Gross I&E Position
Due to changes already occurred, most notably Histopathology move to York from Scarborough, some of the CIPs this scheme allows are already achieving savings, the long term achievement of these schemes relies heavily on the approval of this case, some of these costs will need re-instating if the scheme can't progress.

20. Date of Completion:

19 July 2016

York Teaching Hospital NHS
NHS Foundation Trust

BUSINESS CASE FINANCIAL SUMMARY

REFERENCE NUMBER:	2016/17-21
TITLE:	**Laboratory Medicine Capital Programme to facilitate integration on the York hospital site of the Microbiology and Histology laboratory services, relocate Cytology services within Histology and relocate Blood Science department in Scarborough hospital to the vacated Haldane ward.**
OWNER:	Dr Neil Todd
AUTHOR:	**Paul Sudworth**

Capital

	Total	Planned Profile of Change			
		2016/17	2017/18	2018/19	Later Years
	£'000	£'000	£'000	£'000	£'000
Expenditure	4,883		3,662	1,221	0

Capital Notes *(including reference to the funding source)*:
The funding of this capital project is currently part of the Capital Programme for the 2017/18 Financial Year. It is Expected that 75% of the work will be carried out in 2017/18 with the remaining 25% Carrying over to 2018/19. Also, within the spend it needs noting that there are currently provisions made for the update of the autoclave and that will not be required as that cost is included within the capital costs of this case.

It is assumed the funding for this case would be within the annual trust Capital Programme, therefore no interest charge is included within the finances.

Revenue

	Total Change				Planned Profile of Change			
	Current	Revised	Change		2016/17	2017/18	2018/19	Later Years
	£'000	£'000	£'000	WTE	£'000	£'000	£'000	£'000
(a) Non-recurring			140		0	38	102	0
(b) Recurring								
Income								
NHS Clinical Income	15,695	16,115	420		0	420	420	420
Non-NHS Clinical Income	0	0	0		0	0	0	0
Other Income	0	0	0		0	0	0	0
Total Income	15,695	16,115	420		0	420	420	420
Expenditure								
Pay								
Medical			0					
Scientific & Professional	10,982	10,845	-137	-5.26	0	0	-51	-137
Other (please list):								
Cytology Staffing		71	71	3.00		71	71	71
Support Staff - Clerical Staff	0		0					
WLIs			0					
			0					
	10,982	10,916	-66	-2.26	0	71	20	-66
Non-Pay								
Drugs			0					
Clinical Supplies & Services	7,503	7,463	-40				-20	-40
General Supplies & Services			0					
Other (please list):								
			0					
Transport Costs		120	120				60	120
Staff Excess Travel		60	60				30	60
Additional Cytology Consumables		123	123			123	123	123
Cytology Bloodfast for NLAG		15	15			15	15	15
			0					
	7,503	7,781	278		0	138	208	278
Total Operational Expenditure	18,485	18,697	212		0	209	228	212
Impact on EBITDA	-2,790	-2,582	208	-2.26	0	211	192	208
Depreciation		115	115			100	115	115
Rate of Return		73	73			60	73	73
			0					
Overall impact on I&E	-2,790	-2,770	20	-2.26	0	51	4	20
								+ favourable (-) adverse
Less: Existing Provisions	n/a		0					
Net impact on I&E	-2,790	-2,770	20		0	51	4	20
CIP's Already Taken			377					377
Gross impact on I&E			397					397

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

Income
The additional income within this case is based on the successful tendering for our current Cytology Screening contract, from 2017/18 this will include the North Lincolnshire and Goole (NLAG) portion of the screening programme an additional 30% on top of current screening levels, we assume this will provide an additional £420k of income.

Pay
The pay reduction of 5.26wte within Microbiology will take place over a number of years, the directorates plan for this is to remove these posts by natural wastage and by using staff moving over to York to fill current vacancies. Given current vacancy levels within the directorate we would expect all posts to be removed within 5 years of scheme completion.
Additional staffing of 2x B4 Screeners and 1x B2 MLA will be required for the additional Cytology Screening workload, these will be required from the start of the new contract in April 2017.

Clinical Service and Supplies
The £40k reduction in clinical supplies and services is due to the amalgamation of the York and Scarborough Microbiology labs and relates to £28k consumables and £12k maintenance contract reductions.

Transport Costs
3 additional transport runs are required for this scheme, the cost of these additional runs is included in this case in total despite the requirement for these runs being for services other than Laboratory Medicine.

Excess Travel
Excess Travel costs are included at worst case levels, these will be incurred for 30 months for all staff moving over from Scarborough, this cost will be returned as a recurrent CIP once the payments stop.

Additional Cytology Costs
The additional Cytology Screens will require additional consumable and transport costs, these are based on the assumption that this will bring an additional 300 screens and that the screens will be picked up from Lincoln or Scunthorpe.

Non Recurrent Costs
The costs included in here include £89k of Redundancy costs based on the staff that have indicated they would not be willing to relocate to the York site.

CIPs Already Taken
Due to changes already occurred, most notably Histopathology move to York from Scarborough, some of the CIPs this scheme allows are already achieving savings, the long term achievement of these schemes relies heavily on the approval of this case, some of these costs will need re-instating if the scheme can't progress.

	Owner	Finance Manager	Board of Directors Only Director of Finance
Signed	**Dr Neil Todd**	Neil Barrett	
Dated	**August 2016**	August 2016	

BUSINESS CASE - ACTIVITY & INCOME

Activity

	Total Change			Planned Profile of Change			
	Current	Revised	Change	2016/17	2017/18	2018/19	Later Years
Elective (Spells)			0				
Non-Elective (Spells)							
Long Stay			0				
Short Stay			0				
Outpatient (Attendances)							
First Attendances			0				
Follow-up Attendances			0				
A&E (Attendances)			0				
Other (Please List):							
Best Practice Tariff #NOF			0				
			0				

Income

	Total Change			Planned Profile of Change			
	Current £'000	Revised £'000	Change £'000	2016/17 £'000	2017/18 £'000	2018/19 £'000	Later Years £'000
NHS Clinical Income							
Elective income							
Tariff income			0				
Non-Tariff income			0				
Non-Elective income							
Tariff income			0				
Non-Tariff income			0				
Outpatient							
Tariff income			0				
Non-Tariff income			0				
A&E							
Tariff income			0				
Non-Tariff income			0				
Other							
Tariff income	0	0	0				
Non-Tariff income	15,695	16,115	420		420	420	420
	15,695	**16,115**	**420**	**0**	**420**	**420**	**420**
Non NHS Clinical Income							
Private patient income			0				
Other non-protected clinical income			0				
	0	**0**	**0**	**0**	**0**	**0**	**0**
Other income							
Research and Development			0				
Education and Training			0				
Other income			0				
	0	**0**	**0**	**0**	**0**	**0**	**0**

INVESTMENT APPRAISAL SCORING SHEET - BENEFITS

BENEFITS APPRAISAL		OPTIONS															
		Option 1 Extend 3rd Floor of Laboratories at York to accommodate Cytology, Consolidate Microbiology onto York site and Move Scarborough Blood Sciences to Haldane Ward		**Option 2** Refurbish Histopathology at York, Move Scarborough Blood Sciences to Haldane Ward, Move Cytology off-site allowing for refurbishment of vacated laboratory to consolidate Microbiology.		**Option 3** Extend 3rd Floor of Laboratories at York to accommodate Cytology and Consolodate Microbiology at York		**Option 4** Extend 3rd Floor of Laboratories at York to accommodate Cytology		**Option 5** Relocate Blood Sciences at Scarborough to Haldane Ward		**Option 6** Move Cytology Off-Site and Consolodate Microbiology onto York Site.		**Option 7** Extend 3rd Floor of Laboratories at York, Consolidate Microbiology onto York site and Move Scarborough Blood Sciences to Haldane Ward. Loss of Cytology Service		**Option 8** Do Nothing	
Benefit Criteria Description	**Relative Weighting**	**Raw Score**	**Weighted Score**	**Raw Score**	**Weighted Score**	**Raw Score**	**Weighted Score**	**Raw Score**	**Weighted Score**	**Raw Score**	**Weighted Score**	**Raw Score**	**Weighted Score**	**Raw Score**	**Weighted Score**	**Raw Score**	**Weighted Score**
Consolidate Microbiology onto one Site	5	5	25	5	25	5	25	0	0	0	0	5	25	5	25	0	0
Consolidate Histopatholgy onto one Site	5	5	25	3	15	5	25	5	25	0	0	1	5	5	25	5	25
Provide Suitable Environment for Scarborough Labs	3	5	25	5	25	0	0	0	0	3	15	0	0	5	25	0	0
Reduce need for Business Travel and Travel claims within the directorate.	2	4	20	2	10	3	15	0	0	0	0	2	10	3	15	0	0
Improve working environments of all Laboratories and associated offices	3	5	25	5	25	3	15	2	10	2	10	2	10	5	25	0	0
Allow for Modernisation of Laboratories and Equipment	4	5	25	5	25	3	15	3	15	2	10	2	10	5	25	0	0
Allow Laboratories the capability to take on extra work	5	5	25	5	25	2	10	2	10	2	10	2	10	2	10	0	0
Meet Strategic Demands of Wider Trust in terms of consolidation of services	4	5	25	5	25	4	20	2	10	2	10	0	0	5	25	0	0
Release Pathology Block at Scarborough for ED Development	5	5	25	5	25	0	0	0	0	0	0	0	0	5	25	0	0
Overall Benefits Score			**220**		**200**		**125**		**70**		**55**		**70**		**200**		**25**

INSTRUCTIONS

1. Enter a description for each appraisal criterion against which each option is to be assessed in the 'Description' column. Add further rows as required and check whether the formulae under each 'Weighted Score' column needs adjusting accordingly.

2. Determine and enter the relative weighting (importance) of each appraisal criterion compared to the other criteria in the 'Relative Weighting' column. This will be down to the subjective judgement of the project group. It is recommended that a scale of 1 to 5 is used, where 5 is reserved for the most important criterion, to 1 for the least important criterion in comparison to the other criteria. Where a certain criterion is judged to be of equal importance to another criterion, it is perfectly in order to award a similar weighting to two or more individual criterion. The secret is to judge the relative importance of each criterion; so for example if one criterion has a weighting of 2, but another crierion is judged to be at least twice as important to the overall success of the business case, then it may be appropriate to award a weighting of 4 or more against that criterion.

3. Each option description should be added to the table where indicated. If there are more than 6 options, copy and paste further columns to create room for the extra options, and check the formulae to ensure they have not been compromised.
4. The process is then for the project group to score each option based on the extent that it will deliver against each of the individual criterion, and enter the respective score in the 'Score' column for each option. The 'Weighted Score' column will automatically populate. It is suggested that a scoring range of 1 to 5 is used, where 5 indicates that an option will fully deliver against the criertion, ranging to 1 where the option will barely deliver against the criterion.
5. At the end of the process, the total weighted score for each option will be shown under each option in the 'Overall Benefits Score' row. The option with the highest overall benefits score should be the option that will best deliver against the overall objective criteria for the business case.

INVESTMENT APPRAISAL SCORING SHEET - FINANCIAL

FINANCIAL APPRAISAL		OPTIONS							
		Option 1 Extend 3rd Floor of Laboratories at York to accommodate Cytology, Consolidate Microbiology onto York site and Move Scarborough Blood Sciences to Haldane Ward	**Option 2** Refurbish Histopathology at York, Move Scarborough Blood Sciences to Haldane Ward, Move Cytology off-site allowing for refurbishment of vacated laboratory to consolidate Microbiology.	**Option 3** Extend 3rd Floor of Laboratories at York to accommodate Cytology and Consolodate Microbiology at York	**Option 4** Extend 3rd Floor of Laboratories at York to accommodate Cytology	**Option 5** Relocate Blood Sciences at Scarborough to Haldane Ward	**Option 6** Move Cytology Off-Site and Consolodate Microbiology onto York Site.	**Option 7** Extend 3rd Floor of Laboratories at York, Consolidate Microbiology onto York site and Move Scarborough Blood Sciences to Haldane Ward. Loss of Cytology Service	**Option 8** Do Nothing
		FINANCIAL DATA							
		£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Non-Recurring Expenditure:									
Capital Expenditure	(-ve)	-4,883.000	-4,460.000	-3,712.000	-3,041.000	-2,555.000	-4,133.000	-3,960.000	-1,384.000
Non-Recurring Revenue Expenditure	(-ve)	-140.000	-140.000	-140.000	0.000	-51.000	-140.000	-140.000	0.000
Recurring Income & Expenditure:									
- Income	(+ve)	420.000	420.000	420.000	420.000	-1,440.000	420.000	-1,440.000	-1,440.000
- Expenditure	(-ve)	-400.000	-568.000	-389.000	-413.000	-145.000	-614.000	-191.000	-45.000
- Net Income & Expenditure		**20.000**	**-148.000**	**31.000**	**7.000**	**-1,585.000**	**-194.000**	**-1,631.000**	**-1,485.000**
		FINANCIAL PROFILING & DISCOUNTED CASH FLOW (DCF)							
	Year	**Profile**	**DCF @ 3.5%**	**Profile**	**DCF @ 3.5%**	**Profile**	**DCF @ 3.5%**	**Profile**	**DCF @ 3.5%**	**Profile**	**DCF @ 3.5%**	**Profile**	**DCF @ 3.5%**	**Profile**	**DCF @ 3.5%**	**Profile**	**DCF @ 3.5%**
		£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
	0	-3,747.250	-3,747.250	-3,598.000	-3,598.000	-2,858.000	-2,858.000	-2,273.750	-2,273.750	-3,539.500	-3,539.500	-3,398.750	-3,398.750	-4,706.000	-4,706.000	-2,523.000	-2,523.000
	1	-1,235.750	-1,193.982	-1,298.000	-1,254.128	-932.000	-900.498	-753.250	-727.790	-2,236.500	-2,160.906	-1,262.250	-1,219.586	-2,656.000	-2,566.227	-1,831.000	-1,769.112
	2	20.000	18.851	-148.000	-139.497	31.000	29.219	7.000	6.598	-1,585.000	-1,493.942	-194.000	-182.855	-1,631.000	-1,537.299	-1,485.000	-1,399.687
	3	20.000	18.041	-148.000	-133.503	31.000	27.964	7.000	6.314	-1,585.000	-1,429.749	-194.000	-174.998	-1,631.000	-1,471.244	-1,485.000	-1,339.544
	4	20.000	17.433	-148.000	-129.004	31.000	27.021	7.000	6.102	-1,585.000	-1,381.565	-194.000	-169.100	-1,631.000	-1,421.661	-1,485.000	-1,294.400
	5	20.000	16.845	-148.000	-124.653	31.000	26.110	7.000	5.896	-1,585.000	-1,334.966	-194.000	-163.397	-1,631.000	-1,373.710	-1,485.000	-1,250.741
	6	20.000	16.278	-148.000	-120.457	31.000	25.231	7.000	5.697	-1,585.000	-1,290.032	-194.000	-157.897	-1,631.000	-1,327.471	-1,485.000	-1,208.642
	7	20.000	15.730	-148.000	-116.402	31.000	24.382	7.000	5.506	-1,585.000	-1,246.603	-194.000	-152.581	-1,631.000	-1,282.782	-1,485.000	-1,167.953
	8	20.000	15.201	-148.000	-112.487	31.000	23.562	7.000	5.320	-1,585.000	-1,204.679	-194.000	-147.450	-1,631.000	-1,239.642	-1,485.000	-1,128.674
	9	20.000	14.690	-148.000	-108.706	31.000	22.770	7.000	5.142	-1,585.000	-1,164.183	-194.000	-142.493	-1,631.000	-1,197.970	-1,485.000	-1,090.733
	10	20.000	14.197	-148.000	-105.058	31.000	22.005	7.000	4.969	-1,585.000	-1,125.112	-194.000	-137.711	-1,631.000	-1,157.765	-1,485.000	-1,054.127
	11	20.000	13.720	-148.000	-101.528	31.000	21.266	7.000	4.802	-1,585.000	-1,087.310	-194.000	-133.084	-1,631.000	-1,118.866	-1,485.000	-1,018.710
	12	20.000	13.260	-148.000	-98.124	31.000	20.553	7.000	4.641	-1,585.000	-1,050.855	-194.000	-128.622	-1,631.000	-1,081.353	-1,485.000	-984.555
	13	20.000	12.816	-148.000	-94.838	31.000	19.865	7.000	4.486	-1,585.000	-1,015.668	-194.000	-124.315	-1,631.000	-1,045.145	-1,485.000	-951.588
	14	20.000	12.386	-148.000	-91.656	31.000	19.198	7.000	4.335	-1,585.000	-981.591	-194.000	-120.144	-1,631.000	-1,010.078	-1,485.000	-919.661
	15	20.000	11.972	-148.000	-88.593	31.000	18.557	7.000	4.190	-1,585.000	-948.781	-194.000	-116.128	-1,631.000	-976.317	-1,485.000	-888.921
	16	20.000	11.571	-148.000	-85.625	31.000	17.935	7.000	4.050	-1,585.000	-917.002	-194.000	-112.239	-1,631.000	-943.615	-1,485.000	-859.147
	17	20.000	11.184	-148.000	-82.762	31.000	17.335	7.000	3.914	-1,585.000	-886.332	-194.000	-108.485	-1,631.000	-912.055	-1,485.000	-830.412
	18	20.000	10.810	-148.000	-79.994	31.000	16.756	7.000	3.784	-1,585.000	-856.693	-194.000	-104.857	-1,631.000	-881.556	-1,485.000	-802.643
	19	20.000	10.449	-148.000	-77.323	31.000	16.196	7.000	3.657	-1,585.000	-828.083	-194.000	-101.355	-1,631.000	-852.116	-1,485.000	-775.838
	20	20.000	10.101	-148.000	-74.747	31.000	15.657	7.000	3.535	-1,585.000	-800.504	-194.000	-97.980	-1,631.000	-823.737	-1,485.000	-749.999
	21	20.000	9.763	-148.000	-72.246	31.000	15.133	7.000	3.417	-1,585.000	-773.718	-194.000	-94.701	-1,631.000	-796.173	-1,485.000	-724.903
	22	20.000	9.439	-148.000	-69.849	31.000	14.630	7.000	3.304	-1,585.000	-748.041	-194.000	-91.558	-1,631.000	-769.750	-1,485.000	-700.846
	23	20.000	9.124	-148.000	-67.518	31.000	14.142	7.000	3.193	-1,585.000	-723.077	-194.000	-88.503	-1,631.000	-744.062	-1,485.000	-677.457
	24	20.000	8.820	-148.000	-65.268	31.000	13.671	7.000	3.087	-1,585.000	-698.985	-194.000	-85.554	-1,631.000	-719.271	-1,485.000	-654.885
	25	20.000	8.527	-148.000	-63.100	31.000	13.217	7.000	2.984	-1,585.000	-675.765	-194.000	-82.712	-1,631.000	-695.377	-1,485.000	-633.130
Total Discounted Cash Flow			**-4,630.024**		**-7,155.067**		**-3,276.126**		**-2,892.617**		**-30,363.640**		**-7,637.054**		**-32,651.240**		**-27,399.306**
Net Cost Per Benefit Point Scored (£000)			**-21.046**		**-35.775**		**-26.209**		**-41.323**		**-552.066**		**-109.101**		**-163.256**		**-1,095.972**

INSTRUCTIONS

1. It is suggested that the Directorate's Finance Manager leads on this part of the investment appraisal process. Populate the financial data for each option. This will require that the financial impact for each option present will need costing.
2. The financial impact (Capital and Revenue) for each option will require costing, and the appropriate figures entered in the 'Financial Data' section for each option.
3. The 'Financial Profiling & Discounted Cash Flow' section is designed to comparatively assess the financial impact of each option over their expected lives using the Discounted Cash Flow (DCF) investment appraisal technique. This technique recognises the impact that time has an impact on the value of money i.e. £1 today will be worth less in comparative spending power in 5, 10, 15, etc., years time. The sheet has been designed to assess each option over a period as long as 50 years, although it is expected that the majority of option lives will be a lot shorter than that period; and the Finance Manager will need to decide on the appropriate lifespan of each option in building up the assessment, although it is recommended that each option (unles the option does not extend that far) is assessed as a minimum over 10 years. The DCF has been set at 3.5%, which is the appraisal rate used by th Departmenty of Health.
4. The financial profile for each option should be entered into the three hidden (which will need unhiding) rows between the 'Profile' and 'DCF @ 3.5%' columns. Using Year 0 as the current year, the Finance Manager should be mindful of profiling both capital and revenue expenditure as it will be incurred over the life of the option e.g. it is possible that capital expenditure may extend over 2 or even 3 years, and the profile should reflect this. Equally, net revenue I&E may not reach its full potential in the first year, and may take 2 or more years until it does so. The 'DCF @ 3.5%' column will be automatically calculated when the profile is entered by the Finance Manager in the 'Profile' column. The overall total DCF for each option will be shown on the 'Total Discounted Cash flow' row.

5. The final element of the Investment Appraisal is the combination of each options Overall Benefits Score with the DCF to give a 'Net Cost per Benefit Point Scored'. The option with the highest net cost per benefit score should be the one that will deliver the best cost/benefit mix.

6. Once completed, this scoring sheet should be appended to the business case documentation; used and cross referened in section 6 of the business case narrative to support, but not substitute, the rationale presented in the main business case narrative for arriving at the preferred option.

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 November 2016

Annual Report – Emergency Planning

Action requested/recommendation

The Board are asked to:

- Note the contents of this report
- Support resource investment to secure additional resilience in appropriate training and education for key leaders in emergency planning delivery
- Annual Review in 12 months to assure the Executive Board of robust emergency planning arrangements within the Trust.

Summary

Under the Civil Contingencies Act (2004), NHS organisations and providers of NHS funded care must show that they can plan for and deal with a wide range of incidents and emergencies that could affect health or patient care. This programme of work is referred to in the health community as emergency preparedness, resilience and response (EPRR).

All NHS-funded organisations must meet the requirements of the Civil Contingencies Act (2004), Health and Social Care Act (2012), NHS standard contracts, NHS England Core Standards for EPRR, NHS England Command and Control Framework, and NHS England Business Continuity Management Framework.

The following annual report highlights progress against last year assessment and how the emergency planning agenda will be strengthened and progressed over the next 12 month period.

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

Implications for equality and diversity

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

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	This report has only been presented to the Board of Directors
Risk	No risk.
Resource implications	No direct resource implications.
Owner	Juliet Walters, Chief Operating Officer
Author	Jenny Hey, Deputy Chief Operating Officer
Date of paper	November 2016
Version number	5

Board of Directors – 30 November 2016

Annual Report – Emergency Planning

1. Introduction and background

The previous 12 months have been a busy and eventful year for York Teaching Hospital NHS Foundation Trust (YTH), not just in terms of additional demand on NHS services but also from the variety of unexpected, local and large scale events alongside nationally coordinated industrial action.

Under the Civil Contingencies Act (2004), NHS organisations and providers of NHS funded care must show that they can plan for and deal with a wide range of incidents and emergencies that could affect health or patient care. This programme of work is referred to in the health community as emergency preparedness, resilience and response (EPRR).
All NHS-funded organisations must meet the requirements of the Civil Contingencies Act (2004), Health and Social Care Act (2012), NHS standard contracts, NHS England Core Standards for EPRR, NHS England Command and Control Framework, and NHS England Business Continuity Management Framework.

It is for these reasons stated above that the YTH Board of Directors is aware and supports the work of the Emergency Preparedness Team to continue to drive improvement within its EPRR agenda.

During the last twelve months the Emergency Preparedness Team have assessed risk, worked collaboratively with key stakeholders, partners, managers and clinicians to ensure an effective, resilient and coordinated response to minimise the impact of emergencies and large scale planned events as they occur and to direct planning for the resumption of normal activity.

Trust-wide planning and implementation of special measures were put in place during periods of nationally coordinated industrial action by the British Medical Association. Close engagement and pre-planning across all clinical services ensured a safe level of elective provision with access to all critical services. Regretfully a significant amount of non-urgent appointments had to be re-scheduled; however, all necessary steps were taken to limit disruption to patient care.

The flooding last year across parts of Yorkshire also saw a coordinated and well led response, not only in terms of supporting patients being cared for by our community staff, (in residential areas affected by the floods), but supporting residential homes where there was loss of power and importantly the ability to resume communications, ensuring we were able to quickly resume normal service with both telephone and internet connections, caused by the major flooding of the BT exchange during the floods. Staff came in and worked tirelessly to ensure the hospital was able to function and communicate with external agencies and the general public using our services.

The Emergency Planning team across both hospital sites also worked well with external partners to ensure the coordination of special measures to maintain safe patient care during a number of large scale and international sporting events and protests held in both York and Scarborough. These included the Tour de Yorkshire, York Marathon and the English Defense League march that took place in Scarborough at the same time as a counter demonstration in

York city centre.

It is critical that during any periods of disruption YTH continues to deliver high quality safe care to patients. Robust arrangements must be in place to continue this level of care when unexpected incidents occur or at times of great pressure.

The EPPR Annual Report identifies work undertaken to address key priorities as identified at the last annual self- assessment, Trust compliance with statutory duties and acknowledges its achievements over the last twelve months.

2. Purpose

This EPRR Annual Report provides the Board of Directors with assurance that the Trust has met most of the required EPRR statutory duties and obligations during the period 1 September 2015 to 31 August 2016. The report provides an overview of EPRR activities and sets out EPRR priorities for 2016/17 and the next 12 months prior to annual self- assessment expected in September 2017.

3. Statutory Framework & National Policy Drivers

Under the Civil Contingencies Act 2004, YTH is defined as a Category 1 responder and is subject to civil protection duties which are to:

- Assess the risk of emergencies occurring and use this knowledge to inform contingency planning
- Ensure emergency plans and business continuity management arrangements are in place
- Communicate with the public to ensure they are warned, informed and advised in the event of an emergency
- Share information and cooperate with other local responders to enhance coordination and efficiency

3.1. Strategic National EPRR Framework & Core Standards

The NHS England EPRR Framework contains principles for health emergency planning for the NHS in England at all levels including NHS provider organisations, providers of NHS-funded care, clinical commissioning groups (CCGs), general practices and other primary / community care organisations.

The NHS England Core Standards for EPRR provides the minimum standards that NHS organisations and providers of NHS funded care must meet. YTH are required to undertake an annual self-assessment against the core standards relating to acute Trusts and provide assurance to NHS England (Yorkshire and the Humber) that robust and resilient EPRR arrangements are established and maintained within the Trust. Organisations are expected to state overall whether they believe they are fully, substantially, partially or non-compliant with the core standards.

In September 2016 the Emergency Planning Steering Group assessed EPRR arrangements at YTH as demonstrating a partial compliance level. This means that we have not been able to fully comply with 8 of the 51 key standards and an annual work programme must address those areas of compliance and improve our compliance level. This will be reassessed internally on a quarterly basis and presented to the Executive Board at the end of each quarter.

The Executive Board signed off the statement of compliance on behalf of Board of Directors on

10 October 2016. In addition, there is a requirement for the Board of Directors to receive an annual report including an agreed work programme against the outstanding core standards where the Trust has not met the required standard. Please see **Appendix 1**.

The assurance process will be repeated annually and it should be noted that in order to achieve a greater level of national consistency the core standard definitions have been strengthened in 2016/17, resulting in only partial compliance at this time.

Key priority for 2016/17-18

Due to the timing of this annual report, key areas to address will encompass the 2017 work programme. There is a requirement to drive quality improvements for patients in order to remain a safe, responsive and prepared organisation, including all sites and community services.

Work to achieve significant compliance against EPRR core standards in the 2017 annual assessment and have work programmes in place that address improvement requirements.

4. Accountable Emergency Officer

The Chief Executive is responsible for ensuring that YTH is compliant with the Civil Contingencies Act 2004, supporting statutory legislation and national guidance.
The Chief Operating Officer is the designated Accountable Emergency Officer with responsibility for EPRR within the Trust.

The Chief Operating Officer delegated responsibility to the Deputy Chief Operating Officer to ensure legislative requirements, all underpinning guidance and EPRR core standards were met throughout the year. The Emergency Planning Steering Group supported the Deputy Chief Operating Officer with these responsibilities. The Emergency Planning Team are in transition as new roles are embedded, particularly since the retirement of our designated Emergency Planning Officer in December 2015.

The decision was taken at this time not to appoint to this vacancy and therefore robust team arrangements are in development, including key roles to drive both clinical and non-clinical preparedness. Please see Appendix 2.

5. Emergency Planning Steering Group (EPSG)

The Emergency Planning Steering Group (EPSG) met quarterly to oversee the development and maintenance of Trust emergency and business continuity plans. The group is primarily an assurance group established to ensure compliance with EPRR statutory legislation, strategic framework and core standards. Whilst the group is not supported by a dedicated emergency planning professional, (one of the core standard requirements), the investment in a core group, all trained and committed to robust emergency planning is seen as a key development and one which will be reviewed in 12 months' time. This group is chaired by the delegated Accountable Emergency Officer (Deputy Chief Operating Officer).

The Emergency Planning Steering Group will establish a number of sub groups to support improved compliance across a number of the core standards:

5.1 Major Incident / Serious Untoward Incident Sub Group

To establish an expert group to lead the review, development and capability of both sites in the event of a major incident. This will include training and education, escalation exercises,

development of the on call team and two Table Top exercises planned before the year end.

The Chair will be the Directorate Manager for Emergency Medicine supported by the Senior Patient Flow Manager.

5.2 CBRN / Hazmat Sub Group

The Chemical, Biological, Radiological, Nuclear (CBRN) / Hazmat (Hazardous Material) Sub Group will meet with cross directorate attendance, closely supported by key individuals from Facilities Management. They will ensure that the Trust is aligned with the most recent national CBRN / Hazmat guidance. The Trust has made excellent progress in the last 12 months following an inspection by Yorkshire Ambulance Service during 2015 where key failings were found on both sites. An action plan and progress reports have been provided to Corporate Directors and the Executive Board.

Each site group will be chaired by the Operations Manager for each Emergency Department.

5.3 Business Continuity Sub Group

This critical function has benefited from a named lead, built into the job description of the Deputy Head of Operational Performance, a key member of the Corporate Operations team. This has facilitated a review of our documentation, workshops and training to support directorates to undertake their assessment and plan over the next 12 months to challenge and test those assumptions going forward.

There are identified directorate champions and the Business Continuity Sub Group will be chaired by the Deputy Head of Operational Performance.

5.4 Pandemic Flu Sub Group

The Pandemic Flu Task & Finish Group will be established to lead on specific planning when special measures are required in response to a major outbreak and to ensure robust plans in place. Whilst the policy has been updated, there is requirement to finalise our operational response and agree sign off at our Infection Prevention Steering Group, chaired by the Chief Nurse.

This Group will be chaired by the Senior Patient Flow Manager, supported by key individuals in the Infection Prevention team.

6. Risk Assessment

Assessing the risk of emergencies occurring and using this knowledge to inform contingency planning is a key duty of Category 1 responders as described in the Civil Contingencies Act (2004). Therefore YTH must:

'*Have suitable up to date plans which set out how they plan for, respond to and recover from major incidents and emergencies as identified in local and community risk registers.'*

The National Risk Register 4 provides a national picture of the risks of emergencies occurring. These are usually referred to as 'high impact / low probability events'.

The Deputy Chief Operating Officer attends the North Yorkshire and Humber Local Health Resilience (LHRP). The LHRP have considered all risks within the area and agreed the risk assessment for North Yorkshire and Humber.

EPRR status reports were taken to Hospital and Executive Board including preparations for major events, Industrial Action and learning outcomes from the York Floods.

Key Priority 2016/17:

Deliver all the mandatory standards in line with NHS constitution and all regulatory requirements including improvement of care, capacity and demand management. The EPSG will continue to monitor EPRR threats and hazards to ensure that the Civil Contingencies Act 2004, accompanying statutory duties and EPRR Core Standards are fulfilled by the Trust.

7. Partnership Working

The Trust is represented at health and multi-agency emergency preparedness groups across our health economy within North Yorkshire. This facilitates information sharing and coordination amongst other local responders, a key duty in the Civil Contingencies Act (2004). The groups provide a valuable platform in terms of planning and sharing valuable learning from events and incidents.

8. Organisational Resilience

The Emergency Preparedness Team continue to develop, update and improve Trust-wide resilience plans in alignment with updated national risk registers, local risk registers, national guidance, learning from incidents, events and exercises and in response to new and emerging specific threats or hazards.

All plans apart from the Winter Plan sit within the portfolio of EPRR. Close engagement and collaboration is maintained with the Deputy Chief Operating Officer, leading the development of the winter plan to support escalation during severe operational pressures. The Senior Patient Flow Manager alongside the Acute Care Task & Finish Group have developed and maintained the Operational Plan that supports the Trust to deliver the Winter Plan in times of severe pressure / surge due to seasonal demand in collaboration with health and social care partners across both York and Scarborough.

Although the UK has faced a variety of terrorist threats in the past, terrorist groups have continued to show a level of ambition and willingness to carry out indiscriminate terrorist attacks on crowded places with the prospect of high impact attacks and the potential for large numbers of casualties. The threat from international terrorism within the UK remains severe, which means an attack within the UK is highly likely. A key priority for 2015/16 was to review mass casualty arrangements to support the coordination and management of a mass casualty incident involving terrorist activity directly affecting local areas including West Yorkshire, North Yorkshire and Humber. As a trauma unit we can anticipate being part of any shared response to such an event.

Prevent is the preventative strand of the government counter terrorism strategy and recognises that some vulnerable groups may be susceptible to exploitation. Prevent aims to protect those who are vulnerable to exploitation from those who seek to recruit people to support or commit acts of violence. Prevent is the main strand of concern to local authorities and NHS staff and it is required that all frontline staff have an awareness of Prevent and how it will affect their service area.

The Counter-Terrorism and Security Act 2015 created a general duty on a range of organisations to prevent people being drawn into terrorism, which has been included within the NHS Standard Contract since 2013/14. It is a statutory requirement that healthcare workers

are trained to identify signs of radicalisation with a level of awareness that gives them the confidence to refer individuals for support before related crimes are committed.

The Prevent agenda requires healthcare organisations to work with partner organisations to contribute to the prevention of terrorism by safeguarding and protecting vulnerable individuals who may be at a greater risk of radicalisation and making safety a shared endeavour. The Prevent agenda is overseen by the Head of Safeguarding team and an E learning module is part of our statutory training for all staff. Compliance is monitored monthly with an improving compliance level since the introduction of the E-learning package.

9. Responding to Incidents

Due to the size, age and location of some of our sites, operational services can and do at times suffer a wide range of small to large scale disruption ranging from unexpected flooding to IT, data or utility failures. Whilst a well-established and senior team of operational engineers and on-call managers are in place to respond to such unforeseen incidents, some can have far reaching consequences to patient care and safety and require the implementation of business continuity plans and special measures to maintain safety and address risk.

This is an area of increased focus during 2016/17 with an updated operational policy and a newly emerging steering group to drive improved compliance at directorate and corporate department level.

10. Conclusion

The enclosed report identifies the level and breadth of work covering the EPRR agenda. A strong team delivery is developing and there is a high level of commitment to ensure we are in a state of readiness to respond to both planned and unplanned events. Key to this is the education and training of our staff, our on call teams, clear levels of escalation and respective response.

The annual work programme works to address those areas where increased focus is required to assure the Board of Directors of our continued development and reflection throughout the year.

Author	**Jenny Hey – Deputy Chief Operating Officer**
Owner	**Juliet Walters – Chief Operating Officer**
Date	**November 2016**

Ref:	Core standard description	Improvement required to achieve compliance	Action to deliver improvement	Deadline
2	Appointing an Emergency Preparedness and Resilience (EPRR) professional(s) who can demonstrate an understanding of EPRR principles	Since the retirement of the designated Trust EPRR officer in December 2015 the trust is developing a team of core individuals to lead on aspects of emergency planning The new Senior patient flow manager, alongside DDM's in each ED, have core responsibilities to deliver against the Emergency planning standards The development of a team rather than a designated individual is anticipated to improve ownership of this corporate responsibility Business continuity has also become an identified role within the senior operations team and early progress is being made	The continued alignment of emergency planning to key senior operational posts within ED and Senior Flow post will continue. Development of these individuals to keep abreast of expectations and standards must continue The Team need the support of an expert/knowledgeable emergency planning practitioner. The Trust has an individual within the workforce and 1 day a month has been negotiated to support the key individuals, providing support, attend emergency planning steering group and provide due diligence against the core standards.	November 2016 onwards
5 & 6	Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver its functions (and that those assessments are in line with local and national risk registers).	Whilst risk assessments are undertaken, work is underway to establish an improved /more comprehensive documentation of risk assessments. These are to be piloted October 2016 with an ambition for all to be completed by December 2016 Workshops have been undertaken with clinical directorates as an initial roll out of core operational areas	Directorate managers to ensure details of risk assessments are copied to Emergency Planning Unit (EPU) for inclusion in EPRR risk register; LHRP to advise regarding LRF & LHRP risk priorities	December 2016 & on-going thereafter
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on resources & capacity.	Substantive generic response arrangements are in place; However, arrangements will always need updating to reflect guidance, lessons, emerging &/or specific risks, etc, therefore ongoing need for review of suite of incident plans including Majax, Pandemic flu and escalation response to support patient flow	Emergency Planning Steering Group (EPSG) to maintain ongoing review of incident plans and procedures to reflect requirements of guidance, lessons, emerging &/or specific risks etc., developing &/or supporting the development of specific response plans or arrangements as necessary. Deputy COO – Urgent Care, will be leading on review of current Majax policy, On call arrangements and levels of escalation with all partners in the health economy	On-going

Ref:	Core standard description	Improvement required to achieve compliance	Action to deliver improvement	Deadline
34	Arrangements include a training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	Training plan and training needs analysis for EPRR are in place; However, dependent upon the outcome and roll out for new documentation, it is anticipated additional training requirement will be required	EPRR Training Needs Analysis assumes that competence within a substantive role enables fulfilment of allocated roles within a disruptive or emergency incident. As workforce establishments are reviewed in ED this will enable improved release of staff to support additional training	December 2016 & on-going thereafter
36	Demonstrate organisation wide (including on-call personnel) appropriate participation in multi-agency exercises	There has been comparatively little opportunity to participate in multi-agency exercises in 2016 to date; whilst staff have participated there would be value in an improved /more comprehensive documentation of participation in multi-agency exercises and a sharing of good-practice.	Two learning exercises to be undertaken for each major hospital site to explore and understand current levels of training and competence for silver and gold command. Commissioning groups, ambulance services and local authority to be invited to both events. These events are to be scheduled before December 2016	Dec 2016 & on-going thereafter
37 & 16	Preparedness ensures all incident commanders (on call directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation. Those on-call must meet identified competencies and key knowledge and skills for staff	Training plan and training needs analysis for EPRR are in place; All new personnel onto the on call rota receive support, shadowing and mentorship to undertake the role However, additional capacity needs to be identified to enable development and delivery of appropriate EPRR awareness training relevant to a range of staff.	Senior Clinical Hospital Flow Manager to have key remit to facilitate and drive appropriate training and competencies for clinical site managers and 1st and 2nd On Call Rotas. New post appointment delayed until June 2016 which has meant the schedule has slipped, however 2 key learning events are aimed at bronze, silver and gold command	January 2017 on-going thereafter
DD1	Organisation have updated their pandemic influenza arrangements to reflect changes to the NHS and partner organisations, as well as lessons identified from the 2009/10 pandemic including through local debriefing	The plan has been revised to reflect currently available guidance and organisational chances; Individual directorates / services need to revise business continuity plans to address/implement plan requirements.	The ESPG will support Directorates in assuring pandemic specific business continuity arrangements and will liaise with CCGs & NHS England to confirm communication and command and control procedures for use in a pandemic. The review is underway and under the directorship of Infection Prevention Operation Group	April 2016 & on-going thereafter
DD3	Organisations have undertaken a pandemic influenza exercise or have one planned in the next six months	The Trust will hold an internal exercise or participate in a multi-organisation exercise since updating their local arrangements in the next six months	The ESPG will liaise with CCGs & NHS England to co-ordinate participation within a Pandemic Influenza workshop /exercise and report outcomes to the Board. Senior Patient flow manager with a key responsibility for Operational readiness, is a member of Infection Prevention operational group to support delivery of a planned exercise and review current policies.	Nov 2016 onwards

Emergency Planning Governance