York Teaching Hospital NHS
NHS Foundation Trust

The programme for the next meeting of the Trust's Board of Directors day, which will take place:

on: **Wednesday 24th September 2014**
in: **The Committee Room, Bridlington Hospital, Bessingby Rd, Bridlington YO16 4QP**

Time	Meeting	Location	Attendees
8.30am - 9.10am	Non-Executive Director Meeting with Chairman	Seminar Room	Non-executive Directors
9.15am – 12.15pm	**Board of Directors meeting held in public**	**Committee Room Bridlington Hospital**	**Board of Directors and observers**
12.15pm – 12.30pm	**Presentation from Peter Bowker, Deputy Director of Operations**	**Committee Room Bridlington Hospital**	**Board of Directors and observers**
12.30pm – 1.15pm	Lunch	Hospital Cafeteria	
1.15pm – 2.30pm	Board of Directors to consider confidential information held in private	Committee Room, Bridlington Hospital	Board of Directors

The values, drivers and motivations of the Trust are:

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

These will be reflected during all discussions in the meeting

Restricted – Management in confidence

The next meeting of the Trust's Board of Directors held in public will take place

On: **Wednesday 24th September 2014**

At: **9.15am – 12.15pm**

In: **The Committee Room, Bridlington Hospital, Bessingby Rd, Bridlington YO16 4QP**

A G E N D A					
No	**Item**	**Lead**	**Comment**	**Paper**	**Page**
Part One: General **9.15am – 9.45am**					
1.	**Welcome from the Chairman** The Chairman will welcome observers to the Board meeting.	Chairman			
2.	**Apologies for Absence** No apologies received.	Chairman			
3.	**Declaration of Interests** To receive any changes to the register of directors' declarations of interest, pursuant to section 6 of Standing Orders.	Chairman		A	7
4.	**Minutes of the Board of Directors meeting** To review and approve the minutes of the meeting held on 30th July 2014.	Chairman		B	11
5.	**Matters arising from the minutes** To discuss any matters arising from the minutes.	Chairman			
6.	**Patient Experience** Experience of a patient using the Bridlington Orthopaedic Service.	Interim Chief Nurse/ Mr Brunt			

No	Item	Lead	Comment	Paper	Page
Part Two: Quality and Safety 9.45am – 10.45am					
7.	**Quality and Safety Performance issues** To be advised by the Chairman of the Committee of any specific issues to be discussed. • Patient Safety Dashboard • Medical Director Report • Chief Nurse Report • Quality Effectiveness and Safety Trigger Tool (QUEST) – An Update	Chairman of the Committee		C C1 C2 C3 C4	25 35 59 67 73
8.	**Operation Fresh Start** A verbal update on the progress of Operation Fresh Start.	Director of Operations (Scarborough)		Verbal	
9.	**End of Life Care Annual Report** To receive the annual report on end of life care.	Medical Director	Dianne Willcocks	D	81
10.	**Directorate of Estates and Facilities Patient Led assessment of the care environment 2014 results** To receive for information the report for 2014 assessment.	Director of Estates and Facilities	Mike Keaney	E	89
Part Three: Finance and Performance 10.45am – 11.20am					
11.	**Finance and Performance issues** To be advised by the Chairman of the Committee of any specific issues to be discussed. • Acute Board Update – Implementing the Unplanned Care Strategy • Operational Performance Report • Finance Report • Trust Efficiency Report for August • Finance and Performance Annual Report	Chairman of the Committee		F F1 F2 F3 F4 F5	103 113 123 133 145 155

No	Item	Lead	Comment	Paper	Page
Part Four: Audit Committee 11.20am – 11.40am					
12.	**Audit Committee** To be advised by the Chairman of the Committee of any specific issues to be discussed by the Board.	Chairman of the Committee		G	163
13.	**Governance Document** The Audit Committee has reviewed the key Governance Documents for the Trust and recommends the approval of the documents by the Board of Directors.	Chairman of the Committee		H	179
Part Five: Human Resources 11.40am – 11.55am					
14.	**Human Resources Strategy Quarterly Performance Report – 1 April 2014 – 30 June 2014** To review the report and approve the recommendations.	Interim Director of Human Resources	Dianne Willcocks	I	277
15.	**Education Strategy 2014-2017** To consider the recommendations included in the report.	Interim Director of Human Resources	Sue Rushbrook	J	279
Part Six: Governance 11.55am – 12.15pm					
16.	**Report of the Chairman** To receive an update from the Chairman.	Chairman		K	341
17.	**Report of the Chief Executive** To receive an update on matters relating to general management in the Trust.	Chief Executive		L	345
Any other business					
18.	**Next meeting of the Board of Directors** The next Board of Directors meeting held in public will be on 29th October 2014 in the Boardroom York Teaching Hospital.				

19.	**<u>Any other business</u>** To consider any other matters of business.

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

Draft minutes from the Corporate Risk Committee
Assurance Framework and Corporate Risk Register

'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.

York Teaching Hospital NHS
NHS Foundation Trust

Additions: **Libby Raper** Member of The University of Leeds Court

A

Changes: No changes

Deletions: No deletions

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

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

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

York Teaching Hospital NHS
NHS Foundation Trust

Minutes of the meeting of the Board of Directors of York Teaching Hospital Foundation Trust, held in public in the Boardroom, The York Hospital, on 30 July 2014.

Present: **Non-executive Directors**

Mr A Rose	Chairman
Mrs J Adams	Non-executive Director
Mr P Ashton	Non-executive Director
Mr M Keaney	Non-executive Director
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
Mrs S Holden	Executive Director of Corporate Development & Research/Interim Director of HR
Mr M Proctor	Deputy Chief Executive, Chief Operating Officer
Dr A Turnbull	Medical Director

Corporate Directors

Mr B Golding	Corporate Director of Estates and Facilities

Attendance:

Mrs A Pridmore	Foundation Trust Secretary

Observers: One member of the public and eight Governors:
Mrs J Moreton, Public Governor for Ryedale and East Yorkshire
Mrs A Bolland, Public Governor for Selby
Mrs J Anness, Public Governor for Ryedale and East Yorkshire
Mr P Baines, Public Governor for York
Professor R Jacobs, Partner Governor – York University
Mrs H Mackman, Public Governor for York
Cllr M Beckett, Partner Governor – Voluntary Sector
Mr T Atherton, Public Governor for Bridlington

14/107 Apologies for absence

Apologies were received from Mr A Bertram, Executive Director of Finance, Mrs S Rushbrook, Corporate Director of Systems and Networks, Mrs B Geary, Corporate Director of Nursing

14/108 Declarations of Interests

The Board of Directors **noted** the current list of interests declared. The Board were reminded that if there were any changes to the interests declared they should advise Mrs Pridmore.

14/109 Minutes of the meeting held on the 25 June 2014

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

14/110 Matters arising from the minutes

There were no matters arising from the minutes.

14/111 Patient Experience – The Perfect Week

The Board received, in advance, a report on the report from the 'Perfect Week' which was held at Scarborough during May. The paper reflected the methodology and processes adopted and the outcome for the week. The Chairman asked Mr Proctor to comment on the findings and the next steps.

Mr Proctor expressed that he was impressed at the difference that was made when all parts of the system were brought together, as they were for 'Perfect Week'. He explained that work is now being undertaken to ensure delivery of the 'Perfect Week' principles on a sustainable basis. He added that building-in the methodology on a consistent seven day basis would require a level of investment from the Trust and the CCG. He advised that a business case would be presented to the Board of Directors to consider in the near future, which was expected to delivery the longer-term gains that were evident from the 'Perfect Week'. It was noted that, in the short-term, performance had slipped-back to pre-Perfect Week levels, as the level of resources applied that week could not be sustained.

Mr Keaney commented that he had felt it was a fantastic week, during which the hospital felt under a different level of control. He was, however, concerned that there was no detail in this initial report of time plans or costs. Mr Proctor advised that would be part of the forthcoming business case.

The Board discussed the need to think about the introduction of the methodology into York Hospital. It was agreed that it would be appropriate to implement the actions at the Scarborough Hospital first and, once they are working effectively, start to consider the introduction of the methodology to York Hospital.

The Board discussed the resource implications of the introduction of the methodology. The Board recognised the importance of ensuring it was clear who was making what investment, and it was agreed by the Board that some of that investment must be made by the commissioners. It was noted that the business case was due to be considered by the Corporate Director team on 11 August and would come to the September Board of Directors.

Action: the business case for Perfect Week presented to the Board of Directors at the September meeting.

Mr Crowley added that he was struck by the number of people who were asking if they could help and he was keen that the Trust harnessed that goodwill and enthusiasm. He added that the CCG was interested in engaging with the developments and he believed were keen in engaging with the debate on investment, both in terms of people and

money. This does, however, relate to other system debates that are being held, including the realignment of resources and the use of the Better Care Fund.
Mrs Adams commented that she saw many comparisons between this report and the Intensive Care Support Team findings that will be discussed later in the meeting.

Mr Proctor commented that the principle of using bronze, silver and gold command was helpful. Mr Crowley added that it helped people to understand their authority to act.

Mr Ashton commented that the point about chain of command was important; escalation cannot work without it. He added that if the system does not ensure the required facilities are available, then the whole system will fail. He cited the example of a lady who had to wait in hospital for five weeks for a care plan, because no plan had been put in place by one of the agencies. The Board of Directors **agreed** that a very important element of the process would be to understand other agencies, such as social services and local authorities. The system cannot work as a whole system if there is no understanding of each others issues and concerns.

The Board felt the report was a very good report which was clear on its focus. It was felt that communication during the week was excellent and the principle of the bronze, silver, gold command was the right approach. Ms Raper added that the ongoing engagement was also a key element of the communication aspects that helped the week be a great success.

Mrs Adams commented that it was disappointing that discharge dates were not always set and daily senior review of patients was not always achieved. Dr Turnbull responded by explaining that to make discharge planning meaningful is very difficult, because of unforeseen information or events. It is more important to be clear what is keeping a patient in hospital and preventing their discharge. In relation to review of patients, Dr Turnbull explained that it depends on what Mrs Adams means by review. If she is referencing a traditional ward round, then there would be challenge to a senior review of every patient every day, however, if it is a virtual senior review then he would expect that to be achieved.

The Chairman asked Mr Golding what had been the benefits/issues of the ‘Perfect Week’ for estates and facilities. Mr Golding explained that it had demonstrated some improvements that can be made in working practices, where small changes in practice would be of huge significance to the system.

Mrs Holden added from an HR perspective that it reinforced the values of the Trust; people felt empowered by the event.

Mr Rose asked how Bridlington, Whitby and Malton played into the process that week. Mr Proctor explained that they were part of the process and needed to be included during the debate. Mr Proctor added that the Trust had also been asked to present the findings at a national level.

The Board concluded the discussion and **agreed** the next step was the business case to come forward at the September Board.

14/112 Quality and Safety Committee

Ms Raper highlighted the key points that the Committee wished to raise with the Board:

Falls – She advised that the Committee remained concerned about the high reporting of falls. The Committee recognised the change in reporting requirements, but it seems that there were still a high number of falls being reported. Due to the absence of Mrs Geary, she asked Mr Proctor to comment on why there were a high number of falls and why the Trust seemed to be above the national average.

Mr Proctor advised that falls are internationally recognised as an issue for all organisations. The profile has been raised through the improved reporting, but he is not aware of any evidence to suggest that the Trust is significantly worse than other organisations. He added that the Trust has received external support to help validate the number of falls and the Trust is in the process of introducing a new policy and improved assessment processes. He added that there is also a major education programme in place which will help to reduce the incidence of falls overall. The difficult balance the Trust is trying to maintain is making sure that patients are as independent as they can be while making sure that they are given the right level of support. Occasionally, a patient will fall, even through they have a member of staff with them and not all patient falls result in severe harm.

The Board enquired what the Directors might introduce in relation to falls if money was "no object". Mr Proctor advised that the ward configuration would be different at York, so that observation of patients would be made easier. However, he added that patients still might fall.

"Sign-up to safety" – Ms Raper invited Dr Turnbull to comment on the sign-up to safety campaign. Dr Turnbull advised that there were initially 12 pilot sites; the pilot has been concluded and Trusts are now invited to sign up to safety. He is expecting the Trust to sign up by the 1 August 2014. The aim of the campaign is to reduce avoidable harm by half in the NHS over the next 3 years and save 6,000 lives. The campaign is lead in part by Sir David Dalton Chief Executive of Salford Royal NHS Foundation Trust. Dr Turnbull explained that the Trust is required to sign up to five pledges and develop an action plan against each pledge. The five pledges are:

1. **Put safety first.** Commit to reduce avoidable harm in the NHS by half and make public the goals and plans developed locally.
2. **Continually learn**. Make their organisations more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe their services are.
3. **Honesty**. Be transparent with people about their progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.
4. **Collaborate**. Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

5. **Support**. Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress.

These national pledges reflect the aspirations and expectations of our own Patient Safety Strategy, which is part of the Board agenda for this meeting. Dr Turnbull advised that the approach adopted by the 'Sign up to Safety' system is the opportunity to gain national support and be able to benchmark against those that have signed up.

The Board asked if Dr Turnbull would circulate the summary document.

Action: Dr Turnbull to circulate the summary document on sign up to safety.

The Board enquired who holds the Trust to account. Dr Turnbull advised that the national 'Sign up to Safety' team would expect to hold the Trust to account for compliance against the five pledges.

The Board **agreed** that they would like to see a 3 month report on the 'Sign up to Safety' campaign as part of the Quality and Safety feedback.

Action: Board to receive an update from the Quality and Safety Committee on the 'Sign up to Safety' campaign.

Mr Crowley added that progress has been made already in the Trust and safety is identified as part of everyone's job. The Trust joined NHS Quest; this is just a further development.

The Board **agreed** that the Trust should become part of 'Sign up to Safety'.

Summary Hospital Mortality Indicator (SHMI) – Dr Turnbull advised that the figures for the period January to December 2013 were published on 30 July 2014. For the Trust, the SHMI had increased very slightly from 97.1 to 97.6. The increase was disappointing. The breakdown between the sites was that York had remained stable and Scarborough had increased by 1 point. He added that he is currently reviewing the diagnostic breakdown, but at this stage has not identified any specific areas of concern. He did comment that there had been a change in the key areas – there were more deaths being seen from sepsis, but he felt this was as a result of further education around sepsis and raising the profile of sepsis.

The Board joined Dr Turnbull in his disappointment and thanked him for the comments made. It was recognised, however, that the Trust had made considerable and consistent improvement across the board on mortality over the last two years.

CQC intelligent Monitoring – Dr Turnbull reminded the Board how CQC monitors the Trust. He explained that they use four sources of information: the Trust's registration, the intelligent monitoring, the inspections and "judgment". Dr Turnbull stressed that intelligent monitoring was not part of a league table system, but it does

inform the inspection programme. The Trust is in Band 6 in the latest report, which is the same as the last quarter. This represents the lowest risk; at present the Trust has not received an inspection, but it is anticipated that inspection will take place in the next 12 months. CQC has introduced new indicators this quarter, including:

- Central Alerting System (CAS) safety alerts.
- Patient Led Assessments of the Care Environment (PLACE).
- Monitor's Continuity of Service rating.
- The inclusion of the overall team-centred stroke unit score, as a replacement for the previously included stroke audit indicator.

Other changes to indicators that were included in previous Intelligent Monitoring reports include:

- All readmissions indicators now exclude patients who return for less than one day, unless they die when they are readmitted; these are not included for children's specialist Trusts.
- The Hip and Knee Patient Reported Outcome Measure indicators have been replaced with composite indicators to enable us to make use of the most up to date and relevant data.
- Maternity and mortality outlier cases, where action plans have been passed recently to our local inspection teams, will be classed as risks until the teams can judge that they can be closed.
- Indicators that use mandatory returns data (e.g. referral to treatment, diagnostic waiting times and A&E waiting times) will be classed as risks where data has not been submitted.

In terms of the risks identified, there are two types: risks and elevated risks. In terms of risk, the Trust had two, one related to never events and the other related to staff to bed occupancy. There was also one elevated risk related to referral to treatment time. The report will be available to the public and is published on the CQC website.

Staffing – Ms Raper commented that the Committee has been focusing on the staff to bed ratio and it has been helpful to understand the broader context of how people manage the processes. Mr Raper asked for comment from Mr Proctor on the level of nursing vacancies currently. Mr Proctor advised that within the recruitment of nursing, some is cyclical. Currently the Trust has 60 vacancies for nurses. The will reduce the vacancy level to 25 once the current student nurses are in place in September. He added that there will be a further drive on recruitment for the winter escalation, which will include the "one-stop shops". The Trust is also considering the option of recruiting from abroad. Mrs Holden added that there is some work being considered around collective recruitment abroad by a number of Trusts in the Yorkshire and Humber region. This was discussed at the HR Directors' forum recently.

Professor Willcocks commented that, in the longer-term, thought needed to be given to changing the profile of the workforce. One option would be to think about bringing older nurses back into the workforce. Mrs Holden added that creating different ways of employing staff was also important, currently there are a number of apprentice staff under 18, but only one member of staff under 18 on a substantive contract. At the regional HR

Directors' forum, it was apparent that there were other Trusts having significant recruitment difficulties.

The Board discussed the skill mix and Mrs Holden gave examples of where over the next 6-8 years there would be key vacancies that would need to be filled; changing the skill mix would be one option to address this.

The Board **noted** the comments from the Quality and Safety Committee and the comments made in the Board.

14/113 Quarter 1 Director of Infection Prevention and Control Report

Dr Turnbull commented that the report showed there had been 13 cases of C-Diff this quarter, which was under trajectory. He also advised that the Trust is aiming to undertake a number of deep cleans and so will decant wards to ensure this occurs. The challenge is to find a location to decant wards. Mr Golding commented that it is possible not to have to decant wards, but to deep clean a bay at a time. There is a way of sealing-off a bay so this can be achieved.

Mr Golding commented on the report and asked Dr Turnbull if he would comment on two areas of infection control: MSSA and elective MRSA. Dr Turnbull explained that Meticillin-Sensitive Staphylococcus Aurus (MSSA) was high, but was controllable through good hygiene. Training days have been put in place for nurses and doctors around hand hygiene.

The elective MRSA is a strain that is resistant to common antibiotics. As a result of the level of prescribing of a particular antibiotic because the results of screening a patient and receiving a positive result, the strain of MRSA has become increasing resistant to the antibiotic Mupirocin. Dr Turnbull is now in correspondence with the regional DIPC about the strategy around level of screening.

The Board discussed the measures in place and noted that the same standards apply to community hospitals as do to the acute sites.

Mrs Adams asked about catheter acquired infections and how they were measured. Dr Turnbull advised that they are measured as part of a care bundle.

Mr Rose asked about the development of the facilities for the community hubs and enquired if infection control would be part of those developments. Mr Proctor advised that the environment still needs to be determined and planned, but his expectation would be that they would be part of the developments, although it should be recognised that outpatient and day case infection control is very different to acute requirements and is normally less of a problem.

The Board **approved** the report.

14/114 Finance and Performance Committee

Mr Sweet referred to the minutes from the Finance and Performance Committee and asked if Mr Proctor would comment on the bed reconfiguration. Mr Proctor advised that a

large outline plan with massive benefits had been formulated. To deliver the plan there are a number of steps that must be completed, including agreeing with the specialities the number of beds that will be available for their service. Currently discussions are being held with Orthopaedics to agree the delivery of their service through a smaller bed base. It would not be possible to make any moves until the final configuration is clearly understood by all. Mr Proctor added that there are parallel issues in Scarborough and these are to a degree being determined by the building work, although the issues are less of a problem at Scarborough, as the wards are across the hospital unlike York where they are in one block.

Efficiency Report –Mr Sweet summarised the position of the efficiency programme at the end of June and asked Mr Crowley to comment. He highlighted the concerns of the Committee including the level of recurrent savings. He also referred to the planning gap that exists in the programme up to 2017/18. Mr Sweet added that the Committee were pleased to see that the Trust is using the Service Line Reporting (SLR) system to understand how further improvements can be made.

Mr Crowley confirmed that he and the Executive Directors were acutely aware of the challenge in the system and that Mr Sweet's summary of the position was accurate. He agreed that there was a risk to the forward plan and the level of non-recurrent efficiencies was falling. He added that Monitor had recently confirmed that the process the Trust uses for efficiency planning was good. He added that at the end of quarter 1 he did expect to see further deterioration nationally of the financial position of Trusts. It is hoped and anticipated that there may be some available solutions to support Trusts in quarter 2 and 3. One example being the CCGs are expected to use the 70% marginal rate for non-elective not paid as part of the tariff to reduce the pressure in the system. CCGs have not to date been using the money for that purpose. The Trust is in dialogue with the CCG about the 70% marginal tariff saving and the Trust's expectations. Mr Crowley added that the income represented by the 70% marginal tariff saving is £2.5m at the end of quarter 1 and £10m a year.

Dr Turnbull referred to an article in the HSJ which provided some interesting statistics, including that 85% of 73 Finance Directors polled said they were fairly or very pessimistic about money for the next year and the number of people on waiting lists for treatment in hospital is now at its highest level for six years. This reflects that the NHS is stretched to the limit. Mr Crowley commented that nationally the NHS will balance. Locally the marginal tariff discussion is very important, as is the discussion with the Vale of York about the £1m they are providing to the Urgent Care Board. At present the Vale of York CCG has refused to support any plans the Urgent Care Board have put forward.

Mr Ashton asked if the Trust is formulating a view on what to do at quarter 2. Mr Crowley explained that the Trust can only manage system issues successfully with everyone playing their part, so it has to be discussions that includes every part of the system.

Access targets- Mr Sweet asked Mr Proctor to comment on the position of the 18 week access target. Mr Proctor advised that the performance of the 18 weeks is linked to the Interim Management and Support Team report. He commented that the process the Trust had been through with the IMAS has been very helpful and there were a lot of positives that came out of it. IMAS confirmed that the CPD system in the Trust is gold standard, as is the data system, both being areas they would normally look to improve. They did

identify that we are delivering 18 weeks to the letter of the law rather than the spirit. Patients can only be allowed to exceed time on two grounds: the complexity of the patient and the patient choosing to wait. At present the Trust applies a quota management system and IMAS believes this system needs to be amended. This will result in significant failure for a number of months to get back on track, but the Trust will then be in a position to deliver the 18-week target on a more sustainable basis. Prior to putting this action in place, the Trust will need to discuss the proposal with Monitor and obtain approval from the CCG. The estimation is that it would take 6 to 9 months to get back on track.
In terms of the IMAS plan, it was agreed that would be brought to the Board of Directors through the Finance and Performance Committee at the October Board.

Action: Mr Proctor to arrange for the IMAS report to be presented to the Board of Directors through the Finance and Performance Committee.

Mr Proctor referred to the diagnostic target and confirmed that the position had improved. The issue with the sonographers had improved since two had returned to work, but the Trust was still struggling to recruit to the vacant post. To illustrate the issues, Mr Proctor explained that the CCG had agreed a contract under the 'any qualified provider' banner and the organisation which won the contract was also struggling to recruit specialist sonographers.

In terms of 14 day breast symptomatic, the agreed solution has now been put in place. Patients from Scarborough are travelling to York for their radiological diagnostic procedure, but are in Scarborough for the appointment with the Consultant.

Dr Turnbull added that the Trust is outsourcing the out of hours radiology at York currently and is considering the possibility of introducing this across the Trust.

With regard to 4 hour target, plans have been put in place to achieve the target. As the Trust delivered the target at quarter 4 prior to the additional funding being in place and began to fail as soon as the additional winter funding was removed in April resulting in the fail at quarter 1, it is reasonable to say that the funding was key. It is very difficult to deliver the service when the Trust is paid only 30% of the tariff rate at the margin. He commented that one of the changes made in York is that the target has been split into two 2-hour slots. The first is for the Emergency Department to complete its work; the second 2 hour slot is for the speciality to have the patient admitted. At present, in the Emergency Department in York, they are short of 2 consultants and in Scarborough 1 consultant, with little prospect of being able to recruit to the posts. The Trust is looking at different models and focusing on potentially reducing the minor injuries work. Mr Proctor confirmed that he did not feel confident that the position would change significantly unless more resources are provided.

Dr Turnbull added that he receives a weekly report on the Emergency Department, which showed there had been an increase in the number of patients attending the department and being admitted.

Mrs Holden added that it was well documented that primary care had problems recruiting GPs. The East Coast is particularly badly resourced for GPs and, despite the LETB offering an additional 60 places for training, could not fill the places or vacancies.

The Board discussed the issues in the Department and Mrs Adams made the comment that the issue is part of the patient flow system, not just the Department.

Mr Sweet commented that the ambulance turn round had not improved this quarter. The new handover bays in York had made a difference to the performance in York, but Scarborough had struggled to achieve the targets in the last quarter. The Trust had as a result significant fines it was required to pay. This had been down to the availability of beds.

Mr Sweet referred to the finance report. He advised that the activity levels were close to plan, but significant fines were imposed due to the ambulance turn round performance and additional costs were incurred as a result of the increased use of locum and agency staff.

Mr Crowley advised that the Trust is also in discussion with the CCG around the ambulance turn round fine and is seeking to recover/reinvest this fine. This fits with the discussions the Trust is also having around the 70% marginal tariff. The Board discussed the issues and fully endorsed the approach being taken.

Mr Sweet asked Mr Crowley what would happen if the discussions were unsuccessful. Mr Crowley advised that he did not expect the discussions to fail. He was seeking a response back from the CCG by letter. He believed that quarter 2 is a key point in time as the level of financial frailty increases in organisations. The Trust is also managing the capital programme in a prudent manner.

In terms of locum and agency spend, that is a function of the discussion held earlier in the meeting about the challenges the Trust is facing to recruit. The Board agreed that quarter 2 and 3 remained a concern, but the Board would make a judgement when the time was right about the next steps.

The Board was reminded that Monitor would be at the Board meeting in October when the Board was discussing the performance and submission for quarter 2.

The Board thanked everyone for their contribution to the discussion and for the report from the Finance and Performance Committee.

14/115 Report on the Intensive Care Support Team findings

Ms Raper commented that the report reflects the discussions that have been held during the Board meeting. She recognised that the timeline and actions had been set before the ‘Perfect Week’, but felt that they needed an update. She asked Mr Proctor to update the Board on the timelines and actions, particularly the action for the Emergency Department and the commissioning intentions, which has no timeline.

Mr Proctor advised that there were no surprises in the report and the reason the report was undertaken was as a result of discussions the Trust had had with Monitor. In terms of the actions mentioned, the recruitment issues in the Emergency Department is still outstanding, as discussed earlier in the meeting, and the commissioning intentions action has not changed.

Ms Raper asked if the points in the action plan were being picked up as part of the actions coming out of the 'Perfect Week' and the operations plan. Mr Proctor confirmed they were.

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

14/116 Annual Report of the Workforce Strategy Committee

Professor Willcocks commented that the report demonstrates the links the Committee has with the strategies of the organisation. She advised that the Terms of Reference had been recently revised. Mrs Holden added that since her involvement with the HR Department she had increased the links with other Directors. She added that the ACP work would not have progressed at the speed it did had the Committee not had the right people round the table.

Mrs Adams advised that she was impressed by the Report and the work the Committee had completed. She felt very assured by the summary included in the report. She noted the challenges going forward and the issues around the Workforce Strategy Committee planning for the next 5 to 10 years.

The Board **agreed** with the comments made and **approved** the report.

14/117 Research and Development Strategy

Mr Keaney commented on the strategy. He reminded the Board of the importance of Research and Development and the importance of having a clear strategy. He did ask if Mrs Holden could explain some of the financial opportunities that exist.

Mrs Holden explained the difference between portfolio work and non-portfolio work and outlined the financial benefits that can be gained by undertaking non-portfolio work. She did make it clear to the Board that the Trust was required to undertake a certain level of portfolio work too. At present the portfolio work is worth about £2.6m and involves around 50 research nurses and 10 consultant PAs and the Trust is performance managed against this. The non-portfolio work (mainly with commercial firms) is much more flexible and is within the gift of the Trust to manage. The Trust has the ability to increase the capacity of work and financially the work can be very lucrative. The work with York University and HYMS and involving Professor Charles Lacey is also helpful to the Trust. The Trust constantly seeks to maintain a balance between the two types of studies.

The Board **noted** and approved the strategy.

14/118 Patient Safety Strategy

Dr Turnbull advised that the strategy has been discussed extensively across the Trust and has been discussed in detail by the Quality and Safety Committee. Professor Willcocks felt that it was a smart strategy, shaped by the community priorities. She added that she was pleased to see end-of-life-care included in the strategy.

Dr Turnbull added that the idea was to make the document a statement of intent and to produce an executive summary which would be circulated to all consultants, matrons and

directorate managers. The Board commented that it felt that safety was now embedded into the Board meeting. Dr Turnbull added that this is part of normal business and a very important aspect of the Trust's work.

The Board **approved** the strategy.

14/119 Report of the Chairman

The Board **noted** his report.

14/120 Report of the Chief Executive

The Board **noted** the report.

14/121 Monitor Quarter 1 submission

Mr Crowley presented the draft submission for Monitor and asked the Board to approve the submission. The Board agreed that it recognised the information included in the submission and **approved** the detail.

14/122 Integration Update Report

The Board reviewed the update report and noted that it does not provide any information on the achievements against the IBP. Mrs Holden explained that the paper provided exception information and highlighted the areas where the achievements had not been made, rather than detailing all the achievements.

The Board noted the point Mrs Holden made, but added that the Board is held to account for the requirements of the IBP and so would have like to see the achievements. The Board recognised that the IBP had been superseded by the Strategic Plan. Mrs Holden assured the Board that the plans had been completed, with the exception of those included in the report.

The Board **noted** the information.

14/123 Business Case – 2012/01: EPMA Business Case

Mr Ashton commented that he recognised the implications of the case and that the Board has discussed the requirements for some time and the change programme that fits with the business case. Dr Turnbull added that the business case is part of one of the pledges in the sign up to safety and the patient safety strategy.

The Board noted the information and asked if the capital resources were included in the plan or net of the plan. Mr Golding confirmed they were included in the plan.

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

14/124 Next meeting of the Board of Directors

The next meeting of the Board of Directors will be held in the Committee Room, Bridlington Hospital, on 24 September 2014.

14/125 Any other business

There was no other business.

Outstanding actions from previous minutes

Minute number and month	Action	Responsible office	Due date
13/134 Dementia Strategy	To include an update on the dementia strategy in his board report on a quarterly basis.	Dr Turnbull	February 2014
13/119 Scheme of Delegation (September)	To consider increasing the authority of the Capital Programme Committee to be undertake during the next stage review	Mr Bertram/ Mrs Pridmore	September 2014
14/055.1 2013 - 14/127: Bridlington Orthopaedic Elective Surgery	Evaluation Report pending the release of further capital	Mr Bertram	November 14
14/041 Patient Experience - Matron refreshment	Update the Board on the progress of the introduction of the new nursing structure	Mr Proctor/ Mrs Geary	December 14
14/063 Quality and Safety Committee	Provide the six monthly acuity audit report.	Mrs Geary	June 14
14/083 Finance and Performance Committee	Include dementia screening in his Medical Director report.	Dr Turnbull	July 2014
14/094 Quality and Safety Committee – Trigger Tool	Keep the Board up to date on progress through the Quality and Safety Committee.	Mrs Geary	September 2014

Action list from the minutes of the 30 July 2014

Minute number	Action	Responsible office	Due date
14/111 Patient Experience – The Perfect Week	The business case for Perfect Week presented to the Board of Directors at the September meeting.	Mr Proctor	September 14
14/112 Quality and Safety Committee	Dr Turnbull to circulate the summary document on sign up	Dr Turnbull	Immediate

	to safety. Board to receive an update from the Quality and Safety Committee on the 'Sign up to Safety' campaign.		October 14
14/114 Finance and Performance Committee	The IMAS report to be presented to the Board of Directors through the Finance and Performance Committee.	Mr Proctor	October 14

Quality & Safety Committee – 16th September 2014 Room 26, Second Floor, York Hospital

Attendance: Libby Raper, Jennie Adams, Philip Ashton, Alastair Turnbull, Beverley Geary, Diane Palmer, Anna Pridmore, Liz Jackson, Mike Kearney

Apologies: None

	Agenda Item	AFW	Comments	Assurance	Attention to Board
1	**Last meeting notes**		LR welcomed Mike Keaney to the meeting. The committee reviewed the previous meetings notes and approved them as a true record. **Integrated Dashboard** - DP advised the committee that there is no further progress in the production of the integrated dashboard moving to Systems and Network Services. A further piece of software is needed for this to be possible. **Patient Safety Walk Rounds** – The Committee reviewed the reports and noted that the reports outstanding at the last meeting had all been completed, but currently one report remained outstanding from a walkround JA had been part of. Members of the Committee raised their concerns about the timeliness and completeness of the papers included in the pack this month. The concern was centred on the receipt of the performance reports. The Committee was advised		

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			that the information for the reports had not been available until 16th September which had meant there had been a delay in preparation of the papers. It was reiterated that both the Finance and Performance Committee and the Quality and Safety Committee should receive as part of their papers the full performance reports.		
2	**Matters arising**		LR reminded the Committee of the meeting held during the summer to discuss the Quality Governance Framework draft. She explained that the timeline for consideration and approval by the Board of Directors had been adjusted so the papers would be presented at the October Board meeting. This was to ensure that individuals had an opportunity to have their comments included in the paper and for the paper to be discussed in detail by the Corporate Director Team in advance to it being presented to the Board. LR asked AP to update the Committee on the work completed since the summer meeting. AP confirmed that the paper had been updated following the meeting and would be taken to the Corporate Director meeting over the next couple of weeks. She added that the paper had been included in the information requested by Monitor as part of their current investigations, but it had been clearly marked that it was a draft. The Committee noted the comments and confirmed it was satisfied with the adjustment to the timeline for the completion of the governance of the document. BG updated the Committee on challenges in the maternity area. She confirmed she would bring a further update to the October Committee.		

	Agenda Item	AFW	Comments	Assurance	Attention to Board
3	**SI 2014/7371 System failure maternity services Scarborough**		AJT reminded the Committee of the background to the SI report. He advised that the introduction of the customised foetal growth charts was an important aspect of the recommendations which was now being implemented in Scarborough. Due to the national shortage of sonographers the Directorate have been reviewing other models of staffing provision, one approach has been to provide further appropriate training to all midwives based in Scarborough. The actions from this SI are near completion, the issue that remains outstanding relates to staffing and this was discussed at a recent Directorate meeting. It was agreed that BG would circulate a summary of the Directorate meeting around this issue to members of the Committee.	The committee were assured that this issue was being addressed by the Directorate and the view that the issue was included on the Directorate risk register.	
4	**Integrated Dashboard**		**SI2014/22292 – Patient Safety Issue –** The Committee expressed real concern regarding the circumstances that gave rise to the SI. AJT gave the Committee an overview of the SI related to the particular ward. He advised that the area was opened in advance of some escalation procedures being completed. The evidence from the SI demonstrated that no harm occurred, but provided the Trust with an opportunity to review the mandatory procedures for opening escalation wards and it was understood by the Committee that an Executive Director must approve all decisions for unscheduled escalation areas being opened. **Serious Incidents –** The Committee asked about		

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			the categorisation of SIs, the level of detail provided to the Committee on each one and the timelines with which reports are completed. AJT confirmed that the majority of serious incidents were as a result of slips, trips and falls and pressure ulcers and these are reported differently to all other serious incidents. He added that the length of an investigation following the identification of an SI can vary significantly dependent on the circumstances. The Committee concluded that they would like to see the date the incident occurred; the date the detail was discussed with the Executive Board and the date the SI was closed by the Commissioners to be included in the information provided to the Committee. **Friends and Family test –** The Committee again expressed concerns about the Friends and Family test results, particularly the emergency department and the staff results. BG acknowledged those concerns and added that the token system in Emergency Medicine is planned to be withdrawn by April 2015 as a result work is being undertaken with Systems and Network Services to introduce an electronic option. BG explained to the Committee that the response rate for staff was disappointing low especially for front line staff. Although the comments made by staff were positive. She advised that a new member of staff has been recruited to concentrate on the friends and family test, both for members of the public and staff. This should help provide some improved results.	The Committee noted the comments and the changes being made to the system. It was assured that work was underway to review find another system other than the token system for use in ED. It was also noted that the qualitative data received by the Trust does remain positive.	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			It was agreed that BG will confirm at the next meeting when the roll out will be taking place in community. **Safety Thermometer** - The Committee were pleased to see that the Trust is starting to fall in line with the national average with safety thermometer data on pressure ulcers, VTE and Falls. DP confirmed that this was due to the work being undertaken by Matrons and Pharmacy in validating the data and the definitions becoming clearer. Work will begin on making the definitions clearer and validating the data for catheter associated UTI's over the coming months. The Committee agreed that the data quality group should receive an update. **Dementia Screening –** The Committee raised concerns over the current position on Dementia Screening. AJT confirmed that the Trust is achieving the targets in York and work is being undertaken to improve compliance in Scarborough. **PROMS** – AJT highlighted the PROMs charts and introduced the new data and Groin Hernias and Varicose Veins. **Infection Prevention** – AJT highlighted to the committee that the Trust are well below the threshold for Clostridium Difficile with a significant improvement on last year. We are above the threshold for MSSA. A new Infection Prevention	The Committee were pleased to see the progress against the Safety Thermometer, but noted that there was still significant work to be completed and agreed it would continue to seek assurance against progress The Committee noted the excellent performance	AJT to update the Board on the C-Diff performance

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			Nurse is now in post who will concentrate on reducing these occurrences. The decant and deep clean programme has now been completed in York and on Oak Ward in Scarborough. The opportunity to decant wards in Scarborough had not yet arisen but the deep clean will be undertaken when it does.		
5	**End of Life Care Annual report**		The committee discussed the report which had been put together by the Palliative Care Consultants explaining where we are following the removal of the Liverpool Care Pathway. AJT and BG updated the Committee on the AMBER care pathway (which replaced the Liverpool Care Pathway), can be used as an education tool as well as a plan of care. They assured the Committee that extensive staff training will take place during the implementation of the system.	The Committee felt the report provided excellent assurance on the National Care of the Dying Audit 2013/14 which highlighted some clear areas for action which are being taken forward.	AJT to update the Board
6	**Supplementary Medical Director Report**		**Electronic Prescribing and Management –** The Committee again enquired over progress on this important development. AJT summarised the progress of the introduction of the system. He advised that formal governance arrangements have been put in place to manage the project and the key project group has met regularly and is managing the workstreams effectively. He did add that progress is probably slower than expected mainly due to the huge amount of nurse training being undertaken around medicines administration.	The Committee were pleased to see the progress and supportive of the level of training being given to nursing staff and recognised that this can only benefit the final introduction of the system.	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			Flu Programme 2014 – AJT confirmed to the Committee that the flu vaccination programme is scheduled to commence on the 6th October. Staff will be reminded of their responsibility to have the vaccination. **Information Governance** – The committee discussed the number of information governance issues that occur and that most of these are minor. Any that refer to lost data are discussed at board. BG confirmed that ward handovers still rely on paper and printed patient lists. Work will be undertaken on changing this culture. AJT highlighted to the committee the change in the Coldicott principles and the move to data sharing.	The Committee noted the start date of the programme and was assured that the learning from last year has been taken into account and the systems have been appropriately adapted.	
7	**Supplementary Chief Nurse Report**		**Open and Honest Pilot –** The Committee asked an update on the progress of the pilo**t.** BG explained that NHS England have decided to not progress the open and honest pilot at this stage. The template the Trust used for the pilot will still be used for data collection within the Trust. BG advised that she will be able to obtain further information at the next North of England Chief Nurse meeting, following which BG can update the committee. **Nursing Recruitment** –The Committee asked BG to update the Committee on the progress around the recruitment of nursing staff. BG advised that discussions are currently taking place with North Lincolnshire and Goole Hospitals to explore the	The Committee noted the change of mind of NHS England and agreed that BG should keep the Committee informed of any developments The Committee noted the comments around the safer staffing data and the possible developments around recruitment of staff	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			feasibility of a joint over- seas recruitment campaign. She advised that this had been very successful for North Lincolnshire and Goole Hospital in the past, so part of this discussion was to learn from their experiences. The Committee noted that the timetable for the safer staffing information did not allow for the information to be circulated in advance of the meeting. The information was circulated to all members of the Committee at the meeting. **Workforce development** – The Committee asked about the development of the nursing workforce. BG explained to the Committee that a programme is currently being developed to up skill the unregistered workforce closing the gap between the band 2's and the band 4s on the wards. **Complaints review** – The Committee has remained cognisant of the importance it places on the patient experience department and the outstanding requirements to improve both the complaints process and the broader patient experience area of work. BG agreed with the comments of the Committee and explained that the updated complaints procedure is now in place. Formal complaints training will be put in place and BG will review all complaint responses that are sent out of the hospital. The new Patient Experience Lead is in post and will be leading on the new procedure.	The Committee noted the appointment of the new Patient Experience Lead and look forward to hearing from her at a future Board meeting	BG to update the Board
8	**Quality Effectiveness**		The Committee asked about the priority and speed of the development of this initiative. BG updated	The Committee agreed that this would be kept under	BG to update the Board

	Agenda Item	AFW	Comments	Assurance	Attention to Board
	and Safety Trigger Tool (QUEST) - An Evaluation		the Committee on the 3 month pilot of the trigger tool. The data gave a good overview of the ward performance however it was challenging to pull together. Work is currently being undertaken with Systems and Network Services to find a solution.	review and as progress is made more assurance would be gained.	
9	**Quarterly Quality Report**		The Committee reviewed the quarterly Quality Report. Concerns were raised about issues that had been part of previous Quality Reports where the Trust says they are still monitoring, an example being nursing documents. BG assured the Committee that nursing documentation is being standardised and the fluid chart is the first to be done. Work is also being undertaken on the provision of food in the Emergency Departments and AMU.	The Committee were assured by the information provided	
10	**Healthcare Governance Quarterly Report**		Due to time restraints that Committee had a brief discussion about this report. BG advised that an acuity and dependency audit was completed during August which will be presented to the Quality and Safety Committee and the Board in October.	The Committee noted the richness of the data and the level of assurance that could be gained from the report.	
11	**Any other business**		**Being Open audit report** – The Committee discussed that audit report produced by Internal Audit which had been discussed earlier in the week at the Audit Committee. The Committee enquired about the progress of completing the action. AJT confirmed that there was still some further debated to be held about some of the recommendations and their appropriateness. AJT did confirm to the committee that the 'Being Open' policy has been revised and there will be	The committee were assured by plans to audit the policy in 2015.	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			ongoing staff education on the duty of candour.		
12	**Other** Work Programme Key issues for highlight to the Board		It was agreed that the next meeting of Quality and Safety Committee would take place on ?? October 2014. It was also asked that the November meeting be moved to 19th November 2014. It was agreed this would take place at 2pm on 19th November 2014.		

York Teaching Hospital NHS
NHS Foundation Trust

C1

Patient Safety and Quality Report

September 2014

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

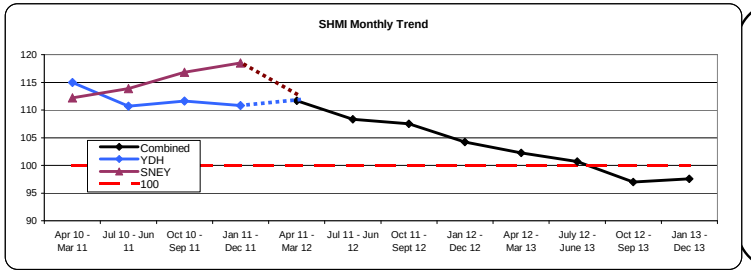
Index

Executive summary

- The SHMI for the period January to December 2013 was published on the 30th July as 97.6.
- 19 Serious Incidents (SIs) were delcared in July and 12 in August.
- No Never Events were reported.
- Patient falls remains the most frequently reported incident category.
- One case of toxin positive c. difficile was identified in July and one case in August.
- Compliance with dementia screening for patients admitted to hospital is below the 90% target.
- The latest Patient Reported Outcome Measures (PROMS) are illustrated on pages 17-19.

Patient Safety

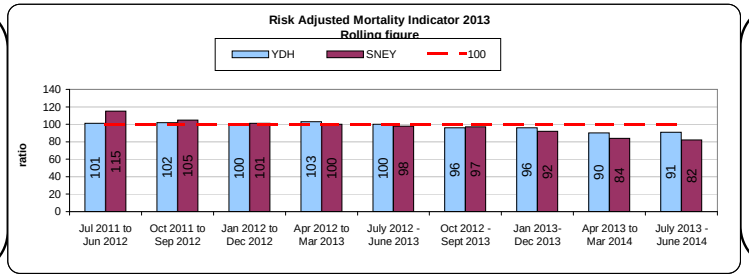
Mortality



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

The SHMI for the period April 2013 to March 2014 is due to be reported on 30th October 2014.

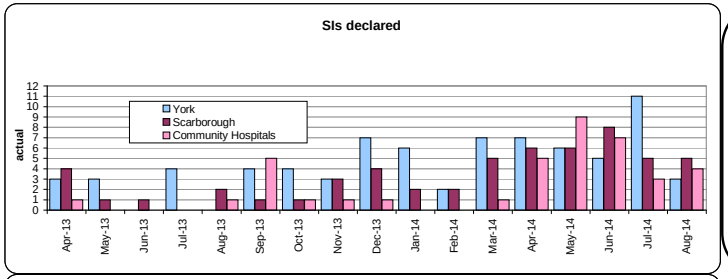
Data source: Information Centre



The Risk Adjusted Mortality Indicator (RAMI) for the reporting period July 2013 to June 2014 indicates only small variation from the previous reporting period.

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

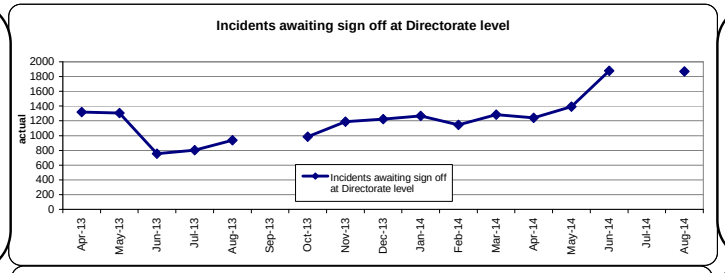
Measures of Harm



There were 31 Serious Incidents (SIs) reported during July and August.

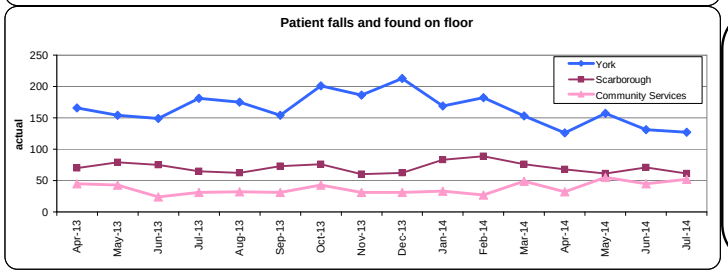
12 of the Sis were related to category 3 pressure ulcers, 1 was a category 4 pressure ulcer, 7 were patient falls, 2 sub-optimal care, 2 medical device related, 3 delayed diagnosis, 1 c.diff, 2 for patients who were in ED over 12 hours and 1 patient safety concerns on a ward at York Hospital.

Data Source: Datix



At the time of reporting there were 1870 incidents awaiting sign-off by the Directorate Management Teams. Risk and Legal are working with the Directorates to facilitate the completion of incident investigations.

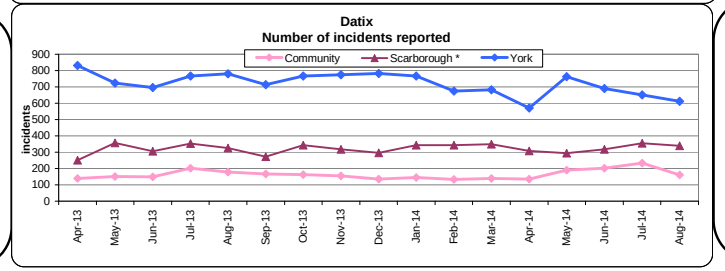
Data Source: Datix



Reduction in the number of patients who incur a fall while in hospital remains a priority for the Trust. 12 patients fell and were found on the floor at the York site, 61 patients at Scarborough and 52 patients within the Community Hospitals in July.

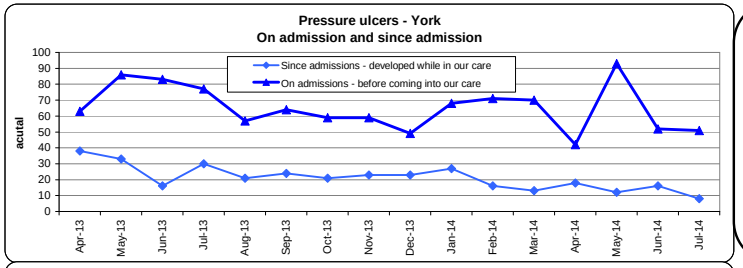
These figures may increase as more investigations are completed.

Data Source: Datix



The total number of incidents reported in the Trust during August was 1112. 612 incidents were reported on the York site, 340 on the Scarborough site and 160 from Community Care/Hospitals.

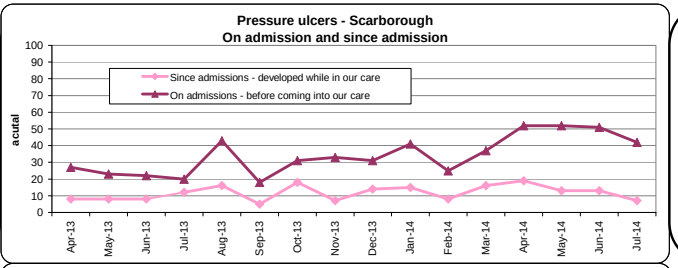
Data Source: Datix



During July 8 pressure ulcers were reported to have developed on patients since admission to York Hospital.

These figures should be considered as approximations as not all investigations have been completed.

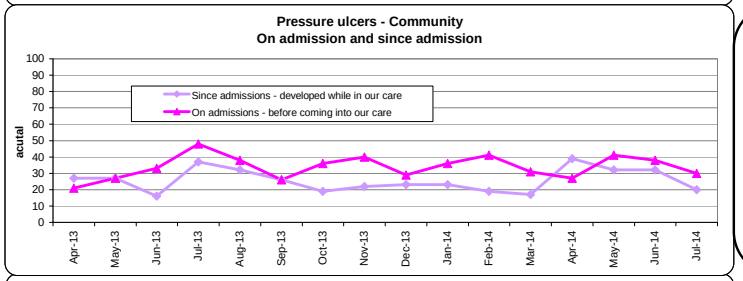
Data Source: Datix



During July, 7 pressure ulcers were reported to have developed on patients since admissions to Scarborough Hospital.

These figures should be considered as approximations as not all investigations have been completed.

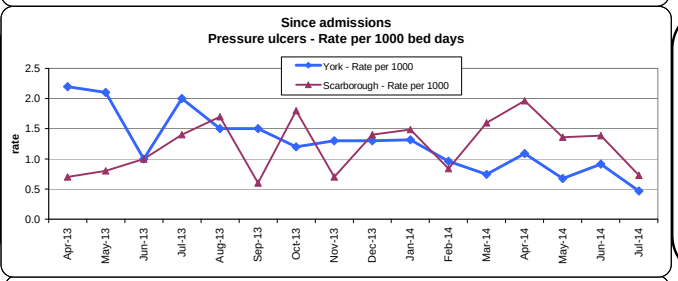
Data Source: Datix



During July 30 pressure ulcers were reported to have developed on patients in our community hospitals or community care.

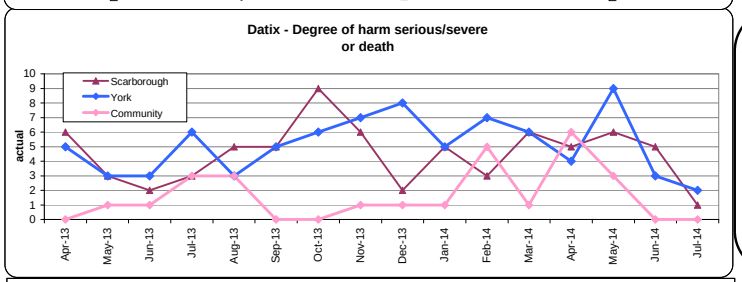
These figures should be considered as approximations as not all investigations have been completed.

Data Source: Datix



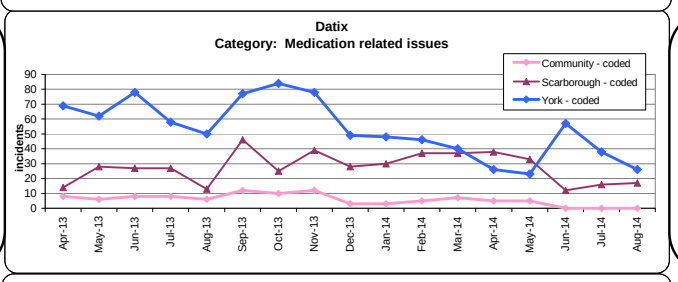
The rate of pressure ulcer development In July in York Hospital in was 0.5/1000 bed days.

The rate of pressure ulcer development in Scarborough Hospital in July was 0.7/1000 bed days.



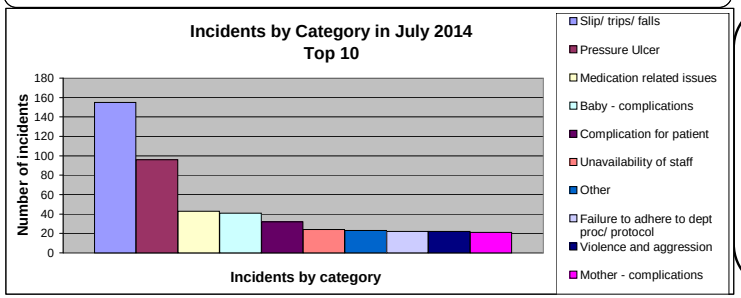
During July a total of 3 patient incidents were reported which resulted in serious or severe harm or death.

Data Source: Datix



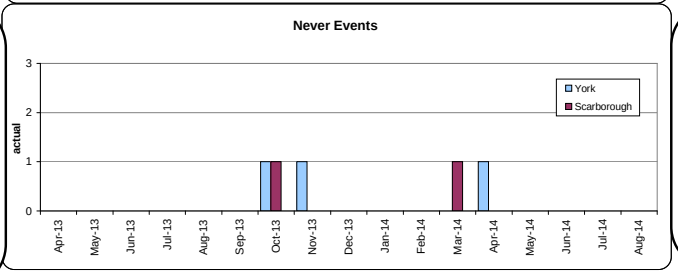
During August there was a total of 43 medication related incidents reported, although this figure may change following validation.

Data Source: Datix



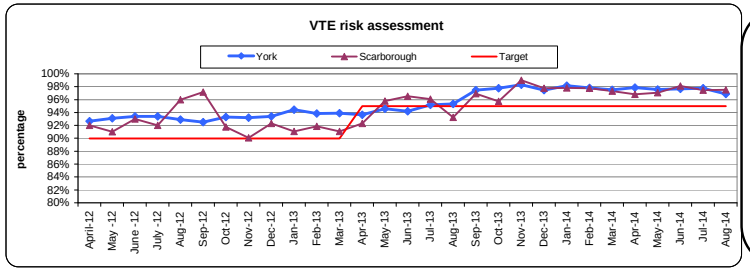
Incidents releting to slips, trips and falls remains the largest category of reported incidents, with pressure ulcers the second largest category.

Data Source: Datix



There were no Never Events declared in July or August.

Data Source: Datix

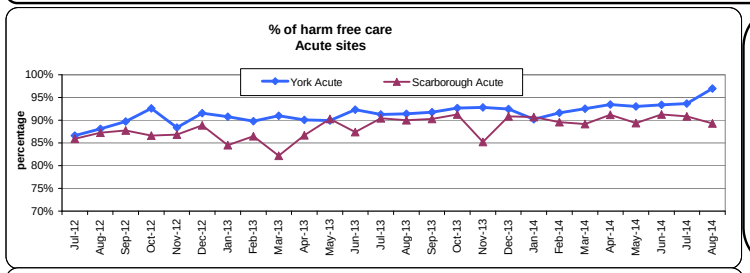


The target of 95% of patients receiving a VTE risk assessment has been maintained on both sites during July and August.

Data Source: Systems & Network Services

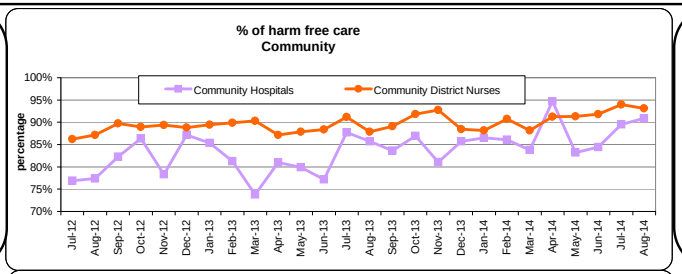
Safety Thermometer

Safety Thermometer
The NHS Safety Thermometer provides a 'temperature check' on harm, by measuring the percentage of patients who are harm free from pressure ulcers, catheter associated urinary tract infections, venous thromboembolism and fall whilst in our care. Collection of robust data on harm free care is linked to the national CQUIN scheme. The Trust has agreed an improvement incentive on delivery of harm free care related to pressure ulcers.



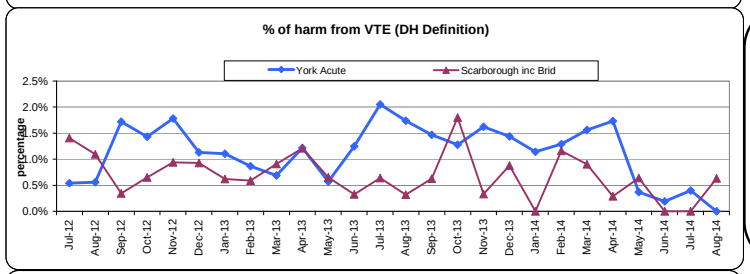
The percentage of patients harm free from pressure ulcers, catheter associated urinary tract infection (CAUTI), falls and VTE is measured as a monthly prevalence score. In August 96.9% of patients at York and 89.3% at Scarborough were audited as care 'free from harm' on the acute hospital sites.

Data source: Safety Thermometer



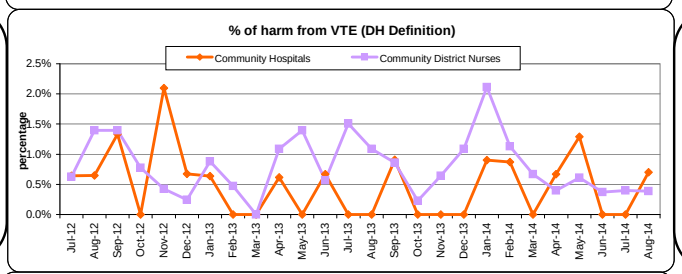
The percentage of patients harm free from pressure ulcers, catheter associated urinary tract infection (CAUTI), falls and VTE is measured as a monthly prevalence score. In August 90.9% of patients in our community hospitals and 93.1% of patients in our care in the community received care 'free from harm'.

Data source: Safety Thermometer



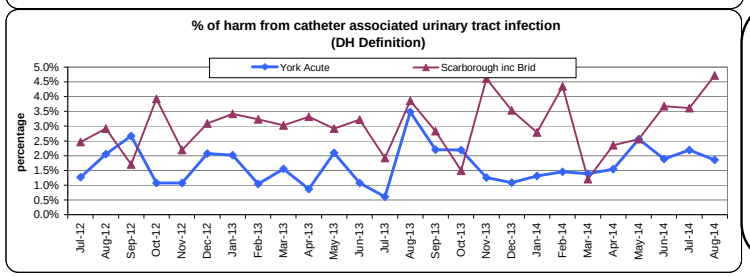
The percentage of patients affected by VTE as measured by the Department of Health (DH) definition, monthly measurement of prevalence, was 0 in York and 0.6% in Scarborough acute hospitals in August.

Data source: Safety Thermometer



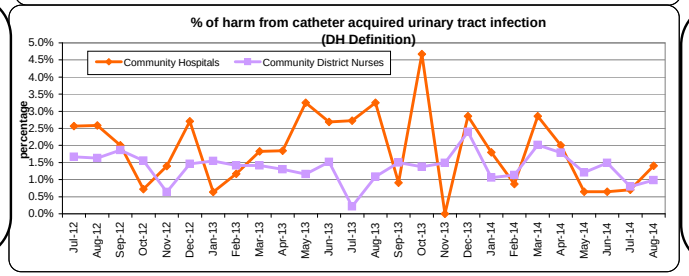
The percentage of patients affected by VTE as measured by the DH definition, monthly measurement of prevalence was 0.7% in community hospitals and 0.39% in community care in August.

Data source: Safety Thermometer



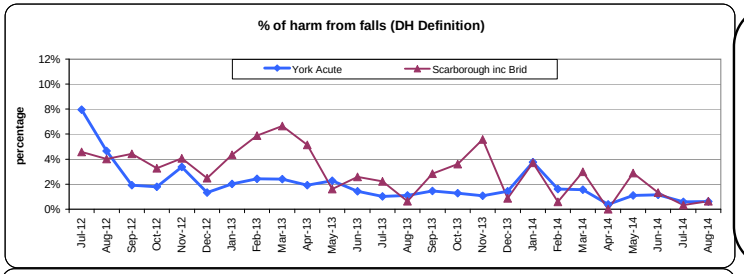
The percentage of patients affected by CAUTI as measured by the Department of Health data definition, monthly measurement of prevalence, was 1.8% in York and 4.7% in Scarborough acute hospitals in August.

Data source: Safety Thermometer



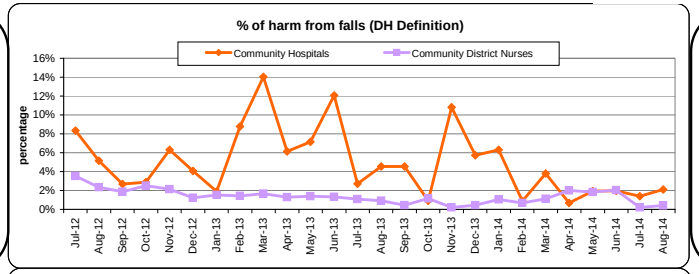
The percentage of patients affected by CAUTI as measured by the Department of Health data definition, monthly measurement of prevalence, was 1.4% in community hospitals and 0.98% in community care in August.

Data source: Safety Thermometer



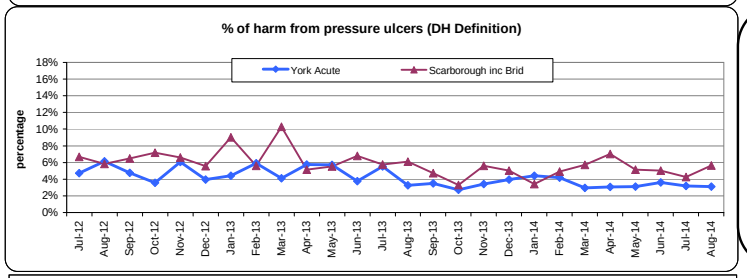
The percentage of patients affected by falls as measured by the Department of Health data definition monthly measurement of prevalence was 0.6% for York and 0.6%for Scarborough acute hospitals in August.

Data source: Safety Thermometer



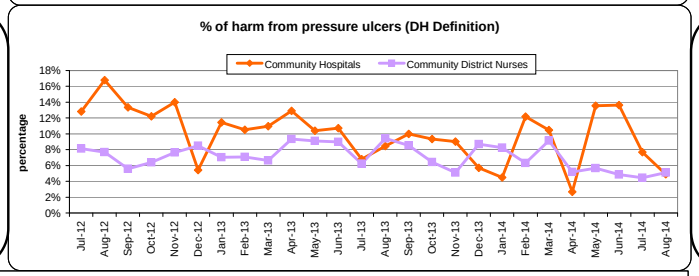
The percentage of patients affected by falls as measured by the Department of Health data definition monthly measurement of prevalence was 0.39% in community hospitals and 2.1% in community care in August.

Data source: Safety Thermometer



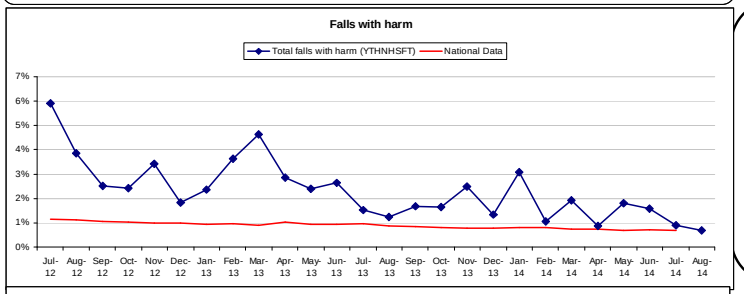
The percentage of patients affected by pressure ulcers as measured by the Department of Health data definition monthly measurement of prevalence was 3% for York and 5.6% for Scarborough acute hospitals in August.

Data source: Safety Thermometer



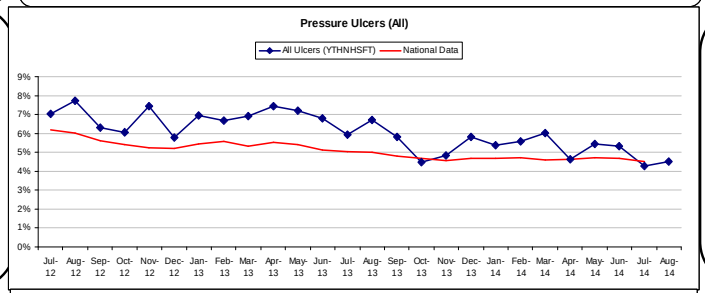
The percentage of patients affected by pressure ulcers as measured by the Department of Health data definition monthly measurement of prevalence was 4.9% in community hospitals and 5.1% in community care in August.

Data source: Safety Thermometer



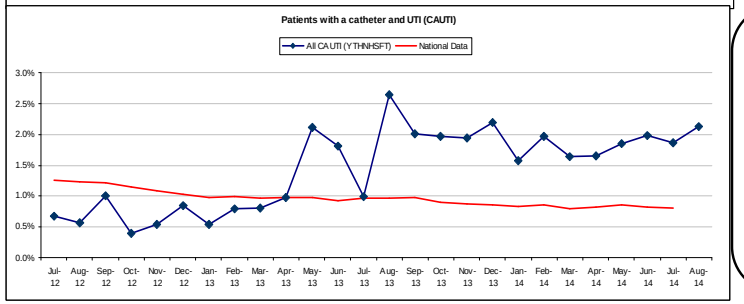
The Trust wide total number of falls with harm as measured for the Safety Thermometer, is now similar to the national average.

Data source: Safety Thermometer



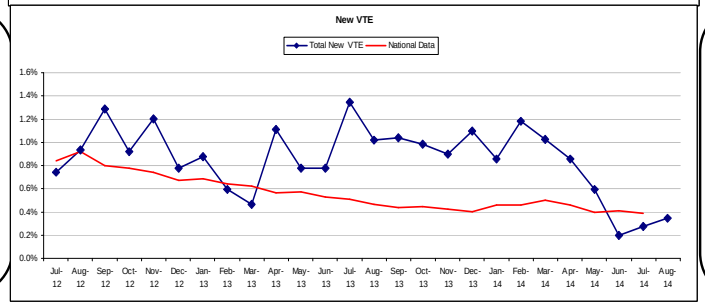
The Trust wide total number of pressure ulcers as measured for the Safety Thermometer is similar to the national average.

Data source: Safety Thermometer



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

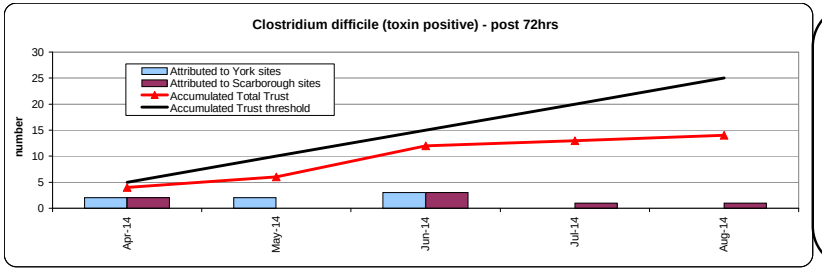
Data source: Safety Thermometer



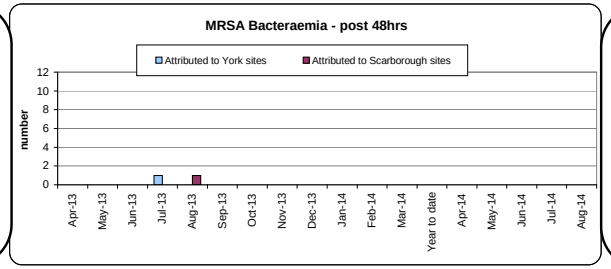
The Trust wide total number of patients with a new VTE as measured for the Safety Thermometer is similar to the national average.

Data source: Safety Thermometer

Infection Control

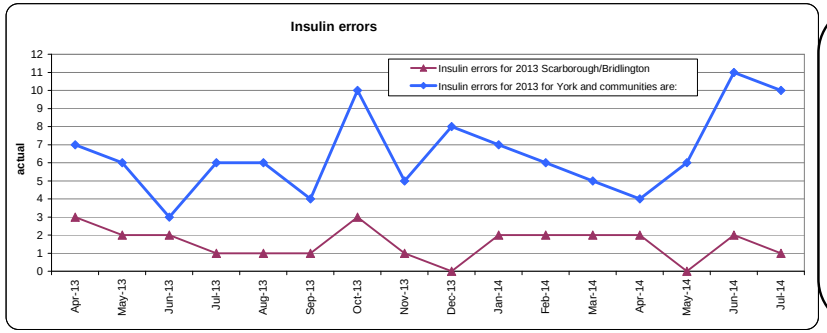


One case of c. diff was identifed in the Trust during July and one case in August. The Trust remains below trajectory at the end of August, with a total of 14 cases identified sine 1st April 2014.



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

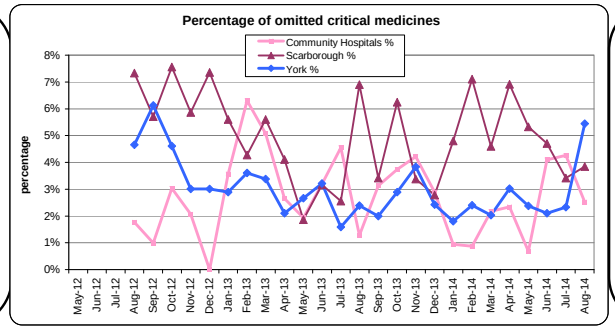
Drug Administration



There were 10 insulin related errors reported at York and Communities, and 1 at Scarborough/Bridlington in July.

The data for is awaiting validation.

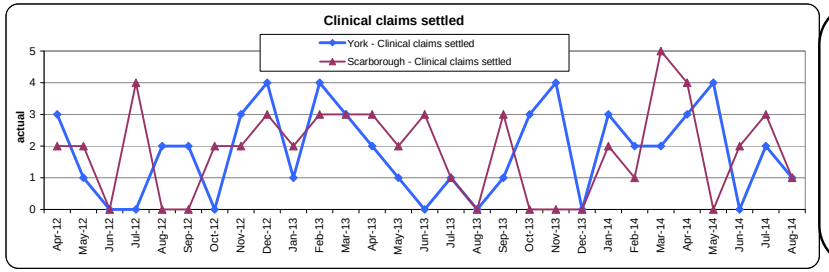
Data Source: Datix



The audit of critical medicines missed during August, indicated 3.9% for Scarborough, 5.5% for York and 2.5% for Community Hospitals.

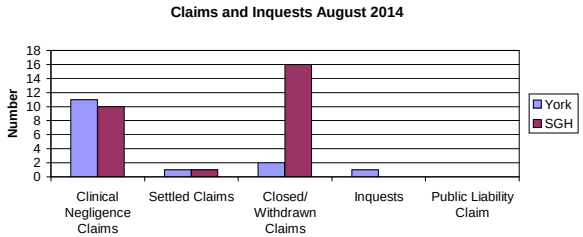
Data Source: Safety Thermometer

Litigation



Two clinical claims were settled in August, one attributed to the Scarborough site and one to the York site.

Data Source: Risk and Legal Services



In August, 11 clinical negligence claims for York site were received and 10 were received for Scarborough. One claim from Scarborough and one from York were settled. No public liability claims were received.

York had two withdrawn/ closed claims and there were 16 from Scarborough.

The was one Coroner's Inquest.

Data Source: Risk and Legal

Patient Safety Walkrounds

Date	Location	Participants	Actions & Recommendations
Wednesday 4th June	Orthopaedic Theatres & Orthopaedic OPD (York Hospital)	Sue Rushbrook – Director Dr Pete Campbell – CD Paul Rafferty – DM Liz Charters – Matron Mike Sweet – NED Sue Kelly - Sister (OPD) Wendy Hartley – Trauma Co-ordinator (Theatres)	**OPD** • GP out of hours patients taking up the clinic rooms. **Action:** Paul Rafferty and Pete Campbell to assess the feasibility of admitting patients into an Orthopaedic assessment area (dependant on the outcome of the ward reconfiguration). • A&E construction allowing for one small waiting room, generating a fall hazard. **Action:** Sue Kelly – Use plaster room waiting area as a sub wait in the short term. • Size of cubicles do not provide sufficient spaces for patients and lack of privacy. **Action:** Sue Kelly – Allow only one family member to accompany patient into the cubicle. Paul Rafferty – Look into the feasibility of relocating outpatients facilities. • Lack of consultation rooms. **Action:** Sue Kelly / Lynda Smith – look at changing medical staff timetable to facilitate reduction in congestion. Paul Rafferty – Look into feasibility of relocating outpatients facilities. **Theatres** • Orthopaedic equipment and stock stored along the corridor making the area difficult to clean and restricts patient access. **Action:** Paul Rafferty by December 2014 – generate business case for the deployment of Omnicell cabinets into theatres (requires enabling works which Richard Morris is leading).
Tuesday 10th June	ED & UCC (York Hospital)	Dr Alastair Turnbull – Director Dr Mike Williams – CD Wendy Quinn – DM	• Staff shortages were highlighted as a safety concern. There are shortages in both junior, consultant grade doctors and nurses.
		Jill Wilford – Matron Jennie Adams – NED	**Action:** steps are being taken to recruit to some of the shortfall in the nursing establishment. An advertisement to replace a consultant that left the trust recently yielded no suitable candidates. The ACP role is being developed. • Patients already assessed by GPs as in need of admission are diverted by our bed managers to come into ED when no inpatient beds are available. **Action:** improve discharge and the work underway to improve the acute flow. • The minor injury bays (nurse led) are used at busy times to hold patients with more major problems. **Action:** Better monitoring of who is where at the central office – now taking place. • The 3 'see and treat' bays that were planned can not be funded at present. It was felt these would have helped to ease the flow of patients through the ED and improve the environment / experience for children. **Action:** space has been created by taking the Majors waiting area and putting the two waiting areas into one.
			• New ambulance arrival bays open in the next week or two, this facility will enable ambulance crews to drop patients off and leave much faster. **Action:** concerns around the possible withdrawal of funding need to be escalated. • The team are anxious to press ahead with plans for 4 further observation beds, will enable single sex accommodation between ED and admission / discharge plus relieve bed pressure elsewhere in the system. • Incident reporting is well embedded but staff shortages mean that key individuals are often unable to attend Clinical Governance Sessions. **Action:** DM to look into possibility of 'overstaffing' on clinical audit days to release key staff. Lead Nurse will attend Matron Sessions in the future due to no ED Matron. • The clinical educator role was commended and compliance with e observations is high. • The proposed arrangements for Liaison Psychiatry (ALPS) were welcomed. • Concerns raised around the responsiveness of the Child Protection Team.
Wednesday 2nd July	Renal Unit (Easingwold, York)	Dr Nigel Durham – CD Kirsty Burlinson – DDM Judith Hartley – Sister Dianne Willcocks – NED	• Ward area is small and inadequate. • Patient toilets – the unit has one toilet for staff and patients to use. There needs to be separate toilets, plus disabled for male and female. • Isolation room has inadequate access to water, has 1 small window, no space, isolated patient is not visible but CCTV has been installed. • Waste area – a risk highlighted taking clean equipment through a dirty area. • The IT connection is slow and old which creates problems for CPD access, unable to open large documents. **Action:** Need to resolve with Sue Rushbrook / Dr Turnbull. Update Risk Register (20 minute delays).
Friday 4th July	ITU & HDU (York Hospital)	Andrew Bertram – Director Dr Jonathan Redman – Lead Clinician Richard Morris – DM Wendy Brown – Matron Mike Sweet – NED John Berridge – Consultant Anaesthetist Elaine Hunter – Lead Sister	• 15% of patients are discharged after 10pm. **Action:** work is currently underway to improve patient flow away from the unit to medical / surgical wards. • Concerns were expressed by medical staff as to the changing education programme, intensive care medicine as oppose to anaesthetic medicine. This may lead to reduced medical trainee numbers. • The 3 side rooms have been identified as sharing a roof void preventing full isolation. **Action:** a small capital scheme is currently being planned to seal each room individually. • The absence of a critical care PAS was

			identified. This caused multiple data entry issues and duplication of tasks. **Action:** Discussions continue with SNS to agree a way forward to develop the CPD to accommodate critical care issues or the integration of an external critical care system.
Wednesday 23rd July	Ward 35 & Ward 37 (York Hospital)	Mike Proctor – Director Dr John Coyle – CD Rob Parnaby – DM Hilary Woodward – Matron Katie Holgate – Matron Dianne Willcocks – NED	• Parts of the ward were 29/30 degrees making patient and staff uncomfortable. There is a shortage of air conditioning units available. **Action:** patients given additional drinks. Operational team to ensure all emergency measures invoked. • A large proportion of the visit was discussing patient falls; - On some occasions 28/30 patients could be assessed as being at high risk of falls. - Some patient falls occur (unavoidably) when patient is with a nurse – 1:1 care does not always help. - Assessment tool is not always a good predictor of those at risk to differentiate degrees of risk. - Shortage of falls sensors. - Assessment of patient footwear important (RCA lesson from recent fall). - Suggested action; HYMS students auditing some aspects of falls work. • Ward 35 is a high performer in terms of number and timeliness of discharges. Other wards need to attain the same. **Action**: for discussion with new Directorate manager once appointed. • Delays in commissioning new equipment on the ward caused by many days delay in PAT testing. **Action:** Escalated to the Estates Team.
Wednesday 23rd July	Lawrence Unit (Bridlington Hospital)	Brian Golding – Director Dr Ed Smith – CD Joanne Southwell – DM Tracey Wright – Matron Libby Raper – NED	• East Riding GP's commission different services than Scarborough Gp's, and so there are differences between what is provided in the Lawrence Unit compared with the sister unit, the Hawthorn Unit at Scarborough. There are no dedicated medical staff for the unit, it relies on the on-call doctor if necessary. There is potential to provide remote medical cover if Telemedicine could be introduced. **Action:** A review of the service has commenced. • Blood samples are sent to Scarborough for analysis. **Action:** consider point of care testing as part of the service review. • Potential under report of adverse incidents. **Action:** to reflect on incidents over the last 6 months.
Tuesday 29th July	Ward 15 (York Hospital)	Brian Golding – Director Mr Jim Taylor – CD Gemma Cuss – DM Wendy Brown – Matron Dianne Willcocks – NED Sophia Bird – Deputy Ward Sister	• The ward is built to accommodate 30 beds but currently houses 32 beds. • Patients are regularly outlying on other wards due to medical / elderly patients using the bed base. Nurse staffing levels and medical review of patients are of concern. **Action:** review bed base and nurse staffing levels. • Within the ward there is a room which is used as an emergency clinic space. The room is unsuitable because it does not have the appropriate equipment or nurse call facilities and staffing levels do not allow adequate observation of patients waiting in this area. **Action:** redesign patient pathway or provide suitable equipment and nurse call facility. • Damaged floor screed, presenting trip hazards. **Action:** report to estates.
Friday 1st August	Cardio-Respiratory Unit (York Hospital)	Patrick Crowley – Director Kirsty Burlinson – DDM Angela Howcroft – Op Support Manager Jane Allen – head of Cardio-Resp Unit Jennie Adams – NED	Awaiting report
Monday 18th August	Renal Unit (Harrogate)	Diane Palmer – Deputy Director Kirsty Burlinson – DDM Chris Foster – Matron	• The New self care unit is almost complete, but the Standard Operating Procedures are not yet finalised. • There is no back up generator for the power supply - The process for interruption to the power supply, particularly for the self care unit needs to be finalised. • There is no facility to lower or raise the patient trolley in the treatment area or the ability to use safety rails on the side of the trolley - A new patient trolley should be purchased for the treatment room.
Friday 29th August	Ann Wright & Oak Wards (Scarborough Hospital)	Dr Alastair Turnbull - Director Dr Ed Jones – CD Rob Parnaby – DM Emma Day – Matron Ward Sisters	• On Oak one recent C.diff case had occurred. Concerns were expressed regarding some consultants attitudes of probiotics. • On Ann Wright Ward concerns were raised about the established level of night staffing (2 +1) which were felt potentially to compromise safety of care at night. Concerns around how best patients with dementia are identified and the removal of the "forget me not" motif as a means of highlighting to staff members that a patient has dementia was discussed. A form of "this is me" is in use and there is good staff awareness in general.

Cancelled walkrounds

- Friday 18th July, Ward 28 and Ward 29. Cancelled due to Mike Proctor unwell.

York Teaching Hospital NHS
NHS Foundation Trust

Malton Community Hospital & Scarborough. South Ryedale Locality
Patient Safety Dashboard – 18/09/14

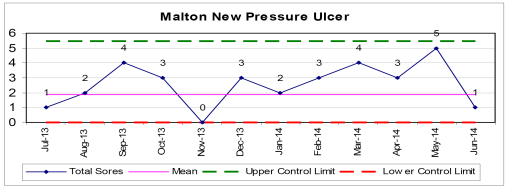
Malton Community Hospital Datix Incident Reporting	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14
Number of incidents reported on - Datix web	32	30	22	20	23	25	14	25	11	32	17	16
Number of medication related incidents	0	1	1	2	0	0	0	0	0	1	1	1*
Number of settled clinical litigation cases	0	0	0	0	0	0	0	0	0	0	0	0
Number of formal complaints	1	1	0	0	0	0	0	0	0	0	0	0
Number of Serious Incidents (SI's)	1	0	3	0	1	0	0	0	0	0	1	0
Number of Critical Incidents (CI's)	0	0	0	0	0	0	0	0	0	0	0	0

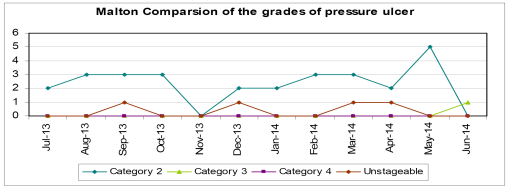
** The pt received his normal morning insulin as prescribed. His BM was not checked again until 1600 hrs when it was unrecordable at Hi - Actrapid was given as prescribed at 1600 by afternoon staff. The pts BM's remained high and further Actrapid was given to secure control of BM later that evening.*
****

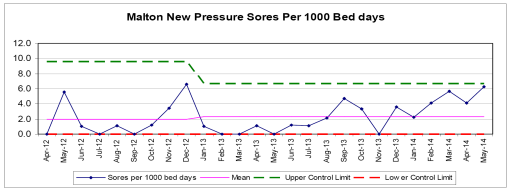
Locality South Ryedale & Scarborough Datix Incident Reporting	Apr 14	May 14	Jun 14	Jul 14
Number of incidents reported on - Datix web	33	33	35	32
Number of medication related incidents	1	0	2	1*
Number of settled clinical litigation cases	0	0	0	0
Number of formal complaints	0	0	1	1
Number of Serious Incidents (SI's)	1	2	2	1
Number of Critical Incidents (CI's)	0	0	0	0

** Syringe driver reprimed.Staff had not followed the correct robust checking and rechecking procedure at set up*

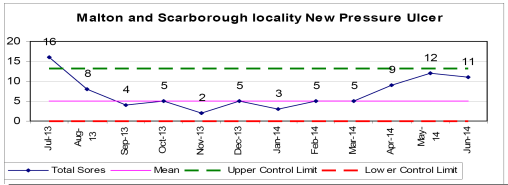
Pressure Ulcer Incidence – Malton Community Hospital

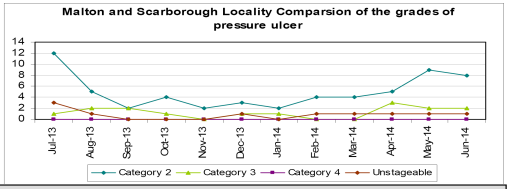




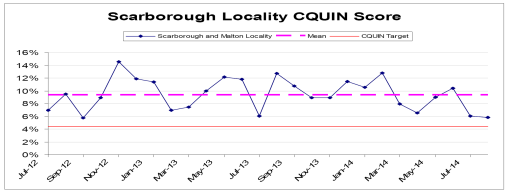


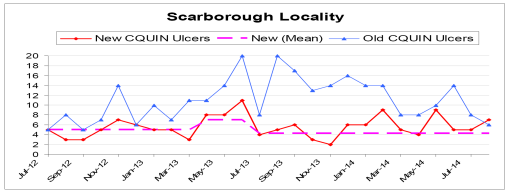
Pressure Ulcer Incidence – Locality South Ryedale & Scarborough



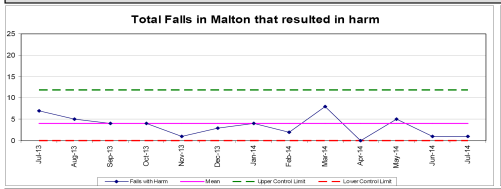


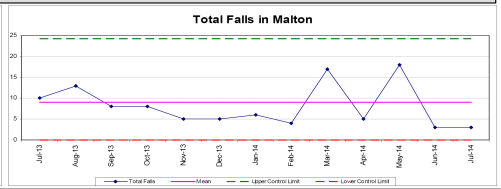
Pressure Ulcer Prevelance – Scarborough and Malton Locality (CQUIN)





Falls Incidence – Malton Community Hospital





	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14
Mean falls with harm per 1000 bed days	5.4	3.5	2	1.2	2.4	4.33	2.8	11.3	0.0	6.3	1.4	1.3

Malton Deaths & Mortality Review

Malton Community Hospital Deaths & Mortality reviews	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14
Number of in-hospital deaths	2 (2%)	5 (52.%)	6 (12.8%)	5 (11.9%)	5 (12.8%)	5 (13.5%)	5 (13.9%)	5 (10.6%)	1 (3.7%)	2 (7.1%)	9 (21.4%)	2 (5.7%)
Number of mortality reviews	0	0	0	1	2	3	0	5	1	2	8	2

Malton Activity

Malton Community Hospital - Activity	Aug 13		Sept 13		Oct 13		Nov 13		Dec 13		Jan 14		Feb 14		Mar14		Apr 14		May 14		Jun 14	Jul 14
	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Fitz
Admissions	19	72	19	69	21	13	20	10	11	22	22	13	15	11	14	35	8	20	27	4	34	42
Discharges	25	75	22	74	26	20	25	15	12	26	24	15	15	21	16	31	9	18	21	7	42	35
length of hosp stay – mean *previous yr	24.2 *NR	26.1 *NR	19.9 *NR	42.5 *8.8	31.8 *11.8	33.1 *14.8	24.3 *15.1	36.8 *22.3	23.9 *15.3	29 *15.5	30 *30.5	39 *16.5	31 *24.5	30 *26.8	17.6 *19.9	18 *22.5	28.8 *24.3	39.4 *30.3	27.5 *24	37.1 *24.2	23.7 *17.3	26.6 *17.5

The Friends and Family Test – Monthly Performance Community Hospitals - Malton

Ward		May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15
Ryedale	Response rate	33.33%											
	Eligible	6											
	Responses	2											
Fitzwilliam	Response rate	50.00%											
	Eligible	16											
	Responses	8											

Safety Thermometer Data

Malton Hospital	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar14	Apr 14	May 14	Jun 14	Jul 14
VTE			0	0	0	0	1	0	0	1	0	0
Falls			0	11	6	5	1	2	1	1	1	0
New Pressure Ulcers			1	1	1	0	2	0	1	1	2	0
Old Pressure Ulcers			5	2	0	1	6	1	1	3	4	0
CAUTI			2	0	1	0	0	1	2	0	1	1
Empty Admin Boxes			4	4	5	13	16	0	2	10	5	0
Omission Code 4			4	4	4	10	5	0	1	5	2	0
Omitted Critical Medicines			1	2	1	0	0	0	0	1	0	1

Scarborough	Aug 13		Sept 13		Oct 13		Nov 13		Dec 13		Jan 14		Feb 14		Mar14		Apr 14		May 14		Jun 14		Jul 14	
Ward	Scar	Rye	Scar	Rye	Scar	Rye	Scar	Rye	Scar	Rye	Scar	Rye	Scar	Rye	Scar	Rye	Scar	Rye	Scar	Rye	Scar	Rye	Scar	Rye
VTE					0	0	0	0	2	0	1	0	2	1	0	1	0	0	0	0	0	0	0	0
Falls					3	0	1	0	0	0	1	1	0	0	1	1	4	0	2	0	1	0	1	0
New Pressure Ulcers					2	1	0	1	3	2	4	2	5	2	4	1	3	1	6	3	1	2	4	1
Old Pressure Ulcers					8	5	12	5	7	10	11	3	7	1	3	4	5	2	7	4	10	2	6	2
CAUTI					3	0	1	1	2	2	1	0	3	0	3	0	1	4	0	0	1	1	0	1

RCA feedback and action planning	

Risk Register

Top 3 Risks on Risk Register	
1.	Fire alarm system at Malton hospital needs updating
2.	Lack of security at Malton hospital at night
3.	Inability to recruit to District Nurse posts

St Monica's Community Hospital & North Locality
Patient Safety Dashboard – 18/09/14

York Teaching Hospital NHS
NHS Foundation Trust

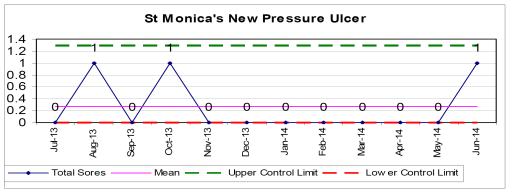
St Monica's Community Hospital Datix Incident Reporting	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14
Number of incidents reported on - Datix web	7	3	3	6	2	4	8	5	3	5	5	7
Number of medication related incidents	0	0	1	1	0	2	0	1	0	1	1	0
Number of settled clinical litigation cases												
Number of formal complaints												
Number of Serious Incidents (SI's)												
Number of Critical Incidents (CI's)												

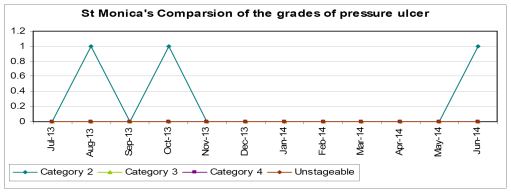
*

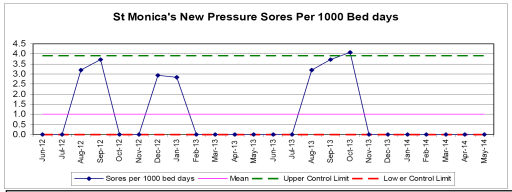
Locality North Datix Incident Reporting	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14
Number of incidents reported on - Datix web	10	6	11	16	15	19	7	10	8	13	5	15
Number of medication related incidents	0	0	0	1	0	2	0	1	0	1	1	1*
Number of settled clinical litigation cases												
Number of formal complaints												
Number of Serious Incidents (SI's)												
Number of Critical Incidents (CI's)												

* Prescribing inappropriate medication

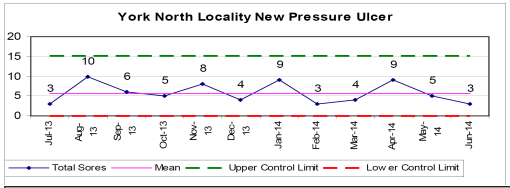
Pressure Ulcer Incidence – St Monica's Community Hospital

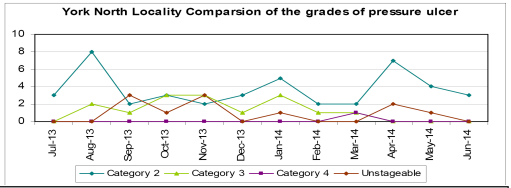




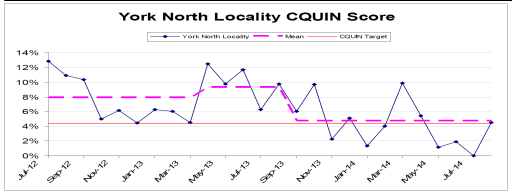


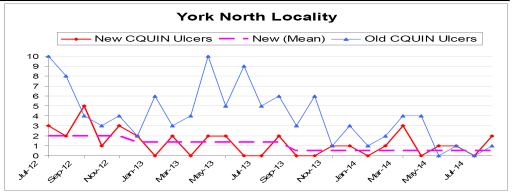
Pressure Ulcer Incidence – Locality North Locality



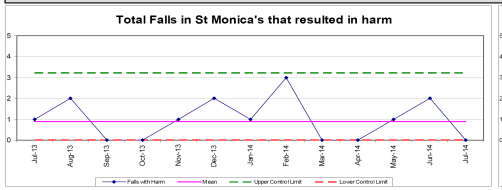


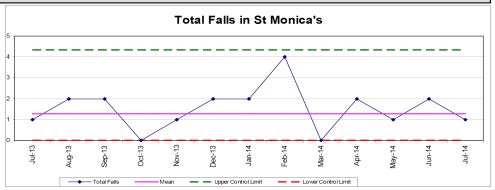
Pressure Ulcer Prevalence – North Locality (CQUIN)





Falls Incidence – St Monica's Community Hospital





	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14
Mean falls with harm per 1000 bed days	6.4	0	0	4.6	7.7	3.0	10.9	0	0	3.0	5.6	0

St Monica's Deaths & Mortality Review

St Monica's Community Hospital Deaths & Mortality reviews	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14
Number of in-hospital deaths	1 (7.1%)	3 (16.7%)	2 (18.2%)	2 (10.5%)	2 (15.4%)	4 (21.1%)	2 (14.3%)	2 (33.3%)	2 (11.1%)	4 (23.5%)	2 (22.2%)	3 (18.8%)
Number of mortality reviews	0	3	1	1	1	3	0	2	2	1	0	1

St Monica's Activity

St Monica's Community Hospital - Activity	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar14	Apr 14	May 14	Jun 14	Jul 14
Admissions	14	20	8	16	19	17	16	6	19	17	9	16
Discharges	14	18	11	19	13	19	14	6	18	17	9	16
length of hosp stay – mean *previous yr*	24.3 *	17.9 *	20.8 *	18.7 *	14.8 *	16.4 *	18.2 *	22.7 *26.9	33.2 *25.1	14.3 *14	27.7 *30.4	22.1 *13.9

The Friends and Family Test – Monthly Performance Community Hospitals – St Monica's

Ward		Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14
St Monica's	Response rate										44.4%		
	Eligible										9		
	Responses										4		

Safety Thermometer Data – St Monica's & North Locality

St Monica's Hospital	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar14	Apr 14	May 14	Jun 14	Jul 14
VTE			0	0	0	0	0	0	0	0	0	0
Falls			0	0	0	0	0	0	0	0	1	0
New Pressure Ulcers			0	1	0	0	0	0	0	0	1	0
Old Pressure Ulcers			0	**0**	1	1	0	3	0	0	1	1
CAUTI			0	0	0	0	0	0	0	0	0	0
Empty Admin Boxes			1	1	3	1	0	3	1	3	1	1
Omission Code 4			0	1	1	0	1	0	3	0	3	1
Omitted Critical Medicines			1	0	0	0	0	1	2	0	0	0

North York Locality	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar14	Apr 14	May 14	Jun 14	Jul 14
VTE			0	0	0	1	0	0	0	0	0	0
Falls			0	0	0	0	1	0	0	1	1	1
New Pressure Ulcers			0	0	1	0	1	3	0	1	0	0
Old Pressure Ulcers			6	**3**	2	1	3	1	4	0	1	0
CAUTI			1	1	1	1	0	2	0	1	2	0

RCA feedback and action planning	

Risk Register

Top 3 Risks on Risk Register	
1.	
2.	
3.	

Selby Community Hospital & Selby Locality
Patient Safety Dashboard – 18/09/14

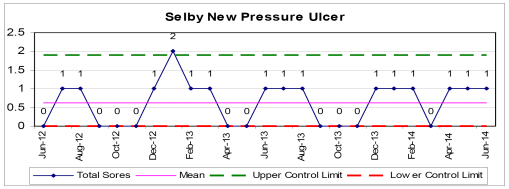
York Teaching Hospital NHS
NHS Foundation Trust

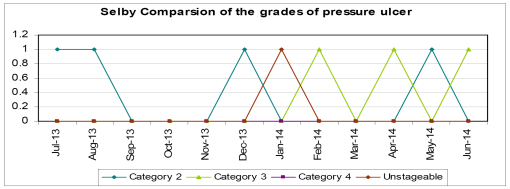
Selby Community Hospital Datix Incident Reporting	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14
Number of incidents reported on - Datix web	12	14	18	16	14	11	10	11	7	17	25	25
Number of medication related incidents	0	3	4	0	0	0	0	0	0	0	2	0
Number of settled clinical litigation cases												
Number of formal complaints												
Number of Serious Incidents (SI's)												
Number of Critical Incidents (CI's)												

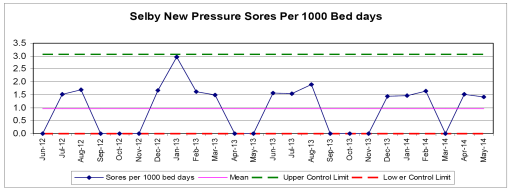
*

Locality Selby Datix Incident Reporting	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14
Number of incidents reported on - Datix web	12	14	10	5	7	13	5	13	14	12	14	9
Number of medication related incidents	0	0	0	1	1	0	0	0	1	0	0	0
Number of settled clinical litigation cases												
Number of formal complaints												
Number of Serious Incidents (SI's)												
Number of Critical Incidents (CI's)												

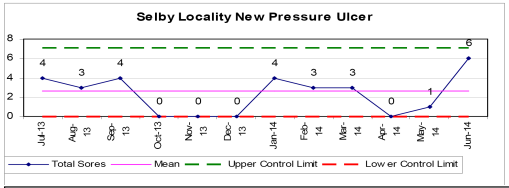
Pressure Ulcer Incidence – Selby Community Hospital

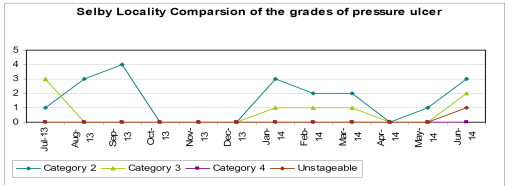




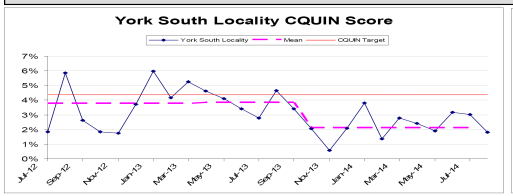


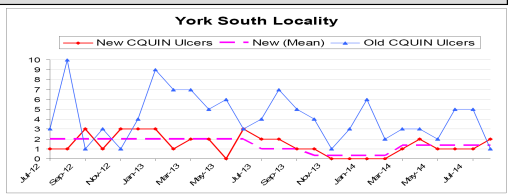
Pressure Ulcer Incidence – Locality Selby Locality



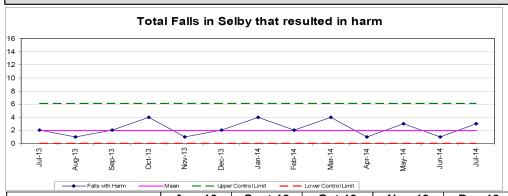


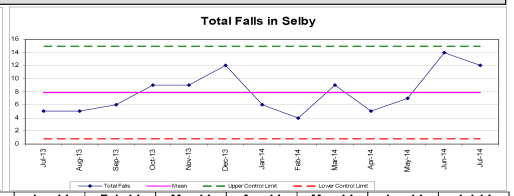
Pressure Ulcer Prevelance – Selby Locality (CQUIN)





Falls Incidence – Selby Community Hospital





	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14
Mean falls with harm per 1000 bed days	1.9	3.8	7.9	1.6	2.9	5.8	3.3	6.5	1.5	4.3	1.5	4.4

Selby Deaths & Mortality Review

Selby Community Hospital Deaths & Mortality reviews	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14
Number of in-hospital deaths	8 (17%)	5 (10.4%)	4 (7.3%)	6 (11.3%)	2 (5.7%)	3 (6.8%)	3 (6.5%)	3 (7.5%)	4 (7.4%)	3 (6.4%)	1 (2.7%)	0 (8.7%)
Number of mortality reviews	7	4	4	6	1	2	2	2	3	3	1	0

Selby Activity

Selby Community Hospital - Activity	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar14	Apr 14	May 14	Jun 14	Jul 14
Admissions	43	45	63	52	37	41	47	40	56	46	37	41
Discharges	47	48	55	53	35	44	46	40	54	47	37	46
length of hosp stay – mean *previous yr	14.3 *	21 *	14.9 *	14.6 *	24.5 *	30.9 *	22.2 *	28 *21.8	18.6 *32.1	28.6 *29.1	25.2 *21.2	27.1 *22.4

The Friends and Family Test – Monthly Performance Community Hospitals - Selby

Ward		Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14
Selby IPU	Response rate										23.53%		
	Eligible										17		
	Responses										4		

Safety Thermometer Data

Selby Hospital	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar14	Apr 14	May 14	Jun 14	Jul 14
VTE			0	0	0	1	0	0	0	0	0	0
Falls			0	0	0	1	0	2	0	0	1	0
New Pressure Ulcers			1	0	0	0	1	0	0	1	0	1
Old Pressure Ulcers			2	**1**	2	1	1	2	0	2	4	3
CAUTI			0	0	0	1	0	0	0	1	0	0
Empty Admin Boxes			2	4	3	1	1	3	1	2	3	3
Omission Code 4			1	1	0	1	3	0	0	0	0	5
Omitted Critical Medicines			2	1	2	0	1	1	1	0	1	3

Selby Locality	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar14	Apr 14	May 14	Jun 14	Jul 14
VTE			1	0	0	0	0	1	0	0	1	0
Falls			0	0	0	0	0	0	2	2	2	0
New Pressure Ulcers			0	0	0	0	0	1	2	0	1	0
Old Pressure Ulcers			2	**0**	1	5	2	3	3	0	1	2
CAUTI			1	3	0	1	0	0	1	1	1	2

RCA feedback and action planning	

Risk Register

Top 3 Risks on Risk Register	
1.	
2.	
3.	

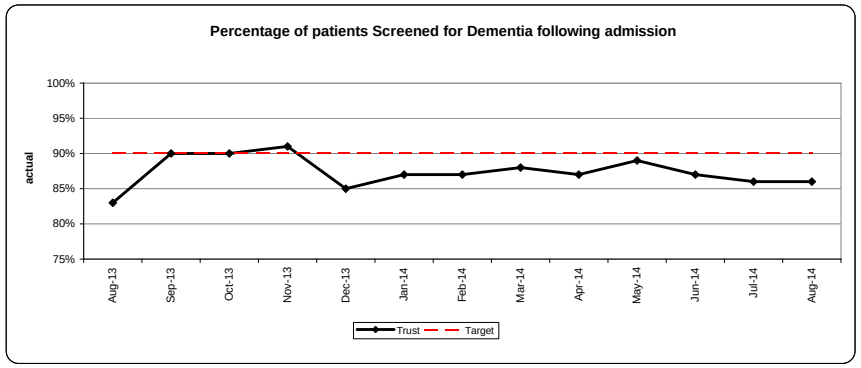
Dementia

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

The Trust is significantly below target for dementia screening.

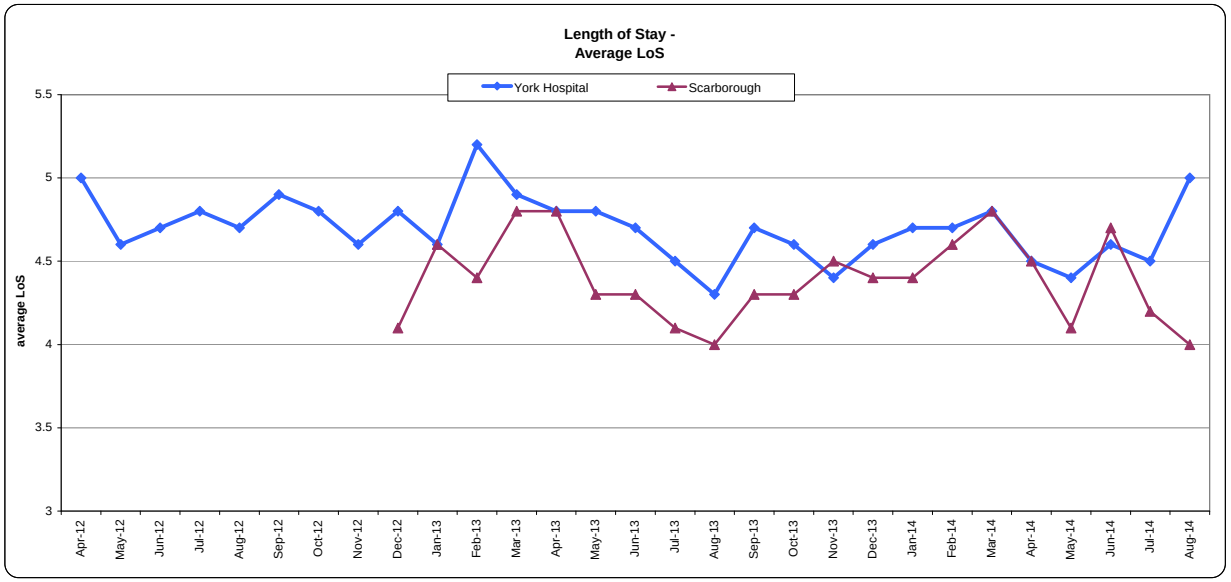
Additional alert strategies are being considered, particularly at the Sacrborough site, to ensure that the sreening is completed within 72 hours of the patient being admitted to hospital.

Data source: Signal



Clinical Effectiveness Dashboard

Clinical Effectiveness



The Length of Stay (LOS) for in-patients (excluding day cases and babies) increased on the York site during August.

Data source: Signal

Report: Patient Safety :4 Sep 2014 > Patient Safety Scorecard
Hierarchy: Trust overview
Site time period: Aug 2013 to Jul 2014 Peer time period: Aug 2013 to Jul 2014

Description	Change	Value Current Period	Value Previous Period	Site Numerator	Site Denominator	Peer 25th Percentile	Peer 75th Percentile	Peer Average	Peer Numerator	Peer Denominator	Rating
Data Quality Index (HRGv4 based)	Current period is 1% worse than previous period.	94.8	96	168,956	178,178	95.4	96.9	95.6	8,237,183	8,617,937	Red
% FCEs with palliative care code	Current period is 3% better than previous period.	0.71%	0.73%	1,247	175,196	1.00%	0.62%	0.79%	67,649	8,522,802	Amber
% Deaths with Palliative care code	Current period is 1% worse than previous period.	15.43%	15.27%	300	1,944	25.03%	15.50%	20.69%	18,665	90,227	Green
% Sign or symptom as a primary diagnosis	Current period is 3% better than previous period.	10.96%	11.32%	19,206	175,196	12.20%	9.04%	10.14%	864,260	8,522,802	Amber
Complication Rate Attributed	Current period is 8% better than previous period.	0.72%	0.78%	986	136,261	0.89%	0.62%	0.82%	59,081	7,220,989	Amber
Misadventure rate	Current period is 6% better than previous period.	0.06%	0.06%	76	136,261	0.12%	0.06%	0.09%	6,761	7,220,989	Green
Outpatient DNA Rate	Current period is 15% better than previous period.	5.50%	6.50%	33,617	611,602	9.10%	7.30%	8.40%	1,171,994	13,885,164	Green
Mortality	Current period is 8% better than previous period.	1.45%	1.58%	1,975	136,261	1.47%	1.15%	1.23%	89,146	7,220,989	Amber
Rate of emergency readmission to hospital within 14 days - COPD	Current period is 8% worse than previous period.	16.40%	15.20%	161	982	18.90%	13.60%	17.50%	16,319	93,049	Amber
Risk adjusted mortality index 2013	Current period is 5% better than previous period.	90	95	1,680	1,870	86	73	80	71,047	88,682	Red
Infection rate following caesarean section	Current period is 2% worse than previous period.	0.35%	0.34%	4	1,149	0.42%	0.11%	0.33%	234	71,252	Amber
Rates of deaths in hospital within 30 days of Non-elective surgery	Current period is 11% worse than previous period.	1.80%	1.60%	161	8,924	1.90%	1.10%	1.50%	7,273	490,242	Amber
Rates of deaths in hospital within 30 days of Elective surgery	Current period is 19% worse than previous period.	0.02%	0.02%	6	27,712	0.04%	0.01%	0.03%	470	1,523,686	Amber
Discharge to usual place of residence within 28 days of emergency admission from there with a hip fracture	Current period is 8% better than previous period.	54.80%	50.80%	349	637	42.20%	55.20%	48.30%	12,483	25,860	Amber

Maternity Dashboard - York and Scarborough

York Teaching Hospital NHS
NHS Foundation Trust

York Maternity Dashboard:

			Measure	Data source		No Concerns (green)	Of Concern (Amber)	Concerns (Red)	Flag Source	September	October	Novenber	December	January
Activity	**Births**	Bookings	1st m/w visit	CMIS from Jan CPD		≤302	302-329	≥330	prev. stats	301	343	330	316	399
		Bookings <13 weeks	No. of mothers	CMIS from Jan CPD		≥90%	76%-89%	≤75%	CQUIN	88%	87%	89%	88%	86%
		Bookings ≥13 weeks (exc transfers	No. of mothers			≥90%	76%-89%	≤75%	CQUIN					
		Bookings ≥ 13wks seen within 2 wk	No. of mothers	Mat Rec		≥90%	76%-89%	≤75%	CQUIN					
		Births	No. of babies	CMIS		≤295	296-309	≥310	prev. stats	296	293	279	285	295
		No. of women delivered	No. of mothers	CMIS						289	283	274	276	288
	Closures	Homebirth service suspended	No. of closures	Comm. Manager		0-3	4-6	7 or more		1	6	6	4	1
		Homebirth service suspended	No. of women	Comm. Manager		0	1	2 or more		0	2	0	0	0
		Escalation Policy implemented	No. of times	Comm. Manager		3	4-5	6 or more		5	3	3	2	3
		Maternity Unit Closure	No. of closures	Matron		0		1 or more		0	0	0	0	0
		SCBU closed to admissions	In utero transfers	Transfer folder		0	1	2 or more		4	3	0	3	0
Workforce	**Staffing**	M/W per 1000 births	Ratio	Matron		≥35.0	34.9-31.1	≤31.0	DH	29.7	28.4	28.4	29.8	31.0
		HCA's	Ratio	Matron					staffing paper	20.02	20.02	20.02	21.01	19.43
		1 to 1 care in Labour		Risk Team										
		L/W Co-ordinator supernumary %		Risk Team						55	48	47	45	51
		Consultant cover on L/W	av. hours/week	Rota		40		≤40	Safer Childbirth	76	76	76	76	76
		Anaesthetic cover on L/W	av.sessions/week	Rota		10		≤10		10	10	10	10	10
		Supervisor : M/w ratio 1 :	Ratio	Rota		12	13-15	15	SHA	15	13	13	13	12
Clinical Indicators	**Neonatal/Maternal Morbidity**	Sponateous Vaginal Births	No. of svd	CMIS		≥65%	64%	≤63%		63.5	68.3	64.8	62.1	61.7
		Operative Vaginal Births	No. of instr. births	CMIS		≤15%	16-19%	≥20%	prev. stats	8.4	10.9	10.7	12.9	9.5
		C/S Deliveries	Em & elect	CMIS		≤24%	24.1-25.9	≥26%	prev. stats	27.7	20.8	24.0	24.5	28.8
		Eclampsia	No. of women	CMIS		0		1 or more		0	0	0	0	1
		Undiagnosed Breech in Labour	No. of women	CMIS		2 or less	3-4	5 or more	prev. stats	1	3	3	1	1
		ICU transfers	No. of women	Risk Team - Datix		0	1	2 or more	prev. stats	0	1	0	1	2
		HDU on L/W	No. of days	Handover Sheet						15	25	15	14	18
		Uterine Rupture from Jan 14	No of women	CPD		0	1	2 or more						0
		BBA	No. of women	Risk Team - Datix		1	2-3	4 or more	prev. stats	2	6	4	1	4
		Meconium Aspirate	No. of babies	SCBU sister		0	1	2 or more	prev. stats	0	0	0	0	0
		Diagnosis of HIE	No. of babies	SCBU Paed		0	1	2 or more	prev. stats	1	0	0	0	0
	Risk Management	SI's	Total	Risk Team		0	1	2 or more		0	0	0	0	0
		PPH > 2L	No. of women	Risk Team - Datix		2 or less	3-4	5 or more		4	7	7	1	1
		Shoulder Dystocia - True	No. of women	Risk Team - Datix		2 or less	3-4	5 or more	RCOG	3	6	6	3	0
		3rd/4th Degree Tear	% of tears (vaginal b	CMIS		≤1.5%	1.6-6.1%	≥6.2%	RCOG	3.7	3.4	6.1	2.8	4.7
	Training Attendance	YMET - Midwives	% of staff trained	Risk Team		≥75%	61%-74%	≤60%		90	90	89	99	94
		YMET - Doctors	% of staff trained	Risk Team		≥75%	61%-74%	≤60%		48	55	50	69	78
		Training cancelled	No. of staff affected	Risk Team		0		≥1		7	1	0	1	1
	New Complaints	Informal	Total	Matron		0	1-4	5 or more		0	0	1	0	3
		Formal	Total	Matron		0	1-4	5 or more		1	2	1	2	2
	New Claims		Total	Directorate Manager		0	1	2 or more		1	0	0	0	2

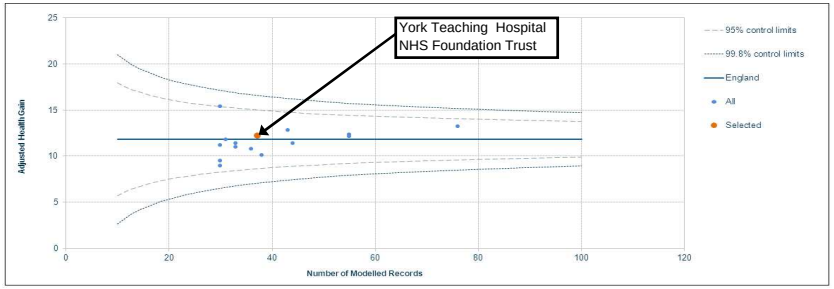
Scarborough Maternity Dashboard:

	Measure	Data source	No Concern(green)	Of Concern (Amber)	Concerns (Red)	Flag Source	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Av. Monthly YtD	Action Log completed (Date)	Notes
Bookings	1st m/w visit	IS - Evolution	≤200	201-249	≥250	prev. stats	200	222	199	165	249	190	201	193	183	185	187		198		
Bookings <13 weeks	No. of mothers	IS - Evolution	≥90%	76%-89%	≤75%	CQUIN	82%	81%	96%	100%	100%	100%	100%	96%	90%	95%	89%		94%		
Bookings <13 weeks (exc transfers etc)	No. of mothers	IS - Evolution	≥90%	76%-89%	≤75%	CQUIN	86%	TBC	96%	n/a	n/a	n/a	n/a	89%	100%	100%	100%		95%		
Bookings ≥ 13wks seen within 2 wks	No. of mothers		≥90%	76%-89%	≤75%	CQUIN								3.0		0.1	0.1		1.1		
Births	No. of babies	IS - Evolution	≤170	171-189	≥190	prev. stats	135	145	131	124	145	128	119	116	119	124	132	158	131		
No. of women delivered	No. of mothers	IS - Evolution	≤170	171-189	≥190	prev. stats	133	142	129	122	143	126	118	119	119	125	134	158	131		
Homebirth service suspended	No. of closures	Comm Team Leader	0-3	4-6	7 or more		0	0	0	0	0	0	0	0	0	1	0	0	0		
Homebirth service suspended	No. of women	Comm Team Leader	0	1	2 or more		0	0	0	0	0	0	0	0	0	1	0	0	0		
Escalation Policy implemented	No. of times	Matron	3	4-5	6 or more		0	0	0	0	0	0	0	0	0	1	0	0	0		
Maternity Unit Closure	No. of closures	Matron	0		1 or more		0	0	0	0	0	0	0	0	0	1	0	0	0		
MLU Closure	No. of closures	Matron	0	1-2	3 or more		2												2	MLU closed from 1/10/13 M/w led care provided on L/W	
MLU Closure	No. of women	Matron	0	1-2	3 or more		1												1	MLU closed from 1/10/13 M/w led care provided on L/W	
SCBU closed to elective admissions	In utero transfers	Risk Team	0	1	2 or more		3	16	3	22	8	4	4	7	26	10	4	21	11		
M/W per 1000 births	Ratio	Matron	≥35.0	34.9-31.1	≤31.0	DH	44.0	44.0	44.0	44.0	44.0	44.0	44.0	44.0	43.0	43.0	43.0	41.0	43.5		
HCA's	WTE	Matron				staffing paper	18.79	19.59	19.59	19.59	18.32	18.32	18.32	18.32	17.92	17.12	17.12	16.72	18.31		
1:1 care in labour		IS - Evolution					96%	96%	98%	99%	96%	98%	99%						97%		
L/W Co-ordinator Supernumary %		L/W Manager					N/A	56%	56%	62.9%	41.93%	55.3%	64.5%	64.5%	70.9%	75%	58%	50%	60%		
Consultant cover on L/W	av. hours/week	Rota	40		≤40	Safer Childbirth	40	40	40	40	40	40	40	40	40	40	40	40	40		
Anaesthetic cover on L/W	av.sessions/week	Rota	10		≤10	Safer Childbirth	3	3	3	3	3	3	3	3	3	3	3	3	3		
Supervisor : M/w ratio 1 :	Ratio	Matron	15	16-19	20	NMC	15	13	13	13	14	14	14	14	14	14	14	14	14		
Spontaneous Vaginal Births	No. of svd	IS - Evolution	≥65%	64%	≤63%		70.4%	64.8%	65.6%	67.7%	68.3%	71.9%	72.3%	76.7%	68.9%	64.0%	76.5%	70.3%	69.8%		
Operative Vaginal Births	No. of instr. births	IS - Evolution	≤15%	16-19%	≥20%	prev. stats	8.1%	8.3%	6.1%	4.0%	3.4%	4.7%	5.9%	3.4%	6.7%	6.5%	3.8%	9.5%	5.9%		
C/S Deliveries	Em & elect	IS - Evolution	≤24%	24.1-25.9	≥26%	prev. stats	20.0%	24.8%	26.0%	26.6%	26.9%	21.9%	21.0%	19.8%	23.5%	29.0%	18.9%	20.9%	23.3%		
Eclampsia	No. of women	IS - Evolution	0		1 or more		0	0	0	0	0	0	0	0	0	0	0	0	0		
Undiagnosed Breech in Labour	No. of women	Risk Team	2 or less	3-4	5 or more	prev. stats	0	1	1	0	0	0	0	1	1	0	0	0	0		
ICU transfers	No. of women	IS - Evolution	0	1	2 or more	prev. stats	1	0	0	0	0	0	0	0	0	0	0	0	0		
HDU on L/W	No. of days	Risk Team					2	2	5	4	2	3	1	3	0	0	2	2	2		
P/N Hysterectomies < 7days p/n	No. of women	IS - Evolution	0	1	2 or more	prev. stats	0	0	0	0	0	0	0	0	0	0	0	0	0		
BBA	No. of women	IS - Evolution	1	2-3	4 or more	prev. stats	1	1	0	1	1	1	0	0	0	0	3	2	1		
Meconium Aspirate	No. of babies	IS - Evolution	0	1	2 or more	prev. stats	0	0	0	1	0	1	0	0	1	0	0	0	0		
Diagnosis of HIE	No. of babies	IS - Evolution	0	1	2 or more	prev. stats	0	0	0	0	0	0	0	0	1	0	0	0	0		
SI's	Total	Risk Team	0	1	2 or more		0	0	0	0	0	1	0	1	0	0	0	0	0		
PPH > 2L	No. of women	IS - Evolution	1 or less	2-3	3 or more		1	0	1	1	0	1	0	2	0	0	2	0	1		
Shoulder Dystocia - True	No. of women	IS - Evolution	1 or less	2-3	3 or more	RCOG	0	4	0	0	1	1	0	0	1	1	0	1	1		
3rd/4th Degree Tear	% of tears (vaginal b	IS - Evolution	≤1.5%	1.6-6.1%	≥6.2%	RCOG	0.8%	1.4%	0.8%	2.5%	4.9%	4.0%	0.0%	0.4%	0.7%	1.6%	0.0%	1.3%	1.5%		
YMET - Midwives	% of staff trained	Risk Team	≥75%	61%-74%	≤60%		77	85	92	98	91	93	93	91	90	94	93	93	91		
YMET - Doctors	% of staff trained	Risk Team	≥75%	61%-74%	≤60%		53	79	82	90	37	92				77	92	92	75		
Training cancelled	No. of staff affected	Risk Team	0		≥1		0	0	0	1	0	0	0	0	0	0	0	0	0		
Informal	Total	Matron	0	1-4	5 or more		0	1	3	1	1	3	2	0	1	0	1	2	1		
Formal	Total	Matron	0	1-4	5 or more		0	1	1	1	1	1	0	2	0	0	0	1	1		
New Claims	Total	Risk Team	0	1	2 or more		0	0	0	0	0	2	1	0	1	0	1	1	1		

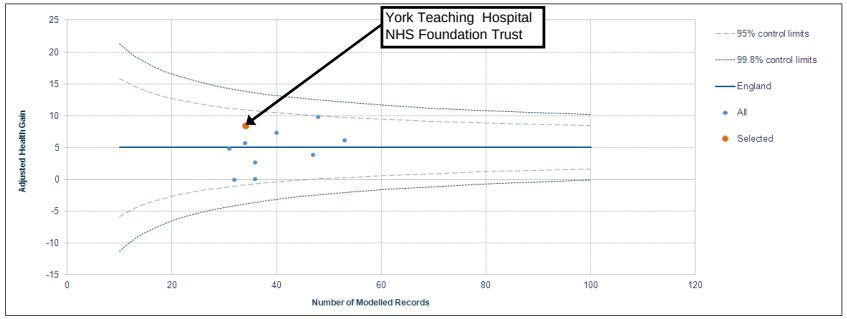
Funnel Plot – casemix-adjusted average Health Gain

April 2013 to March 2014, provisional data (published 14 August 2014)

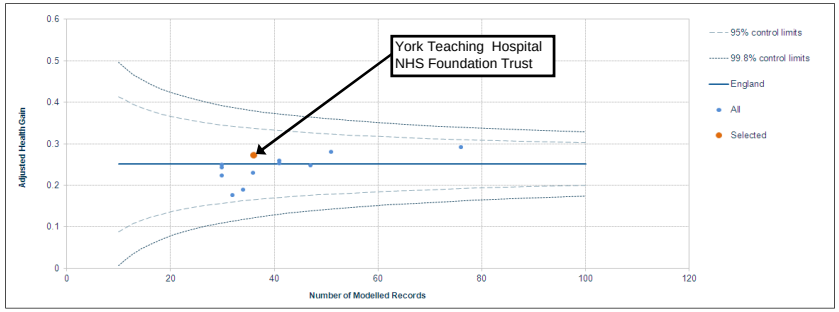
Procedure	Measure	Organisation level	Organisation name
Hip Replacement Revision	Oxford Hip Score	Provider	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST (RCB)



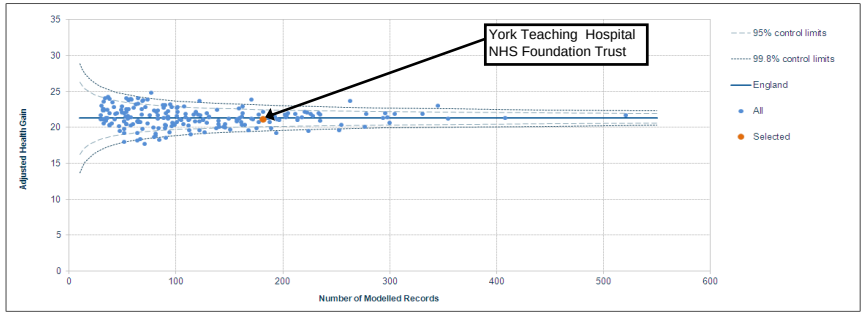
Procedure	Measure	Organisation level	Organisation name
Hip Replacement Revision	EQ VAS	Provider	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST (RCB)



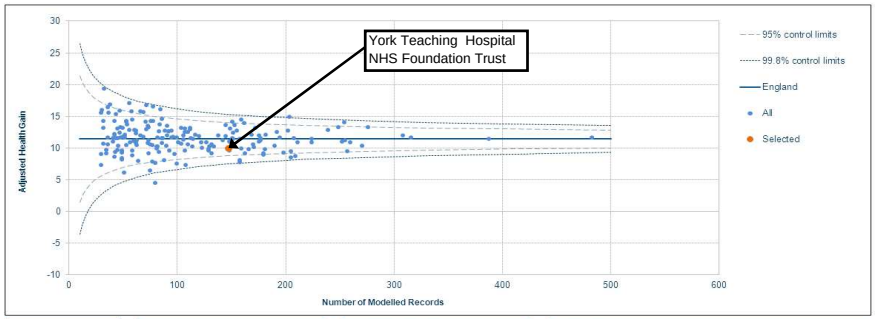
Procedure	Measure	Organisation level	Organisation name
Hip Replacement Revision	EQ-5D Index	Provider	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST (RCB)



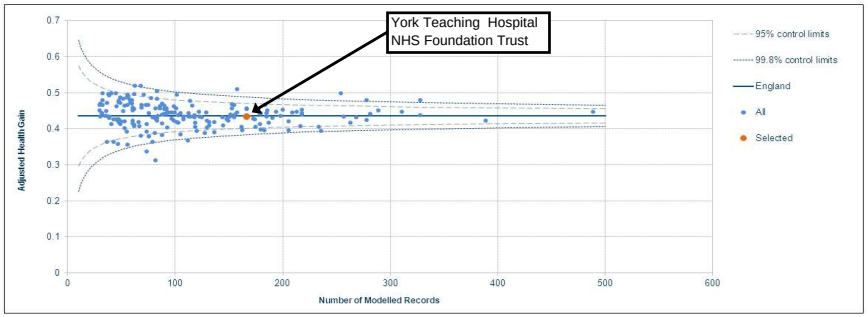
Procedure	Measure	Organisation level	Organisation name
Hip Replacement Primary	Oxford Hip Score	Provider	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST (RCB)



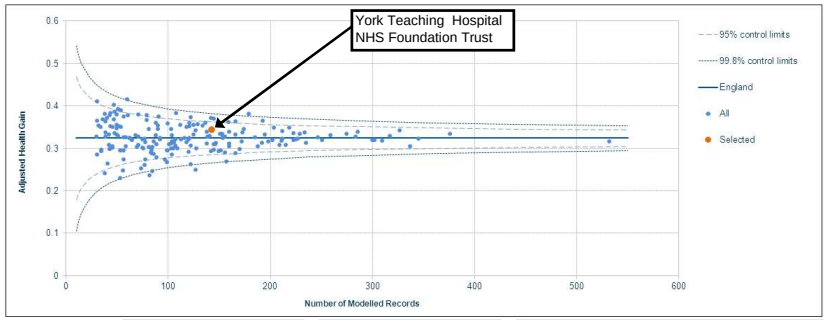
Procedure	Measure	Organisation level	Organisation name
Hip Replacement Primary	EQ VAS	Provider	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST (RCB)



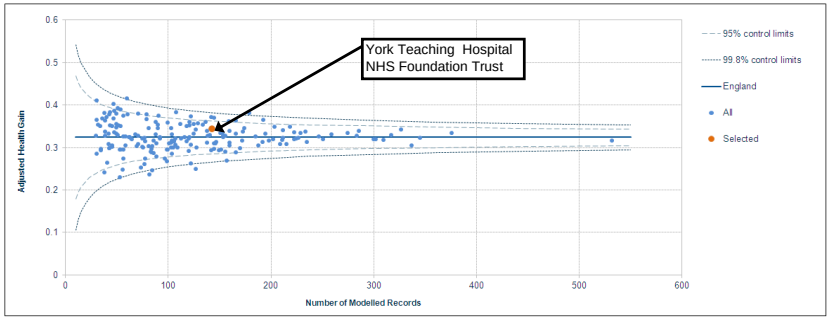
Procedure	Measure	Organisation level	Organisation name
Hip Replacement Primary	EQ-5D Index	Provider	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST (RCB)



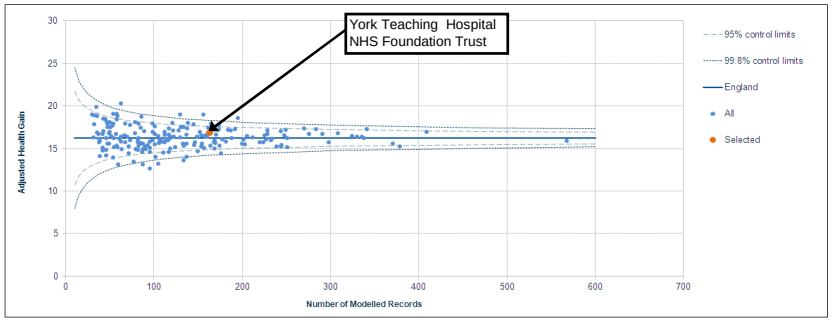
Procedure	Measure	Organisation level	Organisation name
Knee Replacement Primary	EQ-5D Index	Provider	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST (RCB)



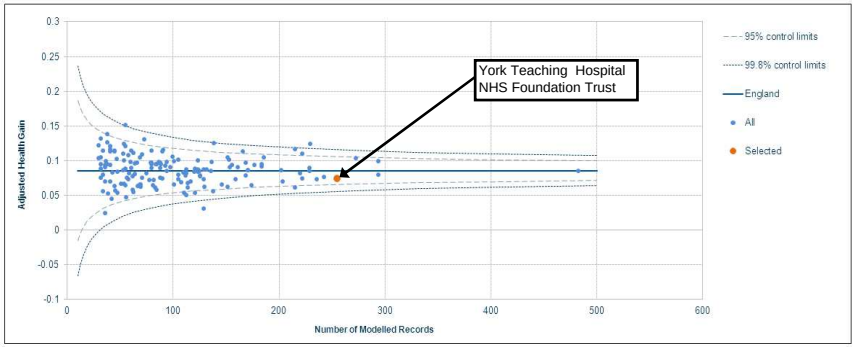
Procedure	Measure	Organisation level	Organisation name
Knee Replacement Primary	EQ VAS	Provider	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST (RCB)



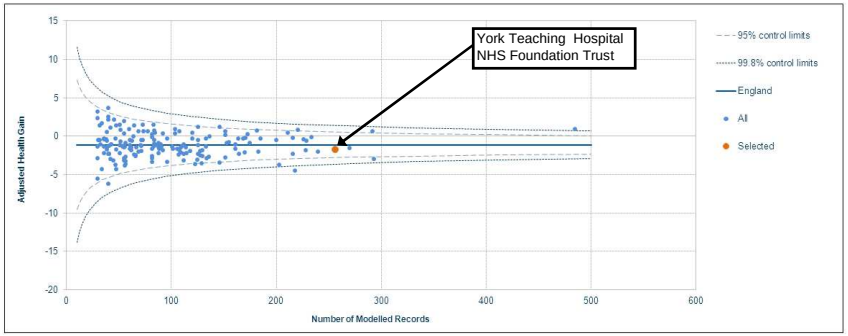
Procedure	Measure	Organisation level	Organisation name
Knee Replacement Primary	Oxford Knee Score	Provider	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST (RCB)



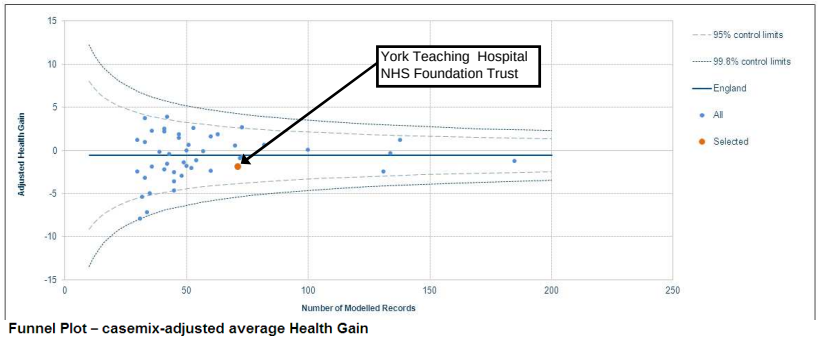
Procedure	Measure	Organisation level	Organisation name
Groin Hernia	EQ-5D Index	Provider	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST (RCB)



Procedure	Measure	Organisation level	Organisation name
Groin Hernia	EQ VAS	Provider	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST (RCB)

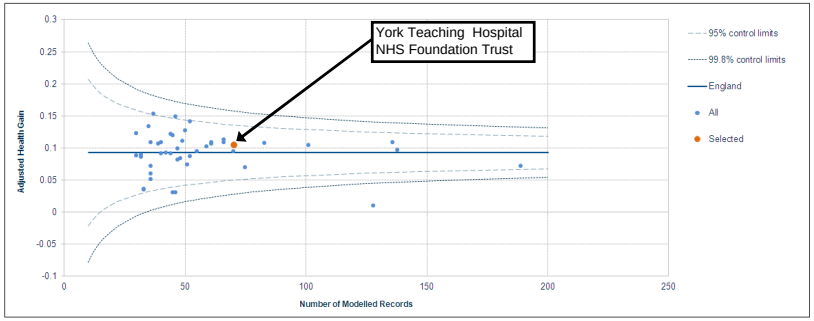


Procedure	Measure	Organisation level	Organisation name
Varicose Vein	EQ VAS	Provider	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST (RCB)

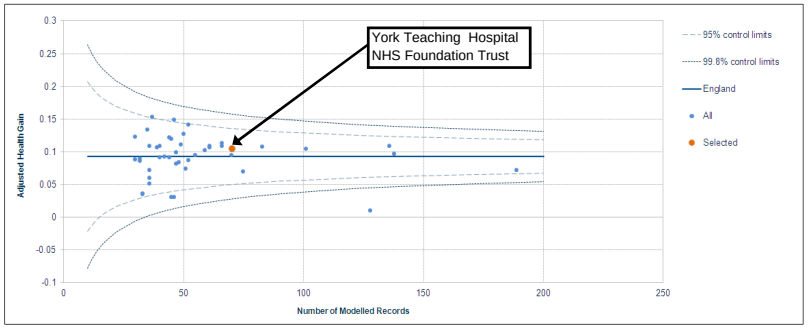


Funnel Plot – casemix-adjusted average Health Gain
April 2013 to March 2014, provisional data (published 14 August 2014)

Procedure	Measure	Organisation level	Organisation name
Varicose Vein	EQ-5D Index	Provider	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST (RCB)

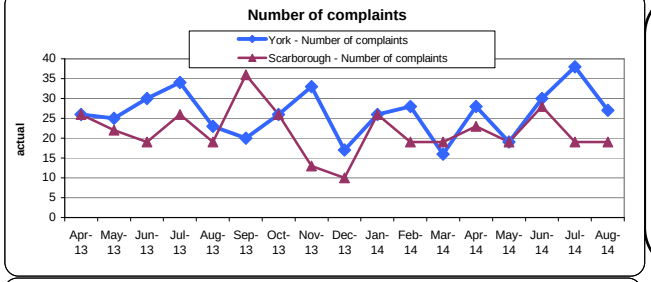


Procedure	Measure	Organisation level	Organisation name
Varicose Vein	Aberdeen Varicose Vein Questionnaire	Provider	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST (RCB)



Patient Experience Dashboard

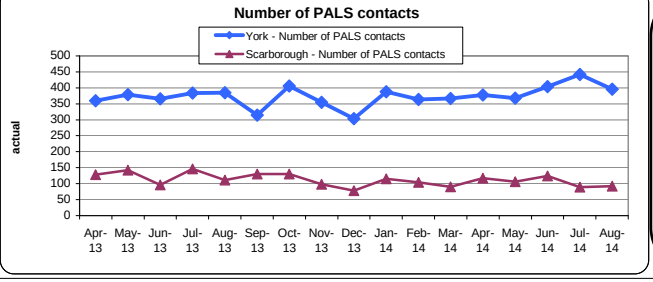
Patient Experience



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

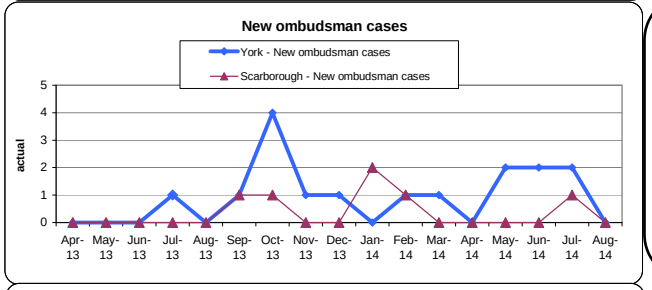
Complaints registered in Scarborough relate to Scarborough Hospital and Bridlington Hospital.

There were 27 new complaints registered to the York site and 19 to the Scarborough site in August.

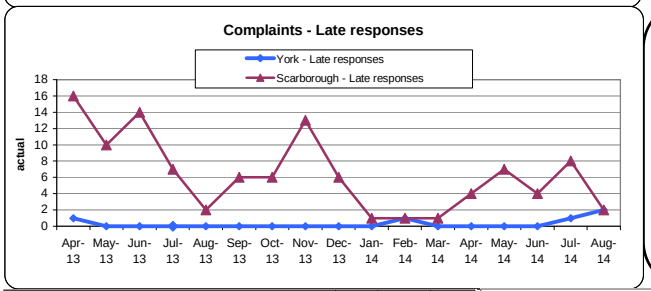


There were 396 PALS enquiries at York Hospital and 92 PALS enquiries at Scarborough in August.

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



There were no new ombudsman cases reported in August.



There was two late responses to complaints at the Scarborough site and two at the York site in August.

Late responses are defined as those complaints which do not meet the agreed response time. Complaint investigations that have been extended and agreed with the complainant are not included unless the extended deadline is not achieved.

Calculating the Net Promoter Score:

The best possible score the Trust can get is 100, where 100% of respondents are 'extremely likely' to recommend ('promoters'). The worst possible score is -100, where 100% of people are 'not likely' to recommend ('detractors'). Everyone who is 'neither likely nor unlikely', 'unlikely' or 'extremely unlikely' to recommend the ward or department counts as 'not likely'.

'Don't know' responses are disregarded when the FFT score is calculated.

People who are 'likely' to recommend are included in the calculation and are counted as 'neutral' (i.e. they are neither promoters nor detractors).

The FFT score is calculated as:

percentage of people extremely likely to recommend

minus

percentage of people not likely to recommend

Complaints by directorate/division (Datix)	York	Scar	S+Y
Child Health (Y)	0	0	0
Clinical Support Services (S)	0	0	0
Community Services (Y)	1	0	1
Corporate (Y, S)	0	0	0
Elderly Medicine (Y)	3	0	3
Emergency Medicine (Y)	1	7	8
Facilities (Y, S)	0	0	0
General Surgery & Urology (Y), Surgery (S)	3	3	6
Head & Neck & Ophthalmology (Y)	3	4	7
Medicine (General & Acute, Y), Medicine (S)	5	3	8
Obstetrics and Gynaecology (Y)	2	1	3
Orthopaedics (Y)	1	1	2
Pharmacy (Y)	0	0	0
Physiotherapy (Y)	0	0	0
Radiology (Y)	2	0	2
Sexual Health (Y)	2	0	2
Specialist Medicine (Y)	1	0	1
Theatres Anaesthetics & CC (Y)	3	0	3

Total August 2014	York	Scar	S+Y
Complaints by subject (Datix)			
Admissions, discharge and transfer arrangements	0	2	2
Aids, appliances, equipment, premises	0	0	0
All aspects of clinical treatment	25	12	37
Appointment delay/cancellation (inpatient)	0	0	0
Appointments, delay/cancellation (out-patient)	0	1	1
Attitude of staff	2	4	6
Communication/information to patients (written and oral)	0	0	0
Complaints handling	0	0	0
Consent to treatment	0	0	0
Failure to follow agreed procedure	**0**	**0**	0
Hotel services, including food	**0**	**0**	0
Mortuary and post mortem arrangements	**0**	**0**	0
Other	**0**	**0**	0
Patients' privacy and dignity	**0**	**0**	0
Patients' property and expenses	**0**	**0**	0
Patients' status, discrimination	0	0	0
Policy and commercial decision of Trust	0	0	0
Total	**27**	**19**	**46**

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

a) Communication - telephones not being answered, various depts.and no facility for enquirers to leave contact details 34259-34541-34589

b) Pain Clinic (Scarborough & Bridlington patients) 34588

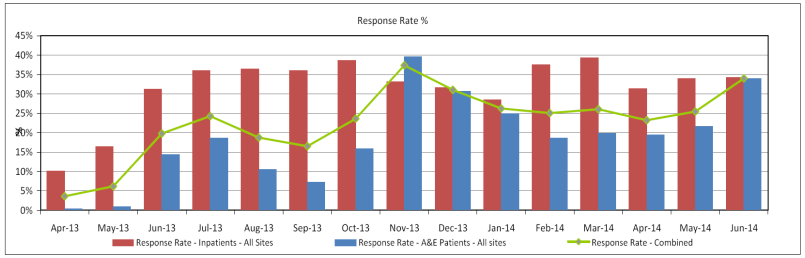
c) SGH - Concerns about attitude of staff in the Max fax clinic. Same member of staff identified and highlighted with complaints team and DM.

The Friends and Family Test
Inpatients/Maternity and the Emergency Department

The Friends and Family Test (FFT) has now been rolled out across the Trust, with all adult inpatients, those attending ED and women accessing maternity services being asked the question "would you recommend this ward/ED/antenatal/labour and postnatal service to your family and friends".The Trust achieved the CQUIN requirements for Q4 and now focuses on the 2014/15 requirments on increased response rate in ED and Inpatients; roll out to community hospital inpatients, all outpatients, day cases and community services. The FFT Steering group and project workstreams continue to meet and take forward the implementation and development of FFT across the Trust. The focus for the Trust, in addition to roll-out is to ensure that the qualitative feedback gained through FFT is used to effectively inform patients of what we are doing to improve their experience of our services. Of 855 comments for April, only 8 comments were negative. A FFT Project Manager is currently being recruited to on a fixed one year contract.

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

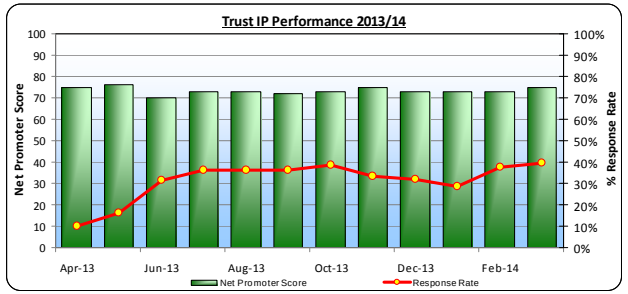
The Friends and Family Test rolled out to Community Hospital Inpatients at the beginning of May, ahead of the national roll-out date of December 2014. Reports will be produced from June 2014.

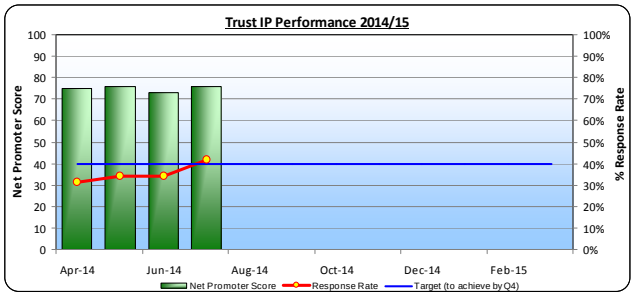


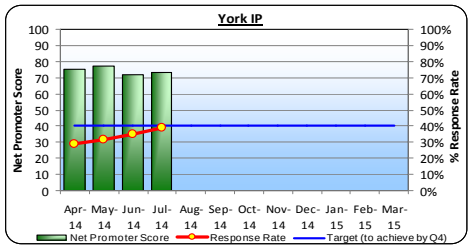
Combined Quarterly Perforamce		No. Eligible	Responses	Target	Response Rate
2013-14	Q1	30,369	2,975	15%	9.80%
	Q2	29,611	5,933	20%	20.04%
	Q3	28,098	8,550	20%	30.43%
	Q4	27,149	7,007	20%	25.81%
2014-15	Q1	29,623	8,186	n/a	27.63%

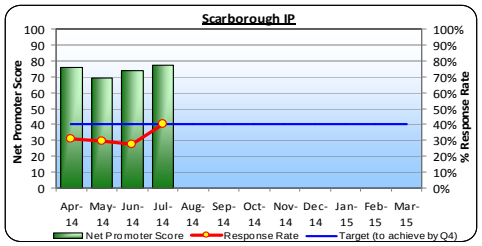
Inpatient Performance

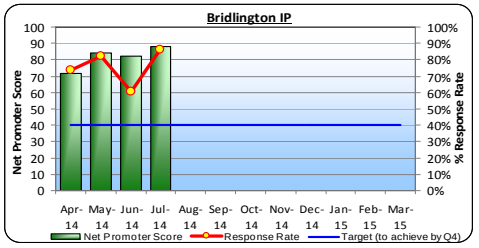
		Apr-14	May-14	Jun-14	Jul-14
Trust	Eligible patients	2988	3206	3129	3246
	Responses	936	1088	1071	1352
	Response Rate	**31.33%**	**33.94%**	**34.23%**	**41.65%**
	Net Promoter Score	75	76	73	76
York	Eligible patients	2003	2182	2153	2187
	Responses	584	686	748	852
	Response Rate	**29.16%**	**31.44%**	**34.74%**	**38.96%**
	Net Promoter Score	75	77	72	73
Sboro	Eligible patients	872	830	810	895
	Responses	269	243	222	359
	Response Rate	**30.85%**	**29.28%**	**27.41%**	**40.11%**
	Net Promoter Score	76	69	74	77
Brid	Eligible patients	113	194	166	164
	Responses	83	159	101	141
	Response Rate	**73.45%**	**81.96%**	**60.84%**	**85.98%**
	Net Promoter Score	72	84	82	88

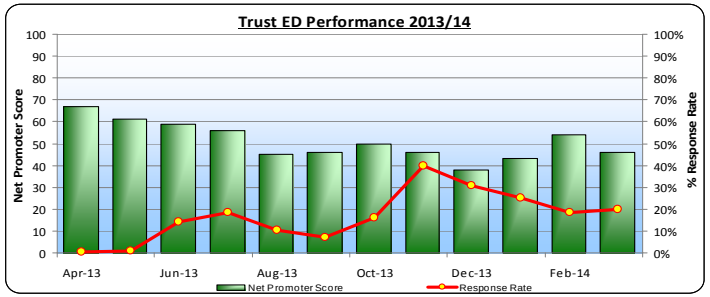






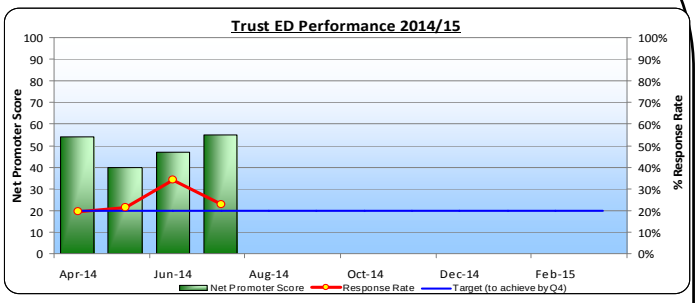


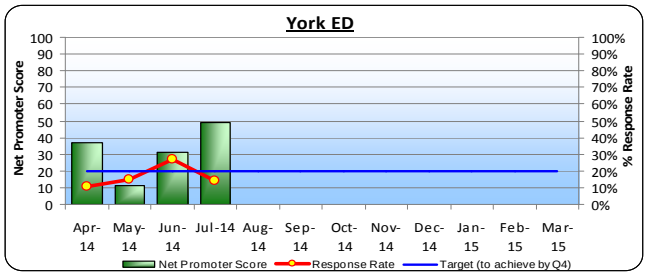


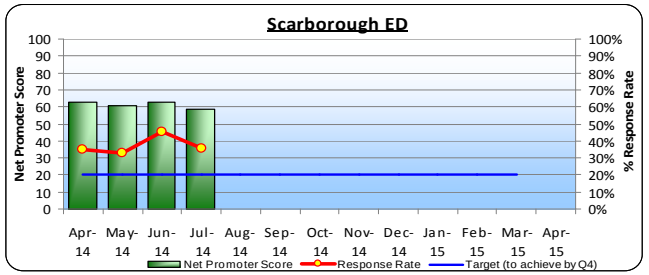


ED Performance

		Apr-14	May-14	Jun-14	Jul-14
Trust	Eligible patients	6467	6970	6863	7244
	Responses	1260	1502	2329	1650
	Response Rate	**19.48%**	**21.55%**	**33.94%**	**22.78%**
	Net Promoter Score	54	40	47	55
York	Eligible patients	4079	4356	4283	4451
	Responses	429	636	1162	647
	Response Rate	**10.52%**	**14.60%**	**27.13%**	**14.54%**
	Net Promoter Score	37	11	31	49
Sboro	Eligible patients	2388	2614	2580	2793
	Responses	831	866	1167	1003
	Response Rate	**34.80%**	**33.13%**	**45.23%**	**35.91%**
	Net Promoter Score	63	61	63	59





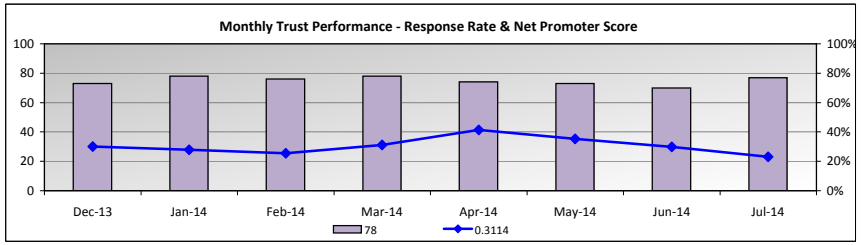


Friends and Family Test - April 2014 data				
Trust Name	**IP Response Rate %**	**IP FFT Score**	**A&E Response Rate**	**A&E FFT Score**
York Teaching Hospital NHS Foundation Trust	31	75	19.5	54
Hull & East Yorkshire Hospitals NHS Trust	39	82	14	63
Harrogate & District NHS Foundation Trust	40	75	21	60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

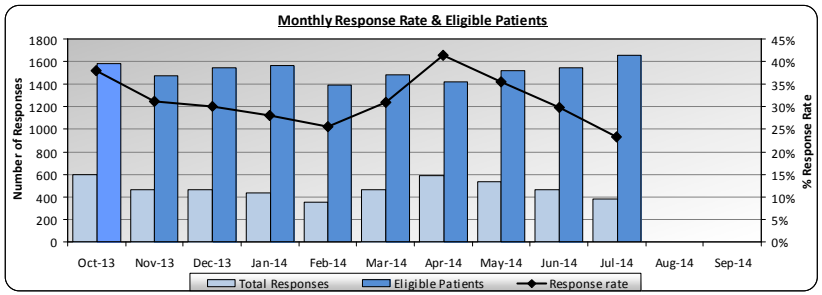
Maternity FFT

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

Trust Performance:

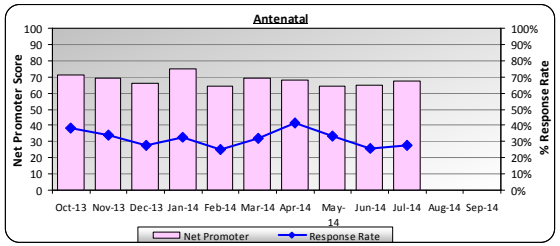


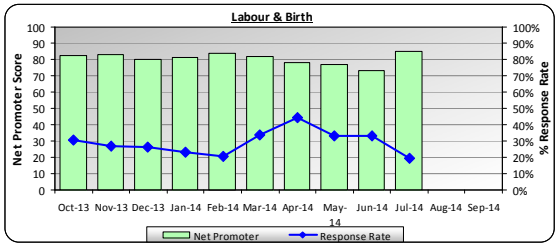
		Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14
Total	Response Rate	37.92%	31.14%	30.01%	27.93%	25.47%	31.06%	41.44%	35.39%	29.82%	23.19%
	Net Promoter	74	78	73	78	76	78	74	73	70	77
Antenatal	Response Rate	38.20%	34.06%	27.79%	32.46%	25.33%	32.11%	41.30%	33.60%	25.97%	27.65%
	Net Promoter	71	69	66	75	64	69	68	64	65	67
Labour & Birth	Response Rate	30.35%	26.76%	26.43%	22.90%	20.92%	33.50%	44.13%	33.25%	32.85%	19.41%
	Net Promoter	83	83	80	81	84	82	78	77	73	85
Postnatal	Response Rate	49.21%	34.48%	46.10%	31.27%	32.01%	38.41%	47.02%	39.23%	37.50%	24.77%
	Net Promoter	72	78	70	73	80	79	70	75	65	85
Postnatal Community	Response Rate	36.61%	29.73%	23.20%	25.75%	25.17%	20.45%	34.20%	37.22%	24.74%	21.06%
	Net Promoter	73	85	79	84	83	83	82	79	81	78

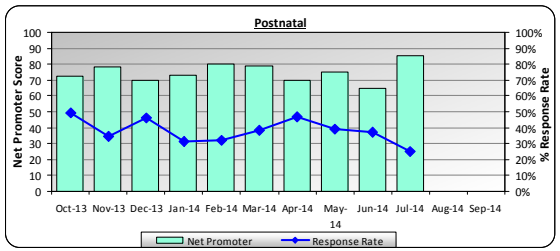


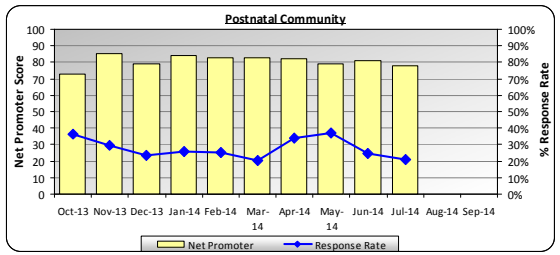
Trust Performance

Report Month	Extremely likely	Likely	Neither likely nor unlikely	Unlikely	Extremely unlikely	Don't know	Total Responses	Eligible Patients	Response rate	FFT Score
Oct-13	77.37%	19.13%	2.16%	0.83%	0.17%	0.33%	601	1585	37.92%	74
Nov-13	80.00%	17.39%	1.74%	0.43%	0.22%	0.22%	460	1477	31.14%	78
Dec-13	75.43%	21.98%	1.72%	0.65%	0.22%	0.00%	464	1546	30.01%	73
Jan-14	80.37%	17.12%	2.28%	0.23%	0.00%	0.00%	438	1568	27.93%	78
Feb-14	78.81%	18.64%	1.98%	0.00%	0.56%	0.00%	354	1390	25.47%	76
Mar-14	79.39%	18.22%	1.74%	0.22%	0.00%	0.43%	461	1484	31.06%	78
Apr-14	75.51%	22.62%	1.36%	0.34%	0.00%	0.17%	588	1419	41.44%	74
May-14	76.02%	20.07%	2.97%	0.37%	0.19%	0.37%	538	1520	35.39%	73
Jun-14	74.40%	21.69%	3.04%	0.43%	0.43%	0.00%	461	1546	29.82%	70
Jul-14	79.43%	17.97%	1.56%	0.52%	0.26%	0.26%	384	1656	23.19%	77









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

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

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

Commissioning for Quality and Innovation (CQUIN) 2014/15

The CQUIN requirements for 2014/2015 are detailed below:

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

C2

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 24 September 2014

Medical Director's Report

Action requested/recommendation

Board of Directors are asked to:

- be aware of the progress on Electronic Prescribing and Management (EPMA)
- be aware of the infection prevention control update
- support the Sign up to Safety Campaign
- support the flu programme
- be aware of the antibiotic prescribing audit results and to consider where improvements can be made.

Summary

This report provides an update from the Medical Director.

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

Implications for equality and diversity

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

Reference to CQC outcomes

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

Progress of report	This report is written for the Board of Director's.
Risk	No additional risks have been identified others than those specifically referenced in the paper.
Resource implications	None identified
Owner	Dr Alastair Turnbull, Medical Director
Author	Diane Palmer, Deputy Director of Patient Safety
Date of paper	September 2014
Version number	1

Board of Directors – 24 September 2014

Medical Director's Report

1. Introduction and background

In the report this month:

- Electronic Prescribing and Medicines Administration (EPMA)
- Infection prevention control
- Consultant appointments
- Sign up to safety
- Flu programme
- Antibiotic prescribing audit results.

2. Electronic Prescribing and Medicines Administration (EPMA)

The introduction of EPMA brings a number of benefits. These include (but are not limited to) the following:

- Improvements to patient safety:
  - Reduction in medication related adverse events
  - Reduction in severity of medication associated incidents
  - Reduction in medication related readmissions
- Enhanced anti-microbial stewardship (antibiotic prescribing) with subsequent reduction in healthcare acquired infections
- Improved management & control of medicines expenditure through enforcing Trust formulary policy / prescribing standards
- Improved efficiency of the discharge process reducing delays
- Reduced stationery costs

Progress to date:

- Project manager in post
- Early design of decision support software commenced by SNS in collaboration with First Databank
- First Databank data load completed – this underpins decision support functions
- Clinical leads recruited and early work commenced
- Regular meetings of Project Board to ensure progress and risks identified
- Significant external funding secured through National bid
- Executive Board briefed by MD of intent, progress and need for support
- Business case for supporting staff and capital expenditure submitted and approved at Trust Board (30th July)
- Statement of Planned Benefits completed and submitted to SHSW Fund: a requirement to support the funding received.
- Recruitment to supporting posts in progress – Pharmacy and admin support posts are progressing well however delays in recruitment to the nursing posts will delay progress in parts of the project

Anticipated progress in next quarter:

- Project plan / programme ratified by Project Board
    - Timescale for software to be ready for 1st stage pilot to be provided.
- Recruitment to all supporting posts for Nursing and Pharmacy
- Formulary management screens development completed
- Ward level medicines administration processes review and process improvement works
- First consultation with large number of clinicians and nurses to be underway – designed to provide information about user needs, current prescribing in particular areas and how prepared areas of the hospital are for EPMA.

3. Infection Prevention Control

C Diff - current incidence is 17 cases since April. Placing is below trajectory. Rolling programme of HPV York site complete with ongoing programme for side rooms.
No current decant facility at SGH due to Maple re-development.
Monitoring and audit of antimicrobial usage by pharmacy department.
Proposed review of all cases with complete PIR at the C Diff Operational meeting attended by Dr Turnbull, IPT, Stuart Parkes and Dr Blackmore to discuss 'avoidable and unavoidable' criteria.

MSSA – S/N Paula Wilson now in post (from ICU) seconded to Infection Prevention to follow up all central line insertion and ongoing management practice and documentation. She will educate ward staff and assist IPT audit and surveillance with data collection.

Ebola – Both ED departments fully briefed re initial activation of precautionary measures. Multidisciplinary meeting held on 21st August to discuss the wider response; this included Operations, Estates and Facilities, Communications and IPT. There is a further meeting to discuss FFP3 fit testing on 29th October. Minutes of Ebola Preparedness meeting attached.

Ebola Preparedness – the meeting took place on 21st August 2014. Items discussed were; management of a possible ebola case and the medium term organisational preparedness for current and future emerging infections.

4. Consultant appointments

Dr Andrew Martin
Consultant in Dermatology
Commenced: 18/08/2014

5. Sign up to Safety / Patient Safety Strategy

The Trust has joined the Sign up to Safety Campaign with the following pledges:

Pledge 1. **Put safety first.** Commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally.

To achieve this we will:

- Ensure that recognised strategies for reduction of mortality such as multidisciplinary ward rounds and care bundles are implemented
- Implement a system of electronic prescribing and medicines administration
- Develop the use of Post-take Check List on all of our acute wards
- Audit use of the deteriorating patient pathway
- Re-design and test the modified clinical pathway for patients with severe sepsis
- Continue to promote better management of patients with diabetes

- Reduce avoidable harm from Healthcare Associated Infection (HCAI)
- Reduce the development of pressure ulcers by 20%
- Reduce the number of patients who fall in hospital and incur severe harm.

Pledge 2. **Continually learn**. Make our organisation more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe our services are.

To achieve this we will:

- Use the information available from Friends and Family Test, PALs, formal and informal complaints and the national patient survey to identify improvements and actions
- On a monthly basis publish information relating to complaints and patients feedback
- As a commitment to developing our culture of safety undertake Patient Safety Walk Rounds and provide a monthly summary report to Executive and Trust Board of Director's
- Refine our systems for mortality review to ensure consistency in all clinical areas and community hospitals
- Use every opportunity to learn from incidents, complaints and litigation by reflecting on our practice and where necessary changing systems of work to ensure that patients are safe in our care and that repetition of avoidable harm is prevented.
- Continue to refine, improve and share learning from the Post Infection Review (PIR) process

Pledge 3. **Honesty**. Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.

To achieve this we will:

- Revise and re-launch our 'Being Open Policy' to ensure the Trust's systems and processes support a culture of transparency and openness and meet the requirements of the new Duty of Candour.

Involve patients in safety by:

- Asking them to let us know if they notice anything of concern
- Alert us to non-compliance, for example with hand hygiene
- Ensuring they are involved as much as they want to be in decisions about their care and treatment
- Ensuring that they understand what we are planning to do before consenting to treatment
- Extending the use of safety briefings
- Developing a 'Patient Safety' internet page
- Enhancing the dissemination of learning from serious incidents.

Pledge 4. **Collaborate**. Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

To achieve this we will:

- Aim to make good use of benchmarking data and peer review to support analysis and facilitate learning.
- Work with the Clinical Commissioning Unit to develop a patient passport for wound care.
- Continue to work with out partner organisations including:
  - NHS QUEST
  - Improvement Academy
  - York University
  - Global Sepsis Alliance

Pledge 5. **Support**. Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress.

To achieve this we will:

- Ensure that our clinical staff are skilled and motivated, our leaders can identify and develop

patient safety behaviours and skills and improvement in the Statutory and Mandatory training through the learning hub and enhancing Doctors training.

- Continue to encourage reporting of errors and incidents in order to learn from them; however we will not tolerate neglect or wilful misconduct.
- Continue to support the patient safety award as part of the Trust annual Celebration of Achievement Event.
- Develop a six monthly Patient Safety Report.
- Run a Trust wide annual Patient Safety Conference.

6. Flu Programme 2014/15

The annual flu vaccination programme is scheduled to start in clinical areas on October 6th. This will initially be targeted focussing on high risk areas such as ED, Theatres, Anaesthetics, Critical Care, Child Health, Acute Assessment Areas etc. It will run in parallel with general directorate walkabouts which were well received previously and the vaccine will be offered to all Trust staff from the beginning of November 2014. At present national indications are not those of a pandemic but the Trust is participating in a surveillance programme of severe influenzal infection, nationally.

Last year the Trust achieved the vaccination rate required of us although this was a slight reduction compared to previous peak performance and it is essential if possible we improve on this. In 2013/14 we operated an opt-in/opt-out programme, initially paper based and later electronic. The response rate was poor (11%), of these 75% of respondents had opted in, 25% opting out providing a variety of responses and overall the exercise probably did not help to promote the campaign. Accordingly Directors have agreed not to pursue a similar opt-in/opt-out system nor specifically to incentivise vaccination as has previously taken place. Rather, the campaign will focus on again emphasising the need for vaccination and its safety.

Figures will be reported externally using the national vaccination collection tool, providing data on four subsets – doctors, nurses, midwives and others. The Medical Director will report back to Board on progress of the vaccination campaign.

7. Monthly Antibiotic Prescribing Audit Results

% of patients on antibiotics	Jul	Aug	Sep	Oct	Nov	Dec
York Hospital	**32%**	**25%**				
Scarborough Hospital	**29%**	**30%**				

ELDERLY MEDICINE DIRECTORATE	Jul	Aug	Sep	Oct	Nov	Dec
Number of antibiotic prescriptions audited	52	52				
Antibiotic prescriptions with INDICATION	87%	81%				
Antibiotic prescriptions with DURATION / REVIEW	81%	79%				

MEDICINE DIRECTORATE	Jul	Aug	Sep	Oct	Nov	Dec
Number of antibiotic prescriptions audited	109	105				
Antibiotic prescriptions with INDICATION	87%	79%				
Antibiotic prescriptions with DURATION / REVIEW	88%	77%				

ORTHOPAEDICS & TRAUMA DIRECTORATE	Jul	Aug	Sep	Oct	Nov	Dec
Number of antibiotic prescriptions audited	20	23				
Antibiotic prescriptions with INDICATION	86%	83%				
Antibiotic prescriptions with DURATION / REVIEW	93%	61%				

GENERAL SURGERY & UROLOGY AND GYNAECOLOGY DIRECTORATES	Jul	Aug	Sep	Oct	Nov	Dec
Number of antibiotic prescriptions audited	51	69				
Antibiotic prescriptions with INDICATION	84%	68%				
Antibiotic prescriptions with DURATION / REVIEW	80%	57%				

HEAD & NECK DIRECTORATE	Jul	Aug	Sep	Oct	Nov	Dec
Number of antibiotic prescriptions audited	14	1				
Antibiotic prescriptions with INDICATION	71%	100%				
Antibiotic prescriptions with DURATION / REVIEW	79%	100%				

8. Recommendations

Board of Directors are asked to:

- be aware of the progress on Electronic Prescribing and Medicines Administration (EPMA)
- be aware of the infection prevention control update
- consider learning and dissemination from serious incidents
- support the Sign up to Safety Campaign
- support the flu programme
- consider the antibiotic prescribing audit results and where improvements can be made.

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

Blank page

C3

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors - 24 September 2014

Chief Nurse Report – Quality of Care

Action requested/recommendation

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

Summary

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

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

Implications for equality and diversity

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

Reference to CQC outcomes

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

Progress of report	Executive Board.
Risk	Associated risks have been assessed.
Resource implications	None identified.
Owner	Beverley Geary, Chief Nurse
Author	Beverley Geary, Chief Nurse
Date of paper	September 2014
Version number	Version 1

Board of Directors - 24 September 2014

Chief Nurse Report – Quality of Care

1. Key priorities

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

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

A number of key priorities and work-streams have been identified and progress continues. The Nursing Strategy Implementation Plan is currently being updated and will be presented to the Trust Board at the October 2014 meeting.
In addition, and in line with the current organisational Governance Review we are currently consulting with senior nurses across the organisation regarding the assurance of the quality of nursing care from ward to board. This will be aligned with all 4 focus areas of the Nursing and Midwifery Strategy.

2. Falls Reduction

To support the roll out and launch of the new 'Inpatient Slip, Trip and Falls' Policy, a new Falls Risk Assessment tool for inpatient units has been developed and approved. The revised policy and risk tool can assure the Trust Board of NICE compliance. A falls reduction training plan is in place. A new training programme is being developed with a planned lunch for the end of September 2014.

The revised community Falls Risk Assessment tool is in the development stage. Current measures in the community are NICE compliant.

A Falls Prevention Implementation Plan has been developed and covers the time period August 2014 to August 2015. The plan is designed to support the achievement of the Nursing and Midwifery Strategy 2013 to 2016 commitment to an overall reduction in the number of falls and the associated degree of harm. The implementation plan outlines current priorities, the action that will be taken and demonstrates progress to date.

The current Root Cause Analysis (RCA) for patient falls was developed to facilitate gathering of information prior to an RCA investigation meeting. The tool is currently being revised to ensure that it can be successfully used as an aid to support the investigation process and to supply sufficient information for use as a Serious Incident (SI) Investigation Report. To ensure wider learning across the organisation and to assure the Commissioners (Clinical Commissioning Groups) a new internal 'Falls Review Panel' will take place September 2014. This Panel will review all SI Reports (falls resulting in harm) to ensure that root causes have been recognised, learning identified and disseminated.

An analysis of SI reports is currently being undertaken to identify patient falls and any themes. Once ward areas or community teams have been identified, additional education, training and

support will be offered.

3. Workforce developments and education

Unregistered workforce:
Developing a high performance support workforce within acute care and community settings (own home & inpatient units) is so critical to maintaining sustainability within the workforce. Currently all new Health Care Assistants (HCA) must achieve within 12 weeks of commencing employment with this organisation the Cavendish standards (a set of 15 standards).

The next phase involves supporting HCA's to complete the Calderdale Framework. The Trust has secured funding for 10 members of staff to become Calderdale Facilitators. The Calderdale Framework is a transformational tool used to improve the way people work. It aims to provide a clear and systematic method of reviewing skill mix roles and service design to ensure safe and effective patient centred care.
The process of implementing the Calderdale Framework leads to the development of a competency based training programme for HCA's which assures quality and safety for the patient, whilst maximizing workforce capability.

Areas of focus:

- Community
- Allied Health care
- Acute settings

In addition, new roles for non registered nurses are being developed to include enhanced clinical skills. The programme will provide a competency based framework and assessments in clinical areas and provide a new dimension to the ward teams supporting the registered workforce – allowing them to focus more upon delivering high quality safe care. The first cohort should begin their training programme before the end of the year and be in clinical practice for winter.

My Well Run Ward
Building on the 'It's My Ward' programme for ward sisters we are developing an additional module called 'My Well Run Ward'. This module will form the next stage of the programme and is designed to allow the ward sisters to embed their previous learning. It will incorporate productive series, 15 steps, LEAN methodology, Quality & Safety Strategy, Infection Control principles and the Nursing & Midwifery Strategy key objectives. The programme is planned to be launched in November 2014.

Deputy Ward Sisters 'Call to Action – Accelerated Leadership' Programme:
In addition, we are also in the process of developing a accelerated leadership programme to support deputy ward sisters. This is aimed at band 6 deputy ward sisters using Talent Management principles and the Nursing & Midwifery Strategy key objectives. It aims to identify leadership potential, support succession planning and provide a group of senior nurses with specialist leadership skills to support teams in difficulty or areas that trigger an investigation or deep dive in to the quality of care, high staff turnover high incidents or similar. The first cohort is planned for January 2015.

Midwifery
The aims of York Midwifery workforce strategy is to work towards achieving an overall midwife to birth ratio of 1:28 (as recommended in Safer Childbirth document) and also to have the right staff in the right place for our specific areas needs which are unique to this Trust (MLU, Whitby community etc.)

Our current ratio is 1:29 for York Maternity.

We are implementing Maternity support workers in the Community teams in support of the midwife role and to help release midwifery time and we are looking at different ways of working for example the way in which we run postnatal clinics; to again release midwifery time in travel (these have been well received and are successful in most teams)

The purpose of the workforce strategy is to look at the specific requirements in all areas of our service to achieve safe staffing levels and one to one care where required (in labour etc.) To aid this work this we have recently purchased an acuity tool specifically designed for the Labour Wards, the audit began in August last month and have restructured Community caseloads using guidance for the Birthrate plus document.

Nursing Recruitment

Significant focus continues on nursing recruitment (both registered and unregistered) with one stop shop events planned over the coming months. Whilst a number of newly qualified nurses are due to take up post in September and October it is anticipated that the number of vacancies will present us with staffing difficulties in the event of an escalation area being opened (as part of our winter resilience and business continuity plans.) Given the difficulties' nationally and the lack of availability of registered nurses we are now considering overseas recruitment and have approached partners at North Lincolnshire and Goole Hospitals to explore the feasibly of a joint campaign. The board will be updated regarding the progress of this initiative in future reports.

4. Care Quality Commission (CQC) Nursing Action Plan

New CQC legislation is likely to come into effect in October 2014 (new CQC regulatory standards). All Acute providers will have a full regulatory inspection by December 2015. The inspection programme covering the period October 2014 to December 2015 has been announced (York Teaching Hospital NHS Foundation Trust is not included in this time period).

The new inspection programme involves a level of scrutiny that has not been experienced before and in order to support Nursing staff; who are likely to be questioned at length by inspectors, an action plan is being developed. The purpose of the action plan is to ensure that mechanisms are in place to assure the Board that nurses are providing safe, effective, compassionate and high quality care.

To get to the heart of patients experiences of care the following five questions are asked of every service	**Following services will be inspected:**
1. Is it safe 2. Is it effective 3. Is it caring 4. Is it responsive to people's needs 5. Is it well led	• Accident and Emergency • Medical Care (including older people's care) • Surgery • Intensive / critical care • Maternity and family planning • Services for children and young people • End of life care • Outpatients

A scoping exercise is being undertaken to identify key nursing issues and will form part of the wider organisational action plan that is being developed in readiness for the new CQC inspection.

5. Patient experience

Staff FFT

The Trust launched the Staff FFT during Quarter 1 (Q1) for a 2-month period via an on-line survey and postcard solutions. In both cases, the user was required to use a password, which was their

employee number. The reason for this was to ensure there were no duplicate entries as well as enabling us to receive analysis on the responses received at a trust and directorate level to help make improvements locally.

Key findings:

- We received an 8% response rate to the survey (674) for Q1; the majority of responses were completed on-line.
- The responses to the survey were mainly positive: 80% of staff were 'extremely likely' or 'likely' to recommend the Trust as a place to receive care or treatment, with 75% that were 'extremely likely' or 'likely' to recommend the Trust as a place to work.
- The top two staff groups that responded to the survey were Admin & Clerical (49%) and Nursing & Midwifery (24%).
- Similarly, the top Directorates that responded to the survey were Systems and Network Services (10%), Women's Health (8%), Human Resources (7%), and Finance (7%).

Detailed comments and results from the survey have been sent to Directorates so that they can share with their teams and feed into any current actions around other initiatives such as the National Staff Survey.

We recognise that the number of responses received were partly hindered by the requirement to use employee numbers as a password as staff didn't always have this to hand or were concerned about the anonymity of the survey. In response to concerns about using the employee number we are going to trial for Q2 asking staff to select their Directorate and Staff Group rather than their employee number to see if this improves the response rate. This will hopefully still provide us with useful quantitative and qualitative data at a Directorate level to support any improvements or changes.

The survey for Q2 will be launched on 1 September, after the summer holiday period for 3 weeks via an on-line open questionnaire only.

FFT

NHS England has issued new guidance in relation to the gathering of information for the patient FFT and from April 2015 the token system used in the Emergency Departments will be withdrawn. Work continues locally to address the current low response rate ant the York site and an initiative to introduce a texting service has begun and a pilot will begin in September in York ED.

Complaints review

As a result of the recent Patient Experience Team review we are planning changes to the way in which we respond to complaints. Once the new approach has been agreed training in investigation techniques and complaints response will begin.

In addition, changes to the patient information supplied by the team and at ward level are currently underway. It is anticipated that the current leaflets will all rewritten and combined into one '*Tell us your Experience'* document which will advocate early resolution, signpost to other services and also collect patient experience. We are developing this in collaboration with other partners and involving patients to ensure involvement with all parties.

The new document will be introduced following approval by the Patient Experience Steering Group (PESG).

Kay Gamble has been appointed as the new Lead for Patient Experience and commenced her new role on 1st September. Kay will be instrumental in implementing the recommendations from the patient experience review and also developing the new Patient Experience Strategy.

6. Recommendation	
The board is asked to receive the update report and current work-streams of the Chief Nurse Team for information.	
Author	**Beverley Geary, Chief Nurse**
Owner	**Beverley Geary, Chief Nurse**
Date	**September 2014**

C4

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 24 September 2014

Staffing Exception Report

Action requested/recommendation

The Board are asked to receive the exception report for information

Summary

The Board of Directors are aware that from May 2014 all organisations are required to report actual versus planned staff in public. This is the forth submission to NHS choices of data of actual against planned staffing for day and night duty in hours; by ward.

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

Implications for equality and diversity

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

Reference to CQC outcomes

Outcome 13

Progress of report

Risk

Resource implications	Potential resources implications where staffing falls below planned or where acuity or dependency increases due to case mix.
Owner	Beverley Geary, Chief Nurse
Author	Beverley Geary, Chief Nurse
Date of paper	September 2014
Version number	Version 1

Board of Directors – 24 September 2014

NHS Choices Nurse Staffing return:

1. Introduction and background

The Board of Directors are aware that from May 2014 all organisations are required to report actual versus planned staff in public. This is the forth submission to NHS choices of data of actual against planned staffing for day and night duty in hours; by ward.

As previously reported work continues to refine the reports in order to give an accurate reflection of the staffing levels on a shift by shift basis. As a result we have continued to base the return on the average bed occupancy rates by ward at 12 midday and 12 midnight, given that the staffing establishment is set on the number of beds on each ward; taking bed occupancy rates into consideration gives a more precise reflection of the safety of the staffing levels. Further work continues to further refine and simplify the process and also to give the greatest accuracy in order that the Board are assured that all areas are staffed appropriately and safely.

A detailed breakdown is attached at appendix 1.

2. High level data by site

		Day		Night	
Site Code	**Site Name**	**Average fill rate - registered nurses /midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses /midwives (%)**	**Average fill rate - care staff (%)**
RCBAW	Archways Intermediate Care Unit	101.8%	96.1%	116.5%	102.4%
RCBNH	Bridlington And District Hospital	125.3%	115.9%	154.8%	131.6%
RCBL8	Malton Community Hospital	134.6%	108.4%	115.0%	115.0%
RCBCA	Scarborough General Hospital	87.0%	88.6%	105.7%	114.5%
RCB07	Selby And District War Memorial Hospital	79.8%	97.5%	105.5%	101.0%
RCBTV	St Helens Rehabilitation Hospital	89.5%	97.0%	106.3%	106.3%
RCB05	St Monicas Hospital	114.4%	79.6%	106.4%	102.7%
RCBG1	Whitby Community Hospital	79.0%	78.0%	81.5%	85.4%
RCBP9	White Cross Rehabilitation Hospital	101.3%	111.5%	106.1%	123.5%
RCB55	York Hospital	97.0%	99.9%	114.9%	126.9%

3. Exceptions

<u>Scarborough Site</u>

- Beech reported fill rates as 76.1% and 76.6% for RNs and HCAs respectively. There are a large number of vacancies in addition to 2 maternity leave and sickness is above the Trust

threshold.

- ITU care staff fill rate is 57.6% due to a vacancy. Due to the specialised nature of the unit, the shifts are not covered with bank staff.
- Maple reported 78.9% care staff due to vacancies and maternity leave
- Ash is reported as 70.4% and 71.4% due to 2 vacancies, although there is still no agreed establishment as the business case remains unfunded.
- Haldane are reporting 77.1% for registered nurses due to vacancies, long term sickness & maternity leave.
- Chestnut ward registered nurse fill rate 77.9% as 3.3 RN vacancies in addition to short term sickness
- CCU RN fill rate 77.0% due to 8.34 vacancies
- Hawthorne - 66.2% and 59.6% fill rate was due to an efficiency gained through working long days.
- Duke of Kent report high fill rates of 173.3% and 167.1% due to low activity.

Bridlington Site

- Kent ward fill rate was 169.8% and 183.3% for RNs and HCAs respectively. This was due to low occupancy, with the ward closing for 4 days. Staff were re-deployed to other areas.
- Lloyd ward is reported as 79.5% 67.2% due to reduced activity. Staff have been redeployed to other areas as required. They also carry a vacancy.

York Site

- 32, 34, 28, 37 all had patients that required 1:1 supervision due to risk factors and therefore are above
- G3 have a number of new starters and are undertaking a period of supernumery status, in addition the Sisters are also working additional hours to supervise the new starters. It is anticipated that this will continue over the next few months due to the
- Extended Stay area this is showing considerable over planned staffing. This is due to planned additional sessions (waiting list initiatives) and the areas being open for longer periods of time.

White Cross Court

Accelerated improvement work continues therefore additional staff are continuing to be deployed at night.

Actions and Mitigation of risk

At least daily staffing meeting are taking place to deploy staff to high risk areas. Where there is low activity (for example Duke of Kent) these staff are moved to other wards in order to improve levels.

4. Recommendation

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

5. 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

Author	**Beverley Geary, Chief Nurse**

Owner	**Beverley Geary, Chief Nurse**
Date	**September 2014**

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

Org: RCB York Teaching Hospital NHS Fc

Period: August_2014-15

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

(Please can you ensure that the URL you attach to the spreadsheet is correct and links to the correct web page and include 'http://' in your URL)

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

Validation alerts (see control panel)	Only complete sites your organisation is accountable for	Hospital Site Details		Ward name	Main 2 Specialties		Day				Night				Day		Night	
							Registered		Care Staff		Registered		Care Staff					
		Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
			YORK HO	11	100 - GENERAL SURGERY	101 - URO	1640.419	1576.18	985.5484	776.59	617.9333	673.25	617.9333	601.75	96.1%	78.8%	109.0%	97.4%
			YORK HO	14	100 - GENERAL SURGERY	101 - UROLOGY	1738.125	1636.5	1158.75	943.75	892.9688	1020.5	595.3125	713	94.2%	81.4%	114.3%	119.8%
			YORK HO	15	120 - ENT	101 - UROLOGY	1480.408	1625.5	1110.306	1101.5	828.3093	946	276.1031	363	109.8%	99.2%	114.2%	131.5%
			YORK HO	16	100 - GENERAL SURGERY		2155.912	1913.5	922.0668	898	1231.768	1232	573.4093	558.92	88.8%	97.4%	100.0%	97.5%
			YORK HO	17	420 - PAEDIATRICS		474.3	1226.42	316.2	485.5	374.8966	1019	0	0	258.6%	153.5%	271.8%	-
			YORK HO	23	430 - GERIATRIC MEDICINE		1928.414	1353.25	1205.259	1308	743.4983	651	743.4983	824.25	70.2%	108.5%	87.6%	110.9%
			YORK HO	25	430 - GERIATRIC MEDICINE		1617.6	1470	1011	873.83	611.8	651	611.8	642	90.9%	86.4%	106.4%	104.9%
			YORK HO	26	430 - GERIATRIC MEDICINE		1825.556	1519.32	1140.972	1097.51	689.2333	630	689.2333	693.67	83.2%	96.2%	91.4%	100.6%
			YORK HO	28	110 - TRAUMA & ORTHOPAEDICS		1806.251	1648.39	1003.473	1149.5	592.6529	647	592.6529	764.5	91.3%	114.6%	109.2%	129.0%
			YORK HO	29	110 - TRAUMA & ORTHOPAEDICS		1061.739	1096.25	530.8696	621.75	389	619.5	194.5	252	103.3%	117.1%	159.3%	129.6%
			YORK HO	31	370 - MEDICAL ONCOLOGY		1917.794	1617.25	852.3529	732.5	658.8824	652.67	329.4412	336.83	84.3%	85.9%	99.1%	102.2%
			YORK HO	32	320 - CARDIOLOGY		2022.509	1615.5	1348.339	1334	694.0854	682.75	694.0854	878	79.9%	98.9%	98.4%	126.5%
			YORK HO	33	301 - GASTROENTEROLOGY	361 - NEPHROLOGY	2123.387	1201.25	1592.54	1316	810.9695	588.17	810.9695	817.17	56.6%	82.6%	72.5%	100.8%
			YORK HO	34	340 - RESPIRATORY MEDICINE	301 - GASTROENTEROLOGY	1829.256	1493	1371.942	1322.75	690.3251	701.5	690.3251	851.75	81.6%	96.4%	101.6%	123.4%
			YORK HO	35	430 - GERIATRIC MEDICINE		1722.387	1493	1076.492	1214	685.6109	640.5	685.6109	777	86.7%	112.8%	93.4%	113.3%
			YORK HO	36 - Acute Stroke Unit	430 - GERIATRIC MEDICINE		1562.147	1605	976.3416	911.25	872.7266	920.75	581.8177	600.67	102.7%	93.3%	105.5%	103.2%

	YORK HO	37	430 - GERIATRIC MEDICINE		1375.714	1148.5	1605	1812.5	708.619	643	708.619	1280.92	83.5%	112.9%	90.7%	180.8%
	YORK HO	39	430 - GERIATRIC MEDICINE		1361.842	1079.75	1134.868	1087.25	708.1579	609.5	354.0789	469.83	79.3%	95.8%	86.1%	132.7%
	YORK HO	Acute Medical Unit	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	2399.4	1977.25	1999.5	1623	1390.35	1456.42	1112.28	1142.5	82.4%	81.2%	104.8%	102.7%
	YORK HO	Coronary Care Unit	320 - CARDIOLOGY		1506.6	1541.42	188.325	117	1145.76	1257	0	0	102.3%	62.1%	109.7%	-
	YORK HO	Extended Stay Area	100 - GENERAL SURGERY	120 - ENT	252	789.32	126	357.08	78.2	320	0	0	313.2%	283.4%	409.2%	-
	YORK HO	Intensive Care Unit	192 - CRITICAL CARE MEDICINE		3682.8	3802	334.8	191.5	2983.75	3168	271.25	77	103.2%	57.2%	106.2%	28.4%
	YORK HO	Short Stay Ward	300 - GENERAL MEDICINE		1785.6	1359.83	1339.2	1329.34	663.09	673.34	663.09	728.84	76.2%	99.3%	101.5%	109.9%
	YORK HO	G1	502 - GYNAECOLOGY		1455	1495.17	727.5	731.67	550.56	647	275.28	462	102.8%	100.6%	117.5%	167.8%
	YORK HO	G2	501 - OBSTETRICS		1590	1237.5	795	534	655.96	681	327.98	601.25	77.8%	67.2%	103.8%	183.3%
	YORK HO	G3	501 - OBSTETRICS		510	854.5	255	346.5	349.37	646	0	11	167.5%	135.9%	184.9%	-
	ARCHWA	Archways	925 - COMMUNITY CARE SERVICES		883.5	783.5	1104.375	1028.25	345.805	356.5	691.61	670	88.7%	93.1%	103.1%	96.9%
	MALTON (	Fitzwilliam	925 - COMMUNITY CARE SERVICES		864.9	1027.67	1513.575	1495.83	634.26	683	634.26	659	118.8%	98.8%	107.7%	103.9%
	SELBY AN	Inpatient Unit	925 - COMMUNITY CARE SERVICES		953.25	891.59	953.25	1103.51	283.03	354.51	566.06	629.66	93.5%	115.8%	125.3%	111.2%
	ST HELEN	St Helens	430 - GERIATRIC MEDICINE		874.2	778.5	1092.75	1034	331.3125	356.58	331.3125	356.5	89.1%	94.6%	107.6%	107.6%
	WHITBY C	War Memorial	925 - COMMUNITY CARE SERVICES		1004.4	787.5	1506.6	1062.08	412.92	352	825.84	682	78.4%	70.5%	85.2%	82.6%
	WHITBY C	Abbey	925 - COMMUNITY CARE SERVICES		655.65	660.5	1092.75	1091.5	353.4	341	353.4	340	100.7%	99.9%	96.5%	96.2%
	BRIDLING	Johnson	430 - GERIATRIC MEDICINE		988.125	949.17	1383.375	1286.83	620.31	587.66	310.155	324.51	96.1%	93.0%	94.7%	104.6%
	BRIDLING	Kent	110 - TRAUMA & ORTHOPAEDICS		511.5	868.75	409.2	750.08	178.25	409	0	94.5	169.8%	183.3%	229.5%	-
	BRIDLING	Waters	430 - GERIATRIC MEDICINE		1069.5	1028.5	1069.5	1016.67	663.09	630	331.545	336	96.2%	95.1%	95.0%	101.3%
	ST MONIC	St Monicas	925 - COMMUNITY CARE SERVICES		446.25	529.33	675.75	602	316.2	347	316.2	371	118.6%	89.1%	109.7%	117.3%
	SCARBOR	Ann Wright	430 - GERIATRIC MEDICINE		1297.35	1190.5	1081.125	1157.92	620.62	682	310.31	605	91.8%	107.1%	109.9%	195.0%
	SCARBOR	Ash	100 - GENERAL SURGERY		1104.375	777.5	883.5	631.25	463.45	418.75	0	21	70.4%	71.4%	90.4%	-

	SCARBOR	Beech	300 - GENERAL MEDICINE		1804.2	1372.96	1578.675	1209.83	1082.52	747.5	721.68	561	76.1%	76.6%	69.1%	77.7%
	SCARBOR	Cherry	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	1860	1797	1488	1310.5	1220.238	1390.5	976.19	1257.5	96.6%	88.1%	114.0%	128.8%
	SCARBOR	Coronary Care Unit	320 - CARDIOLOGY		2480.775	1909.42	451.05	365.75	1309.44	1221	327.36	324.75	77.0%	81.1%	93.2%	99.2%
	SCARBOR	Chestnut	301 - GASTRO ENTEROLOGY	300 - GENERAL MEDICINE	1860	1448.42	1395	1155.83	721.215	680.75	721.215	719	77.9%	82.9%	94.4%	99.7%
	SCARBOR	Duke of Kent	420 - PAEDIATRICS		762.6	1321.75	190.65	318.5	290.16	714.83	145.08	308	173.3%	167.1%	246.4%	212.3%
	SCARBOR	Maple	100 - GENERAL SURGERY		2069.25	1704.91	1448.475	1142.62	1145.76	1092.08	572.88	592.58	82.4%	78.9%	95.3%	103.4%
	SCARBOR	Haldane	100 - GENERAL SURGERY	502 - GYNAECOLOGY	1353.15	1043.51	1127.625	964.83	670.22	640.5	335.11	336	77.1%	85.6%	95.6%	100.3%
	SCARBOR	Holly	110 - TRAUMA & ORTHOPAEDICS		1353.15	1161.75	1127.625	1172.5	670.22	650	670.22	630	85.9%	104.0%	97.0%	94.0%
	SCARBOR	Intensive Therapy Unit	192 - CRITICAL CARE MEDICINE		1897.2	1532	316.2	182	1298.125	1503	0	0	80.8%	57.6%	115.8%	-
	SCARBOR	Oak	430 - GERIATRIC MEDICINE		1822.8	1684.67	1594.95	1885	691.61	913.5	691.61	943.75	92.4%	118.2%	132.1%	136.5%
	SCARBOR	Stroke	430 - GERIATRIC MEDICINE		1692.6	1495.75	846.3	806.5	1015.56	979	338.52	297	88.4%	95.3%	96.4%	87.7%
	SCARBOR	Hawthorn	501 - OBSTETRICS		1143.9	757.5	571.95	341	736.715	713	0	287.75	66.2%	59.6%	96.8%	-
	BRIDLING	Lloyd	100 - GENERAL SURGERY		900	715.41	129.375	87	90	31.5	90	31.5	79.5%	67.2%	35.0%	35.0%
	WHITE CR	Whitecross Court	430 - GERIATRIC MEDICINE		660.3	768	825.375	1001.35	506.23	623.5	253.115	347.5	116.3%	121.3%	123.2%	137.3%

York Teaching Hospital NHS Foundation Trust

Board of Directors – 24 September 2014

End of Life Care Annual Report

Action requested/recommendation

The Board is asked to note the report.

Summary

Around half of all deaths in England occur in hospitals. It is therefore a core responsibility of hospitals to deliver high-quality care for patients in their final days of life and appropriate support to their families, carers and those close to them. Although the Specialist Palliative Care Teams on both sites lead on the majority of the organisational aspects of End of Life Care, the delivery of such care is the responsibility of every member of Trust staff.

In recognition of this York Teaching Hospital has appointed a Non Executive Director, Professor Dianne Willcocks to work closely with the senior medical and nursing staff leading on End of Life Care within the Trust and to provide a valuable link between Trust Board and the clinical teams providing End of Life Care. Following the initial meeting in July 2014 it has been agreed that this group '*End of life leads'* will provide annual and quarterly reports on key organisational issues affecting End of Life Care to the Health and Safety committee and the Trust Board. The annual report will be provided in March each year and summarise the preceding year.

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

Implications for equality and diversity

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

belief, gender and sexual orientation).

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

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	This report was written for the Board of Directors only.
Risk	No risk.
Resource implications	No resource implications.
Owner	Dr Alastair Turnbull, Medical Director
Author	Karen Cowley, Directorate Manager for Specialist Medicine
Date of paper	September 2014
Version number	Version 1

Board of Directors – 24 September 2014

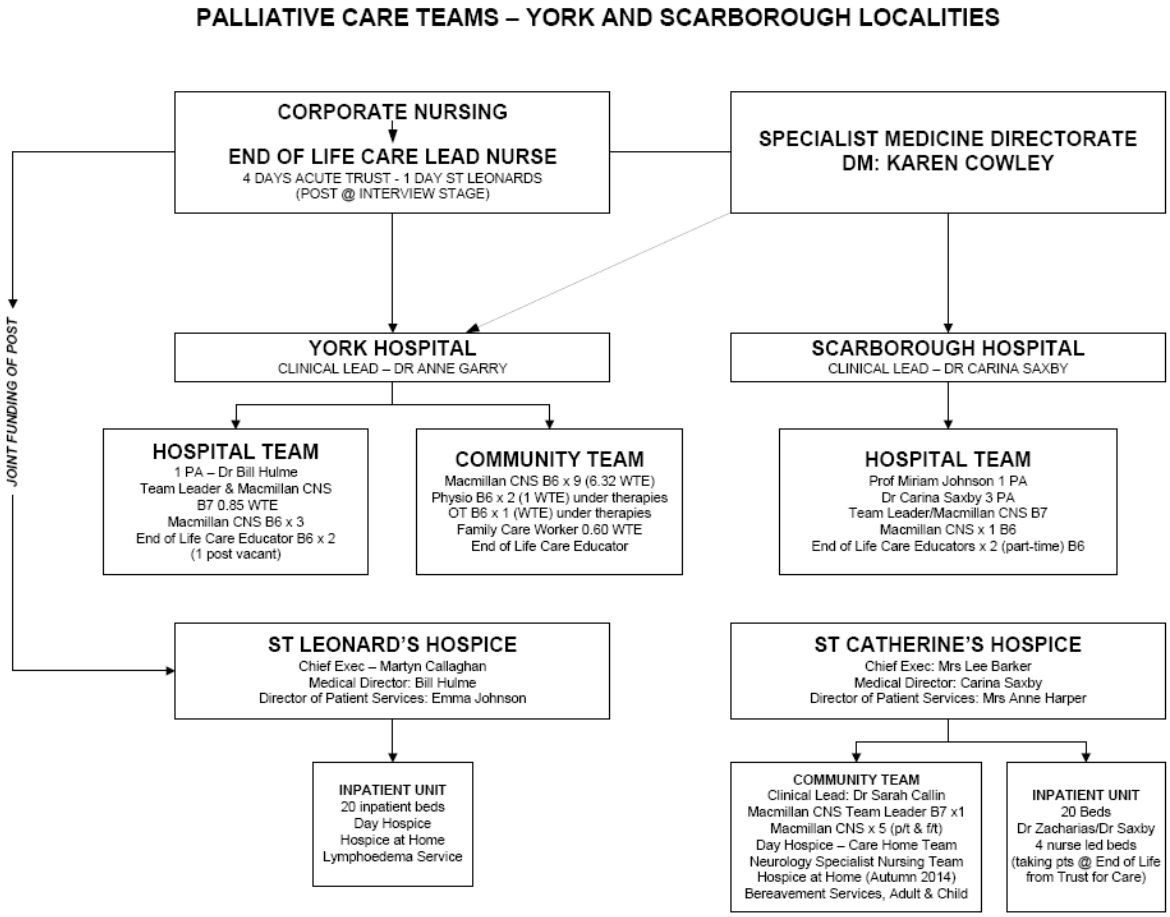
End of Life Care Annual Report

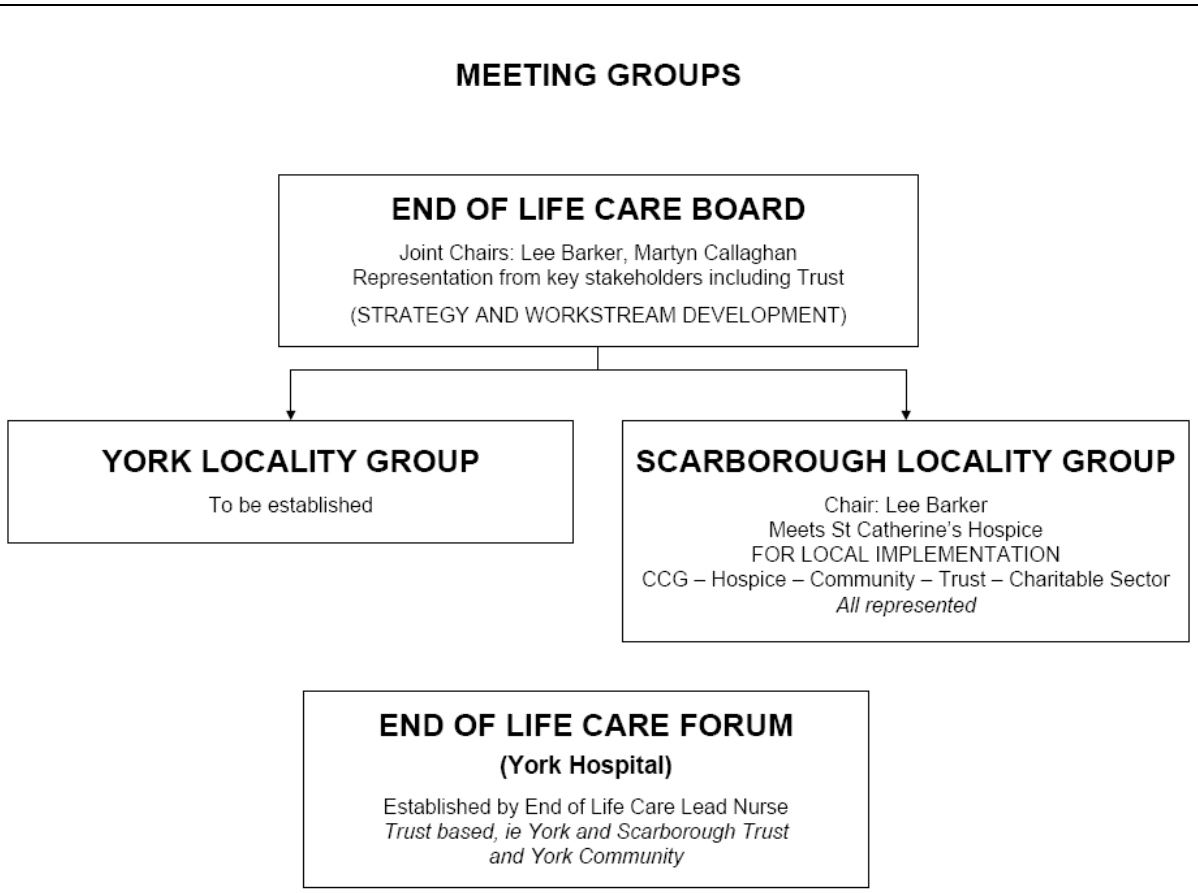
1. Introduction and background

Around half of all deaths in England occur in hospitals. It is therefore a core responsibility of hospitals to deliver high-quality care for patients in their final days of life and appropriate support to their families, carers and those close to them. Although the Specialist Palliative Care Teams on both sites lead on the majority of the organisational aspects of End of Life Care, the delivery of such care is the responsibility of every member of Trust staff.

In recognition of this York Teaching Hospital has appointed a Non Executive Director, Professor Dianne Willcocks to work closely with the senior medical and nursing staff leading on End of Life Care within the Trust and to provide a valuable link between Trust Board and the clinical teams providing End of Life Care. Following the initial meeting in July 2014 it has been agreed that this group '*End of life leads'* will provide annual and quarterly reports on key organisational issues affecting End of Life Care to the Health and Safety committee and the Trust Board. The annual report will be provided in March each year and summarise the preceding year.

2. Organisational Structure of Specialist Palliative Care Teams





3. Liverpool Care Pathway – National and Trust Response

(See flow chart appendix)

The Specialist Palliative Care teams have produced an individualised care plan which will be rolled out across all wards and introduced to the community settings in September 2014. A baseline audit has been performed prior to its launch and a follow up audit is planned for 4-6 months time after which amendments to the care plan will be made if required. The Trust has enrolled in a Research project, "Family's Voice", to compliment the role out of the care plan. It offers relatives the opportunity to complete a feedback sheet daily (or more frequently of they prefer) commenting on how comfortable they feel their loved one is and whether there are any issues they wish to raise with medical and nursing staff. It is part of a national study and has been well received to date by relatives in other areas of the country where the study is already in progress.

4. National Care of the Dying Audit 2013/14 Published May 2014

This audit, which occurs every two years led by the Royal College of Physicians and Marie Curie Cancer Care, reports on organisational and clinical KPI's. The organisational KPI's, our results and action plans are set out below. Each hospital site has participates individually so that site specific issues can be identified more clearly

Description	National % of trusts that achieved KPI	Achieved Yes/No Scarborough	Achieved Yes/No York	Action Plan
Access to information relating to death and dying	41%	No	No	Relates to the provision of 5 specific leaflets. All 5 available in trust but only 4 routinely given out as 1

				given out by registrar rather than ward. To discuss with registrar about ward provision of leaflet need to task each team to discuss this
Access to specialist support for care in the last days of life	21%	No	No	National recommendations are that patients should have access to Specialist Palliative Care face to face assessments 7 days a week 9-5 and 24/7 telephone support advice. End of life nurse exploring option analysis to support 7 day working
Care of the dying; continuing education, training and audit	40%	No	?	End of life care facilitators now in post (MPET funded) with formalised education programme. End of life care now part of mandatory training for nursing staff Areas to be addressed • Medical staff training • Communications skills for all staff • Substantive funding for EofL facilitators MPET funds end 2015
Trust Board representation and planning for care of the dying	28%	No	No	Now achieved. Prof Dianne WIllcocks is NED lead on Trust Board with quarterly and annual reports from End of Life Care group and Medical Director via Quality and Safety Committee
Clinical Protocols for the prescription of medications at the end of life	98%	Yes	Yes	Continue to be available on ward or as part of individual EofL care plan
Clinical provision/protocols promoting privacy, dignity and respect up to and incl after death of patient	34%	No	No	Failed because of absence of pathway or care plan to allow for clear documentation of a MDT decision making process for diagnosing dying – this will be in place from Sept 2014. All other components fulfilled *(check this is same for York)* this is the same
Formal feedback processes regarding bereaved relatives views of care delivery	34%	No	No	This will be incorporated as "real time" feedback from relatives by using "Family's Voice" project along with care plan. *To decide whether this is adequate as wont capture views of carers if patients were not on care plan – think need to consider doing bereavement follow up- 1 month a year*

5. Education

The education work stream has been supported through Multi-professional Education and Training (MPET) funding via Health Education England. These funds have been spent on additional educational support in both the hospital and community. The funding for these posts expires in 2015 in the community and acute services. All audits required by HEE to secure the ongoing funding have been submitted and provided a baseline. There are regular meetings with the LETB team to provide support and guidance.

Prior to the conclusion of the funding for the educator posts, a business case is needed to continue the excellent work started to support these posts in becoming substantive. The funding received has been used to support education in relation to DNA CPR, advance care planning, AMBER care bundle (York), know your 1% (Scarborough) and the last days of life care plan following the removal of the Liverpool Care Pathway (LCP).

A local education strategy is under development to provide a clear acknowledgement of roles and responsibilities. Action and implementation plans have been devised. An over arching plan for education will be informed by the locally developed end of life strategy, helping to maximize productivity with existing resource and secure high standards of care throughout.

6. Initial Statistics

Since June 2013, **458** staff at York acute trust attended end of life care training. 46% of whom are nurses and 34% HCA's.

In the first year 40**%** of nursing staff completing end of life training in Scarborough and Bridlington has been achieved. A small number of allied health professionals have also attended the training days. The Community End of Life Care Educator has held education sessions in different community settings providing training to 30% of the community workforce.

The training will continue to address the difficulties faced in the last days of life, recognising the guidance from the One Chance (2014) and Neuberger report (2013) which requires health providers to improve on education within end of life care across their organisations. Benefits of the training are being witnessed when a ward has had 50% or more of their staff attend the education day.

The plan is to continue to provide a high level of education for all staff and evaluate knowledge and skills 6 months after to ensure the impact of training is measured.
In order to progress end of life care training over the next 12 months we plan to continue to target all disciplines, but wish to identify specific figures for nursing and healthcare staff. The educators are working together to ensure the overarching themes are being met on all sites. We plan to address end of life education for medics. This year the teams have worked with the deanery to provide ½ day education for the F1 and F2 doctors. Training is vital in order to improve the care of the dying and respond to the findings of the Neuberger report (2013).

7. Other initiatives:

AMBER

The AMBER care bundle has been devised by Guys and Thomas in London, helping staff to identify patient's where recovery is uncertain. This tool has shown to reduce length of stay

and cost in a number of organizations whilst also identifying the need to conduct appropriate conversations regarding DNA CPR and advance care planning. This tool has been implemented on 3 wards within the organization at York as part of the agreement for MPET funds. This is supported by face to face ward teachings for consultants, junior doctors and nursing staff.

Shared information

The End of life Care Strategy (2008) identified the need to improve the co-ordination of care, recognising that people at the end of life frequently received care from a wide variety of teams and organisations. The developments of Locality Registers (now Electronic Palliative Care Co-ordination Systems known as EPaCCS) were identified as a mechanism for enabling coordination.

Without a robust end of life data collection achieving shared information with our other health partners is not currently achievable. The team has liaised with the IT team to define what data is essential to record and how this could be collated. Due to the massive current demand on the IT services, development of this is measured.

The aim will be to ensure data can be pulled through to provide information at discharge to the relevant provider of care, aiming to keep the patient wishes at the core of the care.

CQC

End of life care is now one of the key domains that the CQC will examine and report on when they visit. The specialist palliative care teams are working with their End of Life facilitators to identify key areas that all clinical and support staff need to be aware of. This will be disseminated to ward sister level as the responsibility for ensuring staff awareness of these issues should remain with the clinical staff delivering the care.

8. Conclusions

The NCDAH has identified a number of areas where the Trust is failing to meet organisational KPI's. Some of these have already been addressed and action plans for the others are summarised above. National recommendations following the publication of the "More Care Less Pathway" and "One chance to get it right" documents have been incorporated into the individualised care plan for patients in the last days of life but there is ongoing work to deliver the education and support that staff need to ensure that the organisation delivers on all of the 5 priorities of care in a consistently. How we deliver on the 5 priorities of care will be closely examined by the CQC in future inspections.

9. Recommendation

The Board is asked to note the report.

Author	**Karen Cowley, Directorate Manager for Specialist Medicine**
Owner	**Dr Alastair Turnbull, Medical Director**
Date	**September 2014**

Appendix

Post LCP pathway decision making – York Trust

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 24 September 2014

PLACE Results 2014

Action requested/recommendation

The Board of Directors is asked to note and discuss the contents of the published PLACE results in the attached report.

Summary

This paper sets out the process and the results of the Patient Led Assessments of the Care Environment (PLACE) which took place between 26th February and 3rd June this year in all 10 of our properties with inpatient facilities. All the assessments were self assessments with external validators being used and a result is provided against 4 areas: Cleanliness; Food & Hydration; Privacy, Dignity & Wellbeing; and Condition, Appearance & Maintenance. Section 9 of the attached report details the scores for each property against the national averages.

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.

Sustainability assessment

Reference to CQC outcomes

Outcome 5 – Nutrional Needs
Outcome 8 – Cleanliness
Outcome 10 – Safety and Suitability of environmnet

Progress of report	Paper seen by Estates and Facilities Management team
Risk	There may be external interest in local and national scores.
Resource implications	None
Owner	Brian Golding, Director of Estates and Facilities
Author	Carol Tarren, Head of Facilities – Satellite Properties
Date of paper	September 2104
Version number	Version 1

York Teaching Hospital NHS
NHS Foundation Trust

Directorate of Estates and Facilities

PLACE Results 2014

Content

1 Context

The PLACE results were published on 27th August 2014.

2 Process

The Patient Led Assessments of the Care Environment (PLACE) took place between 26th February and 3rd June 2014 on all of the Trust in-patient sites.

All of the assessments were self-assessments with an external validator being used for seven sites i.e. York Hospital, St Monica's, Archways, Whitby Hospital, Malton Hospital, White Cross Court and St Helen's. The external validators used were Ross Mitchell and Stuart Kelly both from Harrogate District Foundation Trust.

Carol Tarren, Head of Facilities – Satellite Properties was able to reciprocate and attended the assessments at Harrogate Trust.

Members of Trust Board of Governors were eligible to act as `patient assessors` within their Trust since their primary role is to represent the interests of patients/public.

In-house training was delivered by Carol Tarren prior to the assessments to ensure the new assessment process was understood by the patient assessors and Trust staff involved in the assessment process.

3 Assessment Process

PLACE teams consisted of the mandatory 50% patient assessors and leads from Facilities, Matrons and the Infection, Prevention and Control team.

The minimum 25 per cent of wards, departments and non-ward areas with varying age and condition was met which allowed the PLACE teams to make informed judgements about the areas visited.

4 Scoring

The range of scoring approach depended on the area and aspect being assessed.

Cleanliness	Pass/Qualified Pass/Fail
	Yes/No
Buildings & Facilities	Pass/Qualified Pass/Fail
	Yes/No
	An answer from a predetermined list of options
Privacy, dignity &	Yes/No
Wellbeing	An answer from a predetermined list of options
Food	Yes/No
	An answer from a predetermined list of options
	Good, Acceptable or Poor (The food quality Assessment only)

The standard assessment criteria were followed for all sites:

5 Results

At the end of the process, each hospital/ unit which has undertaken an assessment is provided with a result against each of the four areas of the assessment namely Cleanliness; Food and Hydration; Privacy Dignity and Wellbeing and Condition Appearance and Maintenance.

This result is calculated by reference to the score (points) achieved expressed as a percentage of the maximum score (points) which could have been achieved had every aspect of the assessment they undertook achieved the maximum score.

With the exception of the assessment of food, the maximum score for any question is 2.

The food assessment is split into two components – an Organisational component which addresses the catering services provided by the organisation, and an assessment of ward based practice and the quality (taste, texture and temperature) of the food provided. The questions in the Organisational section are scored according to a weighting algorithm which reflects the relative importance of each question. To allow for the fact that different hospital types answer a slightly different number of questions there are three weighting algorithms. All questions in the Ward-based component have a maximum score of 2.
Participating organisations and others who may use these data will be able to benchmark their performance or the performance of particular types of organisations.

For the purposes of comparison, a national average of scores from all participating hospitals/ units has been calculated. This average is weighted to take account of the fact that hospitals vary in size and that in larger hospitals not all areas are assessed. The weighting factor used in this calculation is bed numbers. Bed numbers are used since they are common to all organisations, whereas some premises in which assessments are undertaken do not have wards e.g. certain mental health/learning disabilities units and Treatment Centres.

The calculation used to produce the National Average is:-

$$\frac{\text{The sum of [Each site's score (points) multiplied by the number of beds in that site]}}{\text{The total number of beds in all assessed sites.}}$$

Minor changes were made to the Cleanliness and Condition, Appearance and Maintenance sections but these are not considered to have had any significant impact on the comparability between 2013 and 2014.

Due to changes in methodology, comparisons between 2013 and 2014 are not possible for Food and Hydration or Privacy, Dignity and Wellbeing.

6 National Results

The number of assessments undertaken in 2014 was 1,356.

This table details the national highest and lowest scores across the four domains.

DOMAINS	HIGHEST SCORE	LOWEST SCORE	NATIONAL AVERAGE SCORE
Cleanliness	100%	34.6%	97.25%
Condition, Appearance and Maintenance	100%	48.4%	91.97%
Privacy, Dignity and Wellbeing	100%	53.5%	87.73%
Food and Hydration	100%	54.7%	88.79%

7 Regional Comparisons

The table below details the comparisons across the four domains for the four Commissioning Regions.

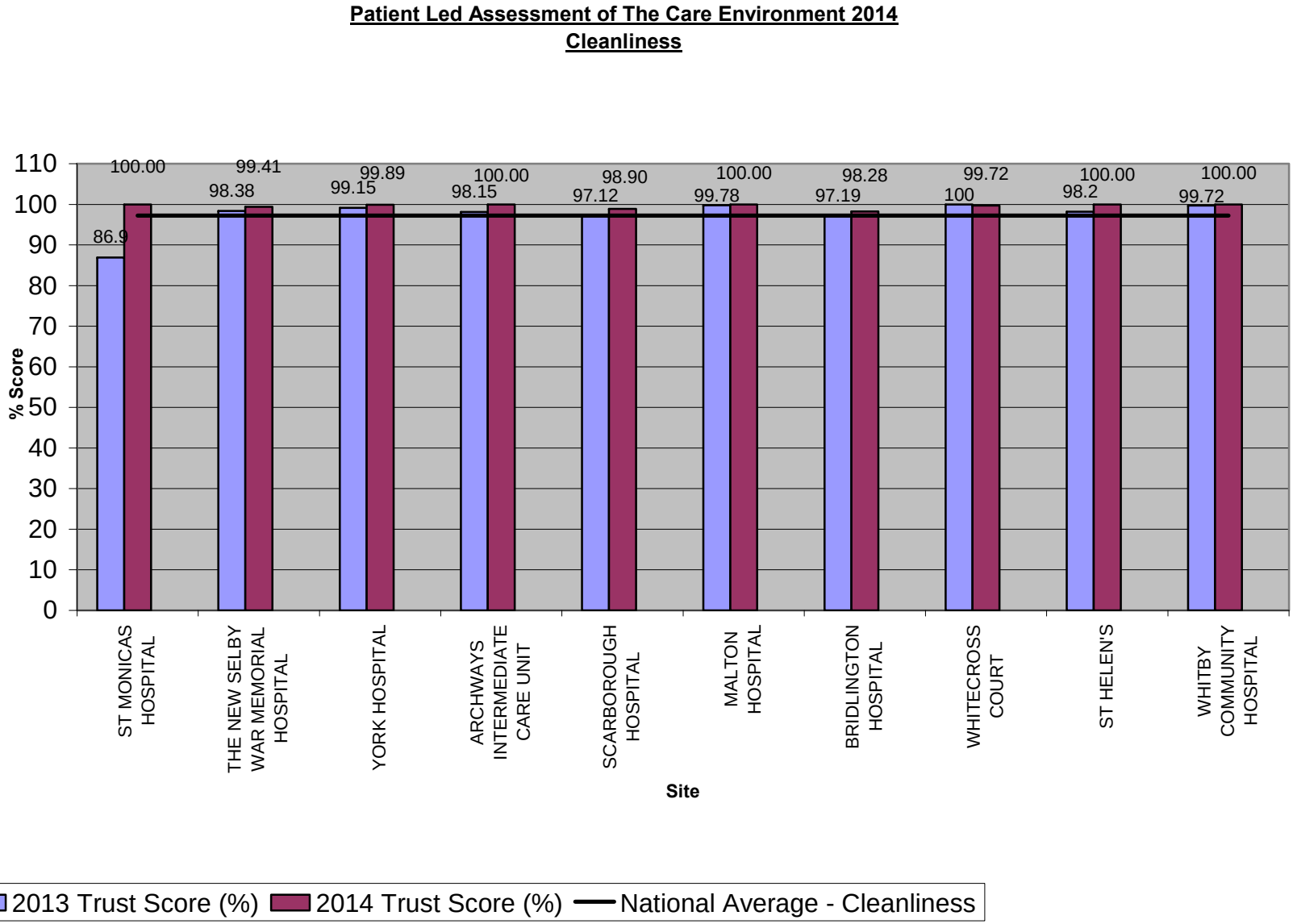
Region	Cleanliness	Condition, Appearance & Maintenance	Privacy, Dignity & Wellbeing	Food
North of England Commissioning Region	97.9%	92.8%	89.5%	88.4%
South of England Commissioning Region	96.95%	91.6%	86.8%	88.7%
Midlands and East of England Commissioning Region	97.1%	91.7%	87.3%	88.1%
London Commissioning Region	97.0%	91.4%	86.5%	89.0%

8 York Teaching Hospital NHS Foundation Trust Results

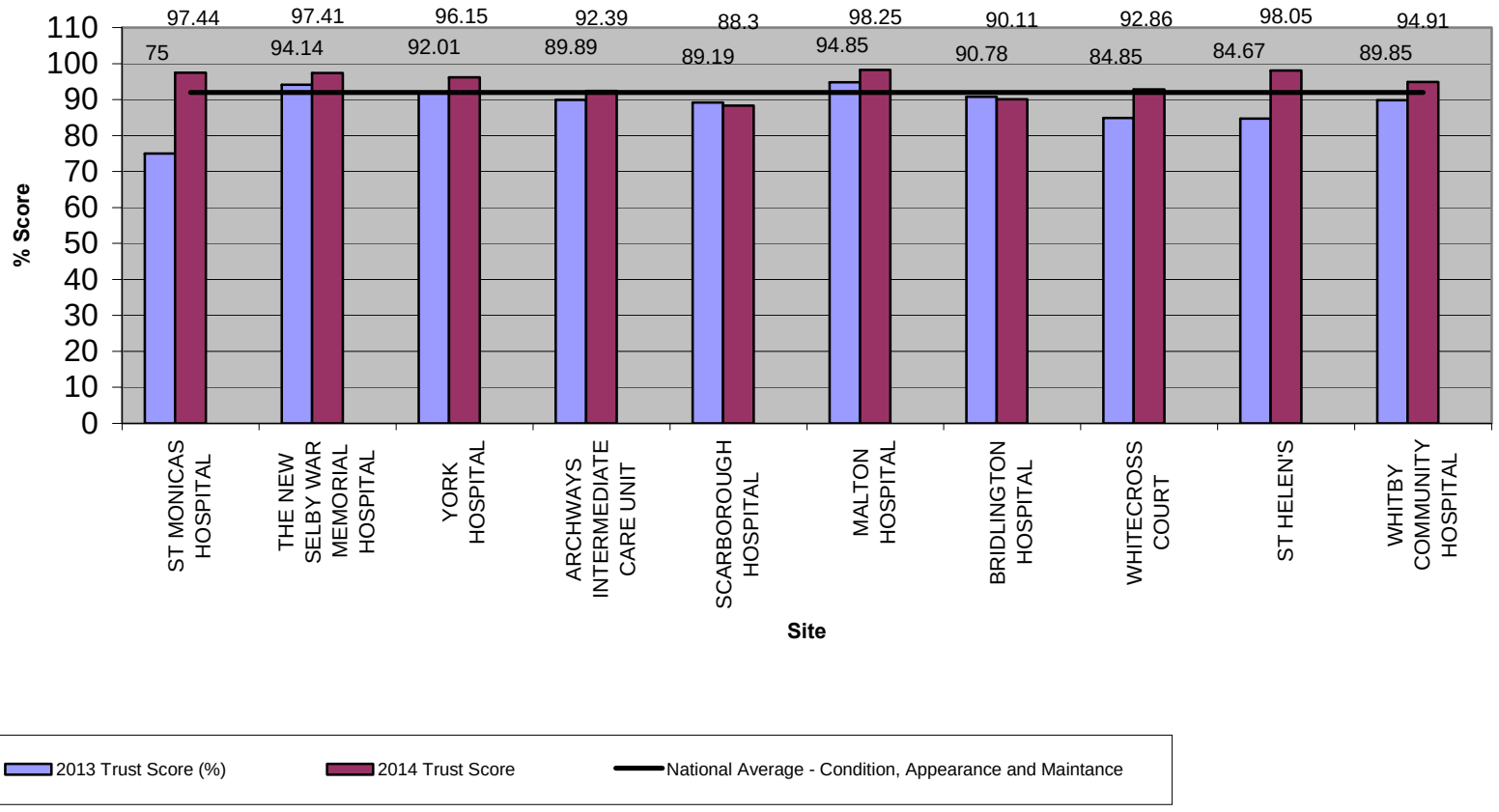
The table below details the final results (%) for York Trust organisation scores against the national averages.

	Cleanliness	Condition, Appearance & Maintenance	Privacy, Dignity & Wellbeing	Food
National Average Score (%)	97.25	91.97	87.73	88.79
York Trust (%)	**99.54** ↑	**93.83** ↑	**82.85** ↓	**80.18** ↓

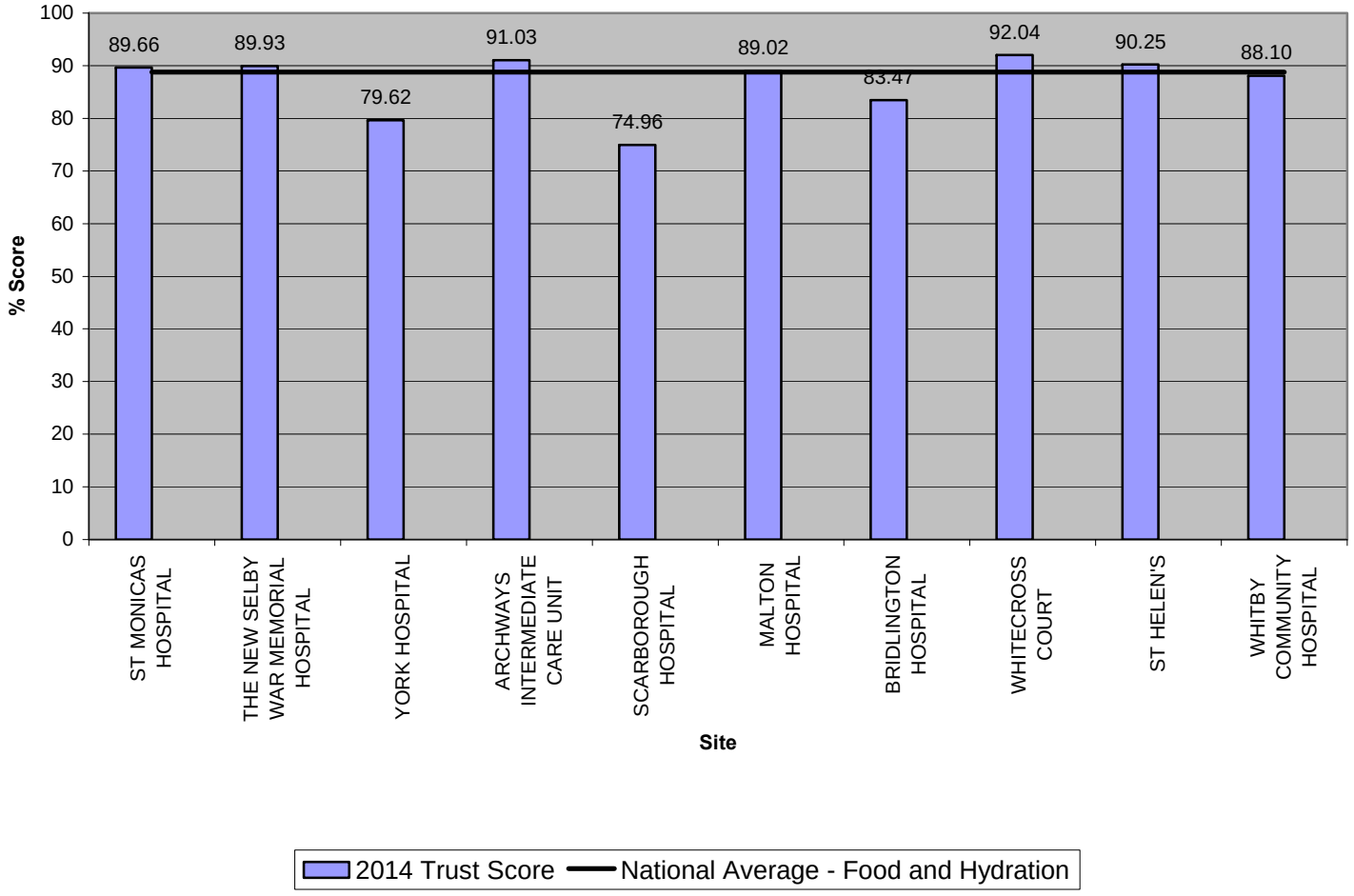
9 Individual Site Results shown as bar charts



Patient Led Assessment of The Care Environment 2014
Condition, Appearance and Maintanace

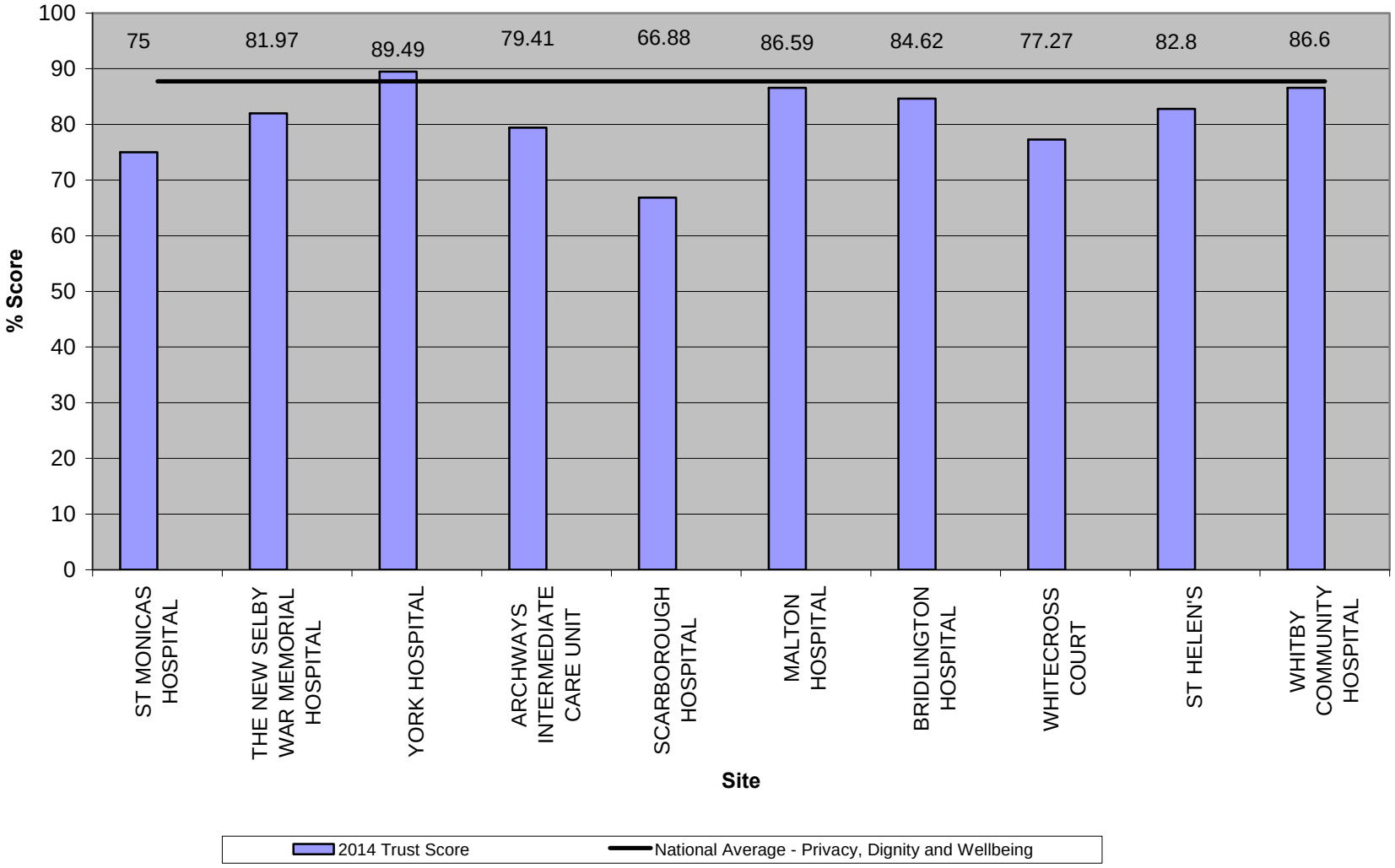


Patient Led Assessment of The Care Environment Results 2014
Food and Hydration



Due to changes in methodology, comparisons between 2013 and 2014 are not possible for Food and Hydration.

Patient Led Assessment of The Care Environment Results 2014
Privacy, Dignity & Wellbeing



Due to changes in methodology, comparisons between 2013 and 2014 are not possible for Privacy, Dignity and Wellbeing.

10 Food Domain

The food scores are reported as an overall Trust % and are then further broken down by site as detailed in the table below.

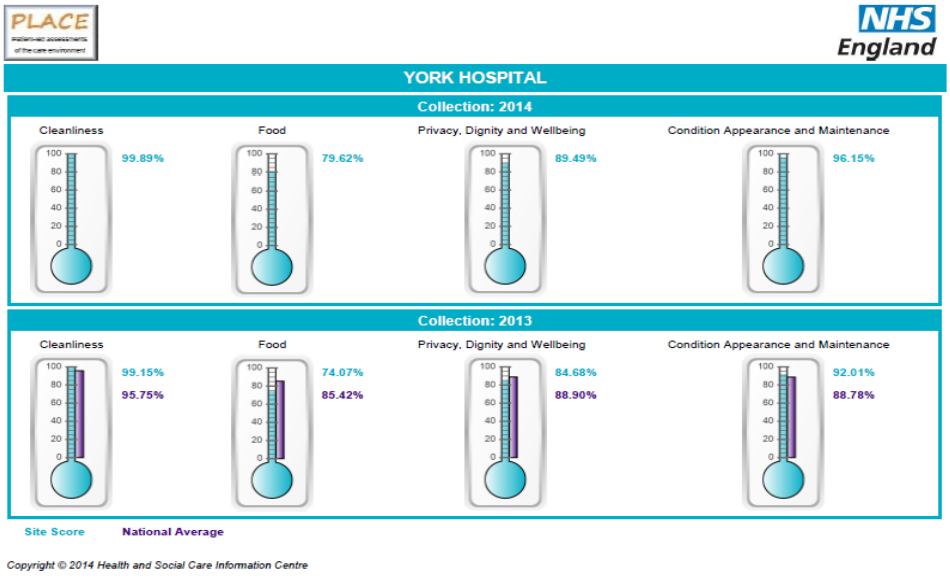
	Food Overall %	Ward Food %	Organisational Food %
York	79.62	79.35	80.93
Scarborough	74.96	74.27	77.23
Bridlington	83.47	87.76	74.17
Selby	89.93	90.94	88.89
Malton	89.02	96.60	80.79
Whitby	88.10	93.21	82.00
St Monica's	89.66	96.90	78.41
Archways	91.03	94.77	86.80
White Cross Court	92.04	93.94	89.73
St Helens	90.25	95.15	84.28

Please note however that due to changes in the assessment methodology and scoring, the 2014 results for Food and Hydration are not considered to be directly comparable with 2013.

11 Public Access to results

The public are able to view York Teaching Hospital Trust's 2014 PLACE results through Health and Social Care Information Centre's (hscic) website in the Thermometer style graphs as detailed below.

However for ease of comparison within this report, bar charts and tables have been used to report the scores.



12 Action Plans

Action plans were completed. These have now been circulated to the individual wards and departments and will be tracked on a monthly basis by Facilities until all actions are closed out.

13 Feedback for Patient Assessors and Governors

The patient assessors and governors are to be invited to attend feedback sessions on 23rd and 25th September which will be facilitated by Carol Tarren. This will allow the 2014 assessment process, scores and action plans to be discussed and identify how any improvements can be made for the annual 2015 assessments.

The future numbers of Patient Assessors and Governors will need to be maintained and reviewed. The Head of Facilities – Satellite Properties and the Trust Public and Patient Involvement Specialist will continue to work together to ensure adequate numbers are available for the 2015 assessment period and that adequate training is delivered.

The Head of Facilities – Satellite Properties will continue to work closely with local Trusts to agree reciprocal arrangements for Peer Review/External Validation.

Finance and Performance Committee – 16th September 2014, Ward 37 Seminar Room, York Hospital

Attendance: Mike Sweet, Chairman
Mike Keaney
Liz Booth
Lucy Turner
Andrew Bertram
Graham Lamb
Steven Kitching
Anna Pridmore
Lisa Gray

Apologies:

	Agenda Item	AFW	Comments	Assurance	Attention to Board
1	**Last Meeting Notes Minutes Dated 22nd July 2014**		The notes were approved as a true record of the meeting. MS welcomed SK as a full member of the Committee.		
2	**Matters arising**		All matters arising from the previous meeting are on the agenda this month to discuss.		
3	**Short term Acute Strategy**		LB presented the "Implementing the Unplanned Care Strategy" paper that will be presented at the Acute Board on 18th September. In future the Acute Board will be split into an Unplanned Care Board and a Planned Care Board The Unplanned Care Strategy has a number of work streams with clearly defined terms of reference and each supported by a senior improvement manager. These are as	The committee were assured that each work stream is	MP to update the Board on this development of the Acute Strategy and related resource issues.

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			follows: **-** Design a multi-specialty integrated assessment space on the York site - Develop acute care pathways (to include ambulatory care documentation and urgent specialist outpatient review) - Establish a multidisciplinary workforce to provide quality services over 7 days to include 7 day diagnostic services - To agree patient centred pathways - Integrated community services and secondary care services It was agreed that the paper should be included in the September Board pack. **Ward Reconfiguration:** The proposal has been agreed and it is anticipated as a first stage the combined AMU / SSW ward will be operational in November / December., **York Handover Area:** The new area at York is working well, but there are concerns at Scarborough where the construction of Maple 2 ward is having an adverse impact on bed availability. A short term solution to the end of October (Maple ward re-opens) is being sought. **GPs in ED:** Recruitment of a GP is underway to enable a 6-month trial to be undertaken. It is anticipated that this will reduce demand pressures in ED, but the difficulty of recruiting and retaining ED staff remains. **ECIST:** LB described the action plan put in place following a visit from Emergency Care Intensive Support Team (ECIST). MS and MK asked that progress against the action plan be reviewed monthly by the Committee. In response to a question from MK the Committee was assured that the predictor tool for bed management is working, However, there remains a need to address the	making progress towards helping the Trust to effectively respond to increasing demands for unplanned and urgent care both in and out of hours. The Committee recognised the continued work being undertaken to resolve the on-going performance challenges around the ED target	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			flow of patients into the hospital throughout the day and this will require discussion with both transport providers and GPs. The committee discussed a need to see a monthly action plan summarising the various documents that contain plans relating to sustained delivery of the 4-hour target. LB agreed to prepare a summary plan and present progress each month.		
4	**Efficiency Report**	CRR 39	The Committee received both the July and August reports for completeness and concentrated on the latest August data. Current delivery is £10.6m, which represents 44% (39% 2013/14) of the £24m annual target. This has improved by £2.8m since June. The in-year gap closed to £2.6m in August which is an improvement from the Trust's position in June (£4.6m). But there are concerns that 73% of the plan is from recurrent schemes which is not in line with current achievements and 20% is high risk The four year planning gap has reduced to £22.2m in August 2014 from £26.1m in June 2014. The in-year planning gap is seen as a key risk and is being exacerbated by the short term unavailability of DMs in some directorates and other key personnel to undertake the work. However it was confirmed all Directorate Manager roles will be filled by the end of the year. MS expressed concern that a number of Directorates are continuing to make little progress against their plans and requested an update on the action being taken to address the matter. AB assured the Committee that the matter is being addressed as a priority and that meetings have already commenced and the Directorates are being required to complete their action plans without delay. Initial	The Committee were assured by the improvement in delivery and the in-year plan since June 2014, and the commencement of the review panels.	AB to update Board on the risks to the achievement of the 14/15 plan and the efficiency review panels.

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			responses have been positive. MK was pleased to see the Obstetrics and Gynaecology CIP action plan (tabled as an example) as it provided a good example of what could be achieved from the review meetings. The Committee is of the opinion that these reviews, coupled with the increased use of SLR data will prove very beneficial in helping the Trust meet its targets. Regular feedback on the review meetings was requested. Discussion on CIP Governance was deferred to October by which time the schedule is expected to have been fully reviewed and updated. The Committee welcomed the newly introduced overview report from SK and suggested that in future it be placed at the front of the report.		
5	**Operational Report**	**AFW** DoF7 COO3 **CRR** 36	**Access Targets –** **18 weeks** – LT confirmed that the Trust had achieved the non-admitted and incomplete pathway targets at aggregate level, although there were specialty fails. The incomplete backlog increased by 75 in the period. The admitted target was failed as planned in line with the current national agreement to help Trusts nationally to reduce their backlog. However, less work than anticipated has been undertaken due to workforce shortages particularly within Theatres, and difficulties in accessing bank and agency staff. LT explained that General Surgery was achieving its targets and, subject to the funding being available over the coming months, it is anticipated that most directorates will be up-to-date by December. NHSE has been advised accordingly. The CCG's have agreed to waive the 18 week fines (£171k) incurred to date with the exception of East Riding CCG who	The Committee was pleased to see that the Trust had achieved the non-admitted pathway target, and understood the challenges around the admitted pathway, including the difficulties around recruiting additional staff to complete the extra work.	MP to update the Board on the 18 week admitted target and the associated funding arrangements and recruitment issues.

Agenda Item	AFW	Comments	Assurance	Attention to Board
		have not signed up to this national initiative. **Cancer -** **14 day Fast Track** – The Trust failed Q1 and expects to fail Q2 and Q3 due to the increase in Fast Track referrals. There has been an overall increase of 17% in referrals in comparison to last year, and for skin the increase is 37%. Similar increases are being experienced nationally. Additional capacity and a referral audit have been implemented for skin cancer to help mitigate the effect of the growth in referrals, and work is also being undertaken at specific cancer and practice level to ensure that GPs are referring appropriately. **14 day Symptomatic Breast** – As expected the trust failed in July and for Q1. However performance has improved in August following the centralisation of the service on to the York site. LT confirmed that the Radiology workforce is being reviewed and also confirmed that the York workforce is coping well with the increased intake. The centralised service is working well, but it is only a short term solution until a full Scarborough service can be re-instated. **Emergency Department** – The Trust failed the July/August target and is predicted to fail in Q2. The rise in admissions continues, and recruitment and retention remains a major concern. **Ambulance Handover** – The York site continues to improve following the opening of the dedicated ambulance handover area. However performance at Scarborough has deteriorated further. MK enquired what is being done in Scarborough to improve the situation. LT confirmed that the re-opening of the Maple Ward at the end of October 2014 will help reduces breaches as more beds will be available. There are also plans being feasibility tested to develop an ambulance turn around bay similar to York. BG confirmed	. The committee were assured that the improved performance in August indicated that the Trust would meet its target going forward. The committee were pleased with the significant improvement at the York site. However, there are concerns for the Scarborough site and sight of the plans is required for assurance.	AJT to report the position with regard to Fast Track and 14 Day Breast Symptomatic from both a Trust and national perspective. MP to provide an update on the ED and Ambulance Hand-Over position at both main sites if not already covered under “Short Term Acute Strategy”.

Agenda Item	AFW	Comments	Assurance	Attention to Board
		that completing such work would take up to a year and an interim solution would need to be considered. MS asked for an update on the plans for a Scarborough Ambulance Handover for the next meeting. It was noted that despite the improvements at York because of the challenges at Scarborough the monthly level of handover fines continues to be in excess of £100k.**CQUIN** – **Dementia and Delirium (3.1a)** - LT advised that this is the only CQUIN with a red rating. There has been significant underperformance in Scarborough, however an improvement plan had been put in place and improvements have been seen in the first two weeks in September. **Care of the Deteriorating Patient – senior review 12hrs – Scarborough (7a)** – LT confirmed this CQUIN is amber. The target is higher for Q2 than that which was achieved in Q1 and there is a concern that staff vacancies may impact achievement. An improvement plan is being discussed. **Friends & Family:** The Committee noted that although the target was achieved F & F performance in ED is declining and remains a challenge. The Committee were advised that under the revised rules and as from April 2015 the current token system would be removed, consequently work was underway to devise new systems of obtaining feedback from the patients who attend the Emergency Department. **First to Follow-Up ratios:** The Committee was advised that for the current year there is no contractual target and that the agreement is for the Trust to comply with the agreed Condition Registers and see no deterioration over the 13/14 year end position. **Infection Prevention & Quality and Safety** **Cdiff**– The Committee noted the continued improvement in	The committee were assured that plans have been put in place, and an improvement is beginning to be seen. The committee were assured that plans are being put in place to enable achievement of the Q2 target. The committee were pleased to see that the improved position continues	AJT to provide an update on the challenges at Scarborough with the Dementia & Delirium question (CQUIN 3.1a, and the new target for 12 hour senior review (CQUIN 7a.

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			the avoidance of C.Diff. The performance report confirms there have been 16 cases to the end of August in comparison to 31 cases this time last year. **6 week referral to diagnostic test** – The Trust failed the target in Q1. LT advised there are issues with the availability of MRI scanning. The machines are being used to capacity given the workforce available. To address the problem discussions are underway to outsource 50 referrals a month to Nuffield.		AJT to advise on the implications
6	**Finance Report**	**AFW** DoF2/ 3/5/7 **CRR** 35, 40, 41	August saw an income and expenditure deficit of £1.1m. This has led to a variance of £1.2m against the Trust's planned position. However the position has improved from a £1.4m deficit in July. The August results continue to assume an acceptable outcome to the discussions with the CCGs regarding the fines for ambulance turnaround failures and the 30% non-elective tariff. AB confirmed that discussions are on-going. GL confirmed that the Trust is challenging the CCGs over some of their non-elective activity reducing schemes, as it is felt they are not investing the fines / retained money as Monitor guidance requires. GL confirmed the Trust's current COSR rating is 4 which is on plan, however failure to receive the extra income from the CCGs will reduce the Trust to a COSR rating of 3, which could result in regulatory action being invoked. **Expenditure Analysis** – The committee was advised that the pay budgets and provisions are overspent by £1.6m for August. This is due to continuing recruitment issues as previously reported and results from the need to employ expensive locums and agency staff. **Contracting Matters** – AB confirmed that all the 2013/14	The Committee was assured that the position is receiving constant attention The committee were assured and pleased that the Trust are challenging the CCGs on how they are reinvesting money.	AB to update the Board on the negotiations with the CCGs and the likelihood of financial regulatory action by Monitor. AB to provide

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			contracting issues have now been resolved. AB advised the committee that Monitor has written to all FTs over its concern around the adverse financial position being reported by many FTs. High level reporting will now be required on a monthly basis, so that Monitor can identify trends and concerns more quickly. However, they have assured the Trusts this data will be independent of the Quarterly returns and will not drive regulatory action. **General -** Given the pay overspend referred to above and the number of other recruitment issues highlighted in this report, Sue Holden has been asked to provide an overview of the current workforce market place.		further information on the latest Monitor national position statement if published
7	**Capital Planning update**		BG advised the committee that the total Capital Programme is £24m and is currently slightly overspent. BG is revising the plan sent to Board in May 2014 and taking it to Board in November 2014 to enable projects to be prioritised as there are currently more plans than funds available. The Trust is looking to recruit 3 new project managers to enable more project management to be brought in-house.	The committee were assured by the level of planning and that the plans were being revisited to enable prioritisation.	BG is asked to update the Board on the following; 1. Scarborough Maternity Theatre Upgrade, 2.Maple Ward and Lilac Ward (Maple 2), 3. Scarborough Paediatrics 4. The refurbishment of the Mallard restaurant.
8	**Finance and Performance Committee Annual Report**		The Committee noted the report and confirmed that the report was a true reflection of the business conducted by the Committee during the period covered by the report.		

	Agenda Item	AFW	Comments	Assurance	Attention to Board
9	**Any Other Business**		The Committee noted that this was the last Finance and Performance Committee meeting that MS would chair. The Committee thanked MS for his diligence and excellent chairing of the Committee. The next meeting will be Chaired by MK and MS will remain a member of the Committee. It was agreed that for the future a schedule / proforma will be developed to enable the committee to track progress against those actions it has been advised of. The schedule would be tabled and updated monthly.		

Blank page

F1

York Teaching Hospital NHS

NHS Foundation Trust

Board of Directors – 24 September 2014

Acute Board Update – Implementing the Unplanned Care Strategy

Action requested/recommendation

The Board is asked to note the report.

Summary

This paper will:

- Describe the strategic context
- Outline progress and associated timescales
- Define risks and benefits
- Set out next steps

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 and Safety Committee
Risk	No risk.
Resource implications	Resource implications do apply and there are a number of business cases that have been developed and will be presented as part of this acute care strategy delivery programme.
Owner	Liz Booth, Director of Operations
Author	Liz Booth, Director of Operations
Date of paper	September 2014
Version number	Version 1

Board of Directors – 24 September 2014

Acute Board Update – Implementing the Unplanned Care Strategy

1. Aim

The aim of the paper is to update the board on progress towards implementing an unplanned care strategy across York and Scarborough Hospital sites. This programme of work consists of six interdependent projects which collectively contribute to the delivery of a modernised and coherent unplanned care pathway. This in turn will enable the Trust to effectively respond to increasing demands for unplanned (and urgent) care both in hours and during the out of hours period. The Acute Board has played a key role in driving and directing this work and ensuring that clinicians are actively engaged in both the planning and implementation of revised pathways and new ways of working.

This paper will:

- Describe the strategic context
- Outline progress and associated timescales
- Define risks and benefits
- Set out next steps

2. Strategic Context

The York Trust acute strategy should not be considered in isolation; it forms part of a wider York and Scarborough health and social care response to the growing demand for urgent and emergency care services.

Demands on health and social care services are unprecedented. Research suggests that:

- Over the last 3 years attendance at all urgent and emergency facilities have risen by 1 million;
- Emergency Departments are at the limit of their capacity, now not simply a phenomenon of winter, but an all year round issue. A consistent response is required, not just a seasonal one;
- It is estimated that 1 in 5 patients can be treated equally well or better out of hospital;
- The average number of consultations in General Practice rose from 4.1 to 5.5 per year between 1999-2008 (and patients are more complex);
- Attendances at Walk in Centres and Minor Injury Units in 2012/13 were in excess of 6.8 million; this constitutes an annual increase of 12% since data was recorded a decade ago;
- Emergency admissions to hospital in England have increased year on year rising 31% between 2002/3 to 2012/13.

Whilst York Trust can not respond to this on its own, it is clear that it has a key role in working with partner organisations to transform urgent and emergency care across the health and social care system, but in particular at York and Scarborough Hospital.

3. Principles

The strategy is underpinned by a number of key principles. These include:

- The creation of a single assessment space that will in turn allow the more efficient use of resources including the medical and nursing workforce
- Senior assessment and delivered care across seven days; this will ensure continuity of care and appropriate and timely senior decision making and clinical intervention. Research suggests that this will support a reduction in hospital mortality.
- Reengineered services, 'built around the patient'.
- New roles that support innovative service models
- A wider range of ambulatory care pathways, with the emphasis on shifting care out of hospital where appropriate (and admission avoidance).
- Better support for people to self care – better and more easily accessible information about self treatment options so that people who prefer can avoid the need to see a health care professional
- Accelerated development of comprehensive and standardised care planning so that important information about a patient's condition, their values and future wishes are known to relevant health and social care professionals. This includes ceilings of care. In turn patients are then better supported before their condition deteriorates or if additional help is required.
- Right advice, right place, first time
- A wider range of urgent care services outside of hospital, so people can choose and alternative to hospital where appropriate

4. Process

Six work streams have been established, each supported by a project team, with clearly defined terms of reference. Each project group has developed a project plan with clearly defined deliverables and associated timescales. Progress against these are reported at the monthly acute board meeting. Issues that cannot be resolved via this group are escalated to the Scarborough and York Hospital Community Boards. Each work stream is supported by a service improvement manager.

5. Work streams – Progress to date

- **Design a multi specialty integrated assessment space on the York site.**

This work consists of two elements:

1. Phase 1 - the planning for and design of a capital scheme/build that will support the development of a single assessment unit on the York Hospital site. A design proposal is currently under consideration by a capital/architect team.
2. Phase 2 - the development of a temporary solution that can be implemented relatively quickly to address the issue of inadequate space and poor environment on the existing acute assessment and short stay ward. The two wards will amalgamate to become one assessment unit. All unplanned admissions will be admitted and assessed on these wards. GP admissions will be directly admitted to the Assessment Unit. A new redesigned reception area will be developed at the entrance of the wards. Anticipated implementation date is December January 14/15.

- **Develop acute care pathways (to include ambulatory care documentation and**

urgent specialist outpatient review).

Generic assessment documentation has been developed for those patients who are admitted and those who need assessment but not admission. In addition a number of acute assessment pathways have been developed and are being piloted. The standardisation of all documentation and pathways will support further integration. A number of key ambulatory care pathways have also been developed, working in partnership with support services and commissioners.

- **Establish a multidisciplinary workforce to provide quality services over 7 days to include 7 day diagnostic services**.

This group has developed a Consultant rota. Despite major gaps in this rota (Acute Care Physicians), work has progressed to implement a phased approach, due to trialled in December. The assessment of nursing requirements to amalgamate ward 21 and 22 has been undertaken. This staffing level is being reviewed as part of the overall staffing acuity work underway across the trust. Allied Health Professional requirements for an extended Acute Assessment Unit have been developed and costed. The requirements to increase AHP to cover other wards 7 days a week has also been costed.

A Care of the Elderly Consultant rota will when fully established provide additional support to patients on the acute assessment ward. Acute and Elderly medicine will cross refer and share patients. Specialty input to the Acute Assessment Ward will be formalised at the same time as the new rota commences.
Pharmacy support to assist earlier supported discharge from the Acute Assessment Unit has been assessed and costed.
Scoping diagnostic services to ensure capacity to support 7 day working has also been considered by this group; a business case has been developed and submitted to the Business Intelligence Unit for review.

- **To agree patient centred care pathways.**

This group has worked with all specialties to investigate and document which groups of patients are managed by each specialties. This work has highlighted a number of areas where a pathway needs to be agreed. For example MSK, Abdominal Pain and End of Life Care.

- **Integrated community services and secondary care services**

A number of work streams have been initiated under the umbrella of the Community Hub programme of work. These work streams are focused on developing a wider range of integrated reablement and intermediate care services in York, Selby, Malton and Ryedale. In addition, a pilot project has just commenced, to provide additional support to care homes; this is predicated on a joint review of patients by a Care of the Elderly Consultant and the patient's GP.

Another key element of this work relates to the development of Selby and Malton Hospital to support a wider range of services delivered outside of hospital. This is includes Care of the Elderly Consultant clinics that provide a real alternative to hospital admission.

6. Risk and Issues

Risk	Mitigation
Lack of clinical engagement	Participation of clinicians in working groups Regular updates and communications to all staff Defined clinical leadership and ownership
Inability to recruit to vacant/new posts	HR plan to support recruitment process Exploitation of clinical networks and opportunities to attract new staff
Additional cost of developing new services	Development of a benefits realisation plan that sets out the benefits of the projects
Lack of staff engagement	Effective and timely communication and information sharing

7. Benefits

Key Benefits	Comments
Patient care improved as services are co located in one assessment area, enabling teams to maximise their expertise	Senior review enhanced. Staff are able to concentrate on patient rather than transferring to SSW
Better patient environment	Calm quite as reception out side the ward to reduce foot fall
Coordinated services, less fragmentation	Joint working between the multi-disciplinary team
Patient focused pathways with more and improved access to 'specialist ' assessment and treatment	Formalised agreed pathways
A wider range of options to support ambulatory and out of hospital care	A model of care and resources to support admission avoidance. Commissioning engaged
Reduced length of stay	Improve patient flow and cost
Services extended over 7 days	Safer care
Reduction in complaints	Quality experience

8. Next Steps

A number of business cases have been developed and will be presented as part of this acute care strategy delivery programme.

9. Recommendation

The Board is asked to note the report.

Author	**Liz Booth, Director of Operations**

Owner	**Liz Booth, Director of Operations**
Date	**September 2014**

Action plan following Emergency Care Intensive Support Team visit

Action Plan								Progress Monitoring - 6 months						End of Year Risk
Category	**Issue**	**Initial Risk (H/M/L)**	**Action/s**	**Update July 2014**	**Operational Lead**	**Responsible Lead**	**Target Date**	**Risk at review (H/M/L)**	**Evidence**	**Further action/s**	**Operational Lead**	**Responsible Lead**	**Target Date**	**Risk (H/M/L)**
Workforce	Difficuly to recruit to Acute care / Emergency Department posts		Develop attractive recruitment package to secure senior staff	Medical staffing situation continues to be a challengewith further loss of Cons staff in York imminent (retirement & resignation). No response to re-advertisement of both York & Scarborough Cons vacancies despite Recruitment and Retention Package.	Wendy Quinn	Mike Williams, Ed Smith	Jun-14			Remuneration agreement with middle grade doctors. Locum appointed for 6 months.				
			Rotate staff across sites	Not yet feasible due to inadequate numbers on each site. To review when staffing improved in either locality.	Wendy Quinn	Mike Williams, Ed Smith	Sep-14							
			Review workforce and explore alternative roles	Time out organised to assess and agree future workforce. Expression of interest gone out to GP to work in Urgent Care Centre	Wendy Quinn	Bev Geary Liz Booth	August							
			Review staffing to support resus	Ambulance bays staffed in York. Scarborough finance team currently costing 4 modelling options for future staffing establishment for ED to incorporate summer and bank holiday staffing model, assessment model, ambulance handover model and team nursing. York finance team reviewing capacity to staff Resus.	Wendy Quinn Jo Southwell	Bev Geary	Aug-14			Developed and implemented an escalation plan for outreach to support ED resus when required.Escalation plans in place. Named nurse on each shift responsible for resus				
Mental Health	Inadequate Psychiatric care		Discussions held with Leeds Partnership and Commissioners to agree a model of care (RAID)	24/7 presence funded for Oct 2014 - recruitment underway. Development of Transitional Waiting area at Bootham.	Liz Booth / Mandy McGale	Mike Proctor	Nov-14			New service EDLS Band 7 and Band 6 stars in October. Development of transitional Waiting area at Bootham				
Community Services	Integrated teams		To integrate discharge teams and standardise complex discharge processes	We have agreed a template for caseload reviews and 2 pilots in community have commenced. Board rounds are up and running in all community hospitals Planning underway Review DLT roles and fuction	Annette Wilkes,Julie Plaxton	Wendy Scott,	Sep-14							
	Commissioning intentions Community		3 CCG agree a standard single principal output driven specification for Ugent Community services.	Agreement that specification required		Wendy Scott Mike Proctor	Dec-14							
			To undertake a case load review to optimise capacity	ECIST carried out a case note review in Community Hospitals	Annette Wilkes	Wendy Scott	Jun-14							
Discharge Processes	Discharge profile does not support flow		Perfect Week planned in Scarborough that will focus on preventing delays across the whole of the health and social care system. This will then be built into a sustainability plan.	Successfully demonstrated improvements to flow and 4 hours in ED at Scarborough through 'a plan for every patient. Business cases in development process. System Resilience Fund to support plans to commence in December due to recruitment lead in period. Planning to achieve cumulative profile of 50% 2 midnights, 75% 7 midnights and 95% 21 midnights	Jo Southwell Julie Plaxton	Mandy McGale liz Booth	Oct-14							

Category	Issue	Initial Risk (H/M/L)	Action/s	Update July 2014	Operational Lead	Responsible Lead	Target Date	Risk at review (H/M/L)	Evidence	Further action/s	Operational Lead	Responsible Lead	Target Date	Risk (H/M/L)
			Safer bundles have been trialed as part of the Perfect Week planned in Scarborough, this will be incorporated in a sustainability plan. Learning shared across whole organisation	Progress with the following daily senior review to increase discharge profile, review dispensary capacity and demand, consider discharge to assess model of care.	Becky Hoskins	Mandy McGale/Liz Booth	Dec-14							
Children in ED	Staffing model does not support best practice in ED re paediatric guidelines for ED.		Joint working group is established between ED GPs and Peadiatrics to review unscheduled care for children based on the recommendations within standards for children and young people in emergency care settings RCPCH	Meeting scheduled to undertake as jont meeting between whole Health Economy	Wendy Quinn	Liz Booth Mandy McGale	Sep-14							
Therapy Services	Conflict between medically fit and safe		To further investigate the Discharge to Assess model of care and work with community redesign projects to standardise process. To develop a training package for all AHP staff relating to the 6 C's / reducing harm to patients by appropriate early discharge from acute hospital care.	Vicki Adams and Sophie Combes researching examples of good practice to support the development of a training package for AHP's. Working with Steve Reed as part of the Community Hub projects to include this principle into the project workstreams. Melanie Liley and Steve Reed meeting 17.07.2014 to discuss and plan for forthcoming workshops.	Vicki Adams / Sophie Combes	Melanie Liley				First session planned for 3 November 2014 with all band 7s includes personal and professional resposibility 6Cs. Embedding principles of discharge into community. Exploring intermediate care and reablement opportunitues				
Information	whole system data not readily available		SRG have an agreed stategy for information sharing. Dashboard in progress	Progress slow to review at next SRG		Becky Case	Nov-14							
Governance	Agree key measurables as a health community		Linked to Dash board. Agreement of KPI for each service development. Monitoring manintained through the Unplanned SRG	Dashboard in development. KPI process in place. Monitoring to continue through SRG		Becky Case	Aug-14							
Bed Management	Current bed management system does not meet the demands of the service.		Predictor tool being trialed as part of the Perfect Week planned in Scarborough, this will be incorporated in a sustainability plan.	Predictor tool incoporated into daily operations. Outcome measures from "PW" experience shared with Board. Implemented Command and control. Learning to be shared with York. Trial senior on site presence OOH		Mandy McGale Liz Booth	Sep-14							
Escalation	Formal escalation processes in place		Implement full capacity protocol	Contacted Royal Liverpool to share practice	Loo Parker	Liz Booth Mandy McGale	Sep-14							
Primary Care	EP		Early pregancy clinics highlighted as a particular problem Scarb Site	To review the process and redesign as required	Kim Hinton	Mandy Mcgale	Dec-14							
Commissioning	Co-ordinated commissioning support		Partnership working through Urgent Care Board nor Unplanned System Resilience Group	Agreement on schemes to support unplanned care		Liz Booth Mandy McGale	Sep-14							

Blank page

F2

York Teaching Hospital NHS
NHS Foundation Trust

Monthly Performance Report

August 2014

Access Targets: 18 Weeks

Indicator	Consequence of Breach (Monthly)	Threshold	Q1 Actual	Jun	Jul	Aug	Q2 Actual
Admitted Pathway: Percentage of admitted patients starting treatment within a maximum of 18 weeks from Referral	**Specialty fail:** £400 fine per patient below performance tolerance **Quarterly:** 1 Monitor point TBC	**90%**	90.9%	90.3%	87.6%	77.5%	
Non Admitted Pathway: Percentage of non-admitted patients starting treatment within a maximum of 18 weeks from Referral	**Specialty fail**: £100 fine per patient below performance tolerance **Quarterly:** 1 Monitor point TCB	**95%**	96.8%	96.6%	96.1%	95.9%	
Incomplete Pathway: Percentage of patients on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	**Specialty fail:** £100 fine per patient below performance tolerance **Quarterly:** 1 Monitor point TBC	**92%**	93.3%	93.3%	93.8%	93.6%	
Zero tolerance RTT waits over 52 weeks for incomplete pathways	£5,000 per Patient with an incomplete RTT pathway waiting over 52 weeks at the end of the relevant month	**0**	1	1	0	0	

Access Targets: Cancer

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

Indicator	Consequence of Breach	Threshold	Q1 Actual	May	Jun	Jul	Q2 Actual
14 Day Fast Track	**Quarterly:** £200 fine per patient below performance tolerance 0.5 Monitor point TBC	**93%**	86.1%	85.7%	85.1%	89.8%	
14 Day Breast Symptomatic	**Quarterly:** £200 fine per patient below performance tolerance 0.5 Monitor point TBC	**93%**	45.6%	41.3%	46.5%	71.0%	
31 Day 1st Treatment	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**96%**	98.6%	99.0%	97.6%	96.9%	
31 Day Subsequent Treatment (surgery)	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**94%**	96.4%	96.3%	95.5%	96.4%	
31 Day Subsequent Treatment (anti cancer drug)	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**98%**	100.0%	100.0%	100.0%	98.7%	
62 day 1st Treatment	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point tbc	**85%**	87.8%	87.1%	84.6%	89.9%	
62 day Screening	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point tbc	**90%**	96.6%	100.0%	100.0%	100.0%	
62 Day Consultant Upgrade	General Condition 9	**85%**	50.0%	none	100.0%	-	

Emergency Department

Indicator	Consequence of Breach (Monthly)	Threshold	Q1 Actual	Jun	Jul	Aug	Q2 Actual
Percentage of A & E attendances where the Patient was admitted, transferred or discharged within 4 hours of their arrival at an A&E department	£200 fine per patient below performance tolerance (maximum 8% breaches) **Quarterly**: 1 Monitor point TBC	**95%**	93.9%	93.0%	93.0%	92.5%	
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 30 minutes	£200 per patient waiting over 30 minutes in the relevant month	**> 30min**	534	219	191	144	
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 60 minutes	£1,000 per patient waiting over 60 minutes in the relevant month	**> 60min**	224	73	95	84	
Ambulance Handovers over 30 and 60 Minutes by CCG	**Ambulance Handovers over 30 and 60 Minutes by CCG**	**Breach Category**	**Q1 Actual**	**Jun**	**Jul**	**Aug**	**Q2 Actual**
	NHS VALE OF YORK CCG	30mins - 1hr	176	57	26	15	
		1hr - 2hrs	101	29	7	10	
	NHS SCARBOROUGH AND RYEDALE CCG	30mins - 1hr	141	68	64	65	
		1hr - 2hrs	56	20	27	40	
	NHS EAST RIDING OF YORKSHIRE CCG	30mins - 1hr	96	48	46	30	
		1hr - 2hrs	26	12	32	24	
	NHS HAMBLETON, RICHMONDSHIRE AND WHITBY CCG	30mins - 1hr	27	10	10	10	
		1hr - 2hrs	5	1	8	3	
	OTHER	30mins - 1hr	41	11	22	24	
		1hr - 2hrs	19	6	16	7	
Trolley waits in A&E not longer than 12 hours	£1,000 per incidence in the relevant month	**> 12 hrs**	0	0	1	1	
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%**	97.4%	98.0%	To follow	To follow	

Mortality

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q1 Actual	Jun	Jul	Aug	Q2 Actual
Mortality – SHMI (YORK)	**Quarterly:** General Condition 9	**TBC**	93				
Mortality – SHMI (SCARBOROUGH)	**Quarterly:** General Condition 9	**TBC**	104				

Infection Prevention

Indicator	Consequence of Breach (Monthly)	Threshold	Q1 Actual	Jun	Jul	Aug	Q2 Actual
Minimise rates of Clostridium difficile	*Schedule 4 part G* **Quarterly:** 1 Monitor point tbc	**59**	12	6	1	3	
Number of Clostridium difficile due to "lapse in care"	*TBC*	**TBC**	TBC	TBC	TBC	TBC	
Number of E-Coli cases	**Quarterly:** General Condition 9	**108**	30	8	6	7	
Number of Methicillin Sensitive Staphylococcus Aureus (MSSA) cases	**Quarterly:** General Condition 9	**35**	14	4	6	1	
Zero tolerance MRSA	£10,000 in respect of each incidence in the relevant month	**0**	0	0	0	0	
Notification of MRSA Bacteraemia to be notified to commissioner within 2 working days	General Condition 9	**100%**	n/a	n/a	n/a	n/a	
Post Infection Review (PIR) of MRSA bacteraemia/SI report to be provided to the commissioner within 14 working days of the case being identified in line with national data capture system	General Condition 9	**100%**	n/a	n/a	n/a	n/a	
Post Infection Review (PIR) completed	TBC	**TBC**	n/a	n/a	n/a	n/a	
Elective admissions are screened for MRSA prior to admission	**Quarterly:** General Condition 9	**95% by Q4 TBC**	87.9%	90.3%	88.1%	87.9%	
Emergency admissions are screened for MRSA within 24 hours of admission	**Quarterly:** General Condition 9	**95% by Q4 TBC**	71.2%	71.3%	74.3%	69.6%	

Quality and Safety

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q1 Actual	Jun	Jul	Aug	Q2 Actual
Percentage of Patients waiting less than 6 weeks from Referral for a diagnostic test	£200 fine per patient below performance tolerance	**99%**	97.6%	98.5%	98.6%	98.4%	
Sleeping Accommodation Breach	£250 per day per Service User affected	**0**	0	0	0	0	
All Patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the Service User's treatment to be funded at the time and hosp	Non-payment of costs associated with cancellation and non- payment or reimbursement (as applicable) of re-scheduled episode of care	**0**	1	1	0	0	
No urgent operation should be cancelled for a second time	£5,000 per incidence in the relevant month	**0**	0	0	0	0	
Cancelled operations within 48 Hours of the TCI due to lack of beds	General Condition 9	**65 per month**	63	20	47	6	
VTE risk assessment: all inpatient undergoing risk assessment for VTE, as defined in Contract Technical Guidance	£200 in respect of each excess breach above threshold	**95%**	97.2%	97.6%	97.5%	97.1%	
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%**	99.7%	99.8%	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%**	5.9%	4.8%	6.3%	Not available	
All ELECTIVE patients to have an Expected Discharge Date (EDD) recorded in the patient case notes or patient management system within 24 hours of admission	General Condition 9	**Q1 - 89% Q2 - 90% Q3 - 92% Q4 - 95%**	85.9%	90.4%	85.7%	85.7%	
Delayed Transfer of Care to be maintained at a minimum level	TBC	**TBC**	1548	593	760	636	
Trust waiting time for Rapid Access Chest Pain Clinic	None	**99%**	100.0%	100.0%	100.0%	100.0%	
No patient cancelled more than twice by the Trust for non-clinical reasons. All new dates to be arranged within 6 weeks of the cancelled appointment	General Condition 9	**90%**	Annual statement of assurance				
Outpatient clinics cancelled with less than 14 days notice	General Condition 9	**200 per month**	348	137	198	157	
Reduction in number of hospital cancelled first and follow up outpatient appointments for non-clinical reasons where there is a delay in the patient treatment	General Condition 9	**Baseline 784; end Q2 745; end Q4 722**	2236	760	753	687	
% of ED Admissions With a NEWS Score		**TBC**	78.8%	78.5%	80.6%	78.9%	
% Compliance with WHO safer surgery checklist	No financial penalty	**100%**	100.0%	100.0%	100.0%	100.0%	
Readmissions within 30 days – Elective	The CCG will apply a % penalty following Flex and Freeze validation. (ER)	**08/09 outturn awaiting figure from CCG**	371	137	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**	1247	429	2 month coding lag	2 month coding lag	
Reduction in the number of inappropriate transfers between wards and other settings during night hours (Reduction in avoidable site transfers within the Trust after 10pm)	General Condition 9	**Q2 onwards 80 p.m. (TBC)**	256	78	76	89	

Quality and Safety

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q1 Actual	Jun	Jul	Aug	Q2 Actual
Care of the Deteriorating Patient: All acute medical, elderly medical and orthogeriatric (FNoF) admissions through AMU to be seen by a senior decision maker (registrar or nurse)	General Condition 9	**80% by site**	87.9%	87.0%	91.2%	78.9%	
Number/Percentage women who have seen a midwife by 12 weeks and 6 days (as per IPMR definition)	General Condition 9	**90%**	93.7%	99.4%	99.8%	98.6%	
Number/Percentage of maternity patients recorded as smoking by 12 weeks and 6 days that are referred to a smoking cessation service subject to patient consent	General Condition 9	**95%**	100.0%	100.0%	100.0%	100.0%	
Proportion of stroke patients who spend >90% of their time on a stroke unit	Non delivery of 90% at Q4 £5,000 In line with GC9 where the provider fails to meet the quarterly trajectory an action plan will be delivered. Maximum sanction of £5k in line with respective finance baselines (TBC)	**80%**	86.9%	96.0%	89.5%	one month behind	
Proportion of people at high risk of stroke who experience a TIA are assessed and treated within 24 hours of seeing a health professional	Non delivery of Q4 £5,000 In line with GC9 where the provider fails to meet the quarterly trajectory an action plan will be delivered. Maximum sanction of £2k in line with respective finance baselines (TBC)	**70% (TBC)**	86.7%	88.6%	86.8%	one month behind	
Proportion of patients presenting with stroke with new or previously diagnosed AF who are anti-coagulated on discharge or have a plan in the notes or discharge letter after anti-coagulation	General Condition 9	**65%**	95.0%	100.0%	100.0%	one month behind	
Percentage of stroke patients and carers with joint care plans on discharge from hospital to have a copy of their care plan (except RIP or who refuse health/social care assessment/intervention)	General Condition 9	**70%**	n/a	n/a	n/a	n/a	
Patients who require an urgent scan on hospital arrival, are scanned with in 1 hr of hospital arrival (TBC)	No financial penalty	**50%**	82.6%	75.0%	66.7%	one month behind	
Proportion of stroke patients scanned within 24 hours of hospital arrival	No financial penalty	**90% (TBC)**	91.6%	93.8%	97.1%	one month behind	
Transmission of IDLs to GPs within 24 hours of discharge (Q1-Q3 elective and non-elective activity IP only excluding DC, Maternity and by end Q4 to include surgical DC activity too) - Quarterly audit undertaken on Scarborough and Ryedale and East Riding patients and triangulated with Trust information. Method of measurement will be in line with agreed methodology.	Failure to deliver the quarterly target will result in the application of a £4k penalty per quarter Maximum sanction of £16K per annum based upon respective commissioners financial baselines (TBC)	**Q1 - 90%** **Q2 - 91%** **Q3 - 93%** **Q4 - 95%**	76.0%	79.5%	78.7%	74.9%	
Immediate Discharge Letters (IDLs) handed to patients on Discharge	General Condition 9	**98%**	Annual letter of assurance to be provided to CMB				
Quality of Ward IDLs (Quarterly audit undertaken on Scarborough and Ryedale and East Riding patients and triangulated with Trust information. Method of measurement will be in line with agreed methodology)	Failure to deliver quarterly trajectories at Trust aggregate level for each quarter will result in the application of a £10K sanction relating to each underperforming quarter. Maximum sanction of £40k per fiscal year. The penalty will be applied by the commissioners in line with respective finance baselines (TBC)	**Q1 - 90%** **Q2 - 91%** **Q3 - 93%** **Q4 - 95%**	Quarterly audit				
Quality of ED IDLs (Quarterly audit undertaken on Scarborough and Ryedale and East Riding patients and triangulated with Trust information. Method of measurement will be in line with agreed methodology)	Failure to deliver the quarterly target will result in the application of a £6k penalty per quarter. Maximum sanction of £24k in line with respective finance baselines (TBC)	**Q1 - 90%** **Q2 - 91%** **Q3 - 93%** **Q4 - 94%**	Quarterly audit				
All Red Drugs to be prescribed by provider effective from 01/04/14	£50 penalty for any request to primary care for prescription of Red Drugs (TBC)	**100% list to be agreed**	CCG to audit for breaches				
All Amber Drugs to be prescribed by provider effective from 01/04/14	No financial penalty	**100% list to be agreed**	CCG to audit for breaches				
NEWS within 1 hour of prescribed time	None - Monitoring Only	**None**	86.6%	86.1%	87.3%	86.6%	

Never Events

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q1 Actual	Jun	Jul	Aug	Q2 Actual
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**	0	0	0	

District Nursing Activity Summary

Indicator	Source	Threshold	Q1 Actual	Jun	Jul	Aug	Q2 Actual
District Nursing Referrals (excluding Allied Health Professionals)	GP	n/a	1735	546	680	500	
	Community nurse/service	n/a	697	187	320	220	
	Acute services	n/a	642	179	235	133	
	Self / Carer/family	n/a	391	103	125	142	
	Other	n/a	225	78	97	84	
	Grand Total	n/a	3690	1093	1457	1079	
District Nursing Contacts	First	n/a	2616	835	1008	712	
	Follow up	n/a	32198	10566	10268	10256	
	Total	n/a	34814	11401	11276	10968	
	First to Follow Up Ratio	n/a	12.31	12.65	10.20	14.40	
Community Hospitals average length of stay (days)	Archways	n/a	23.4	28.3	23.4	20.1	
	Malton Community Hospital	n/a	24.5	23.6	22.8	17.4	
	St Monicas Hospital	n/a	24.5	26.9	20.5	24.7	
	The New Selby War Memorial Hospital	n/a	13.8	17.6	18.0	11.1	
	Whitby Community Hospital	n/a	21.1	22.6	20.1	18.4	
	Total	n/a	20.4	22.8	20.8	17.6	
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	8	2	2	2	
		Emergency	66	21	36	24	
	Malton Community Hospital	Elective	4	1	1	2	
		Emergency	89	33	42	35	
	St Monicas Hospital	Elective	9	0	7	3	
		Emergency	36	9	9	14	
	The New Selby War Memorial	Elective	68	12	21	19	
		Emergency	71	25	20	22	
	Whitby Community Hospital	Elective	0	0	0	1	
		Emergency	152	50	41	44	
	Total	Elective	89	15	31	27	
		Emergency	414	138	148	139	

Monthly Quantitative Information Report

York Teaching Hospital NHS
NHS Foundation Trust

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Complaints and PALS												
New complaints this month	51	38	58	57	46							
Complaints at same month last year	52	48	49	59	42							
Number of complaints upheld (cumulative)*	not known yet	not known yet	not known yet	not known yet	not known yet							
Number of complaints partly upheld (cumulative)**												
Number of Ombudsman complaint reviews	0	2	0	3	0							
Number of Ombudsman complaint reviews upheld	0	0	0	0	0							
Number of Ombudsman complaint reviews partly upheld	0	1	1	2	0							
Late responses this month (at the time of writing)***	4	7	4	9	4							
Top 3 complaint issues												
Aspects of clinical treatment	39	27	34	39	37							
Admission/discharge/transfer arrangements	5	2		3	2							
Appointment delay/cancellation - outpatient	3				1							
Staff attitude		4	6	10	6							
Communications			5	3	0							
New PALS queries this month	495	474	528	531	488							
PALS queries at same time last year	488	521	462	563	498							
Top 3 PALS issues												
Information & advice	107	118	168	140	158							
Staff attitude	61				15							
Aspects of clinical treatment	53	87	99	104	93							
Appointment delay/cancellation - outpatient		66	59	67	56							
**note: upheld complaints are reported quarterly to allow for investigation timescales*												
***note: we do not record partly - if a complaint generates 1 or more actions for improvement then it is reorded as upheld*												
****note: if extensions are made in agreement with the complaint, responses are not considered late*												
Serious Incidents												
Number of SI's reported	19	21	20	19	13							
% SI's notified within 2 working days of SI being identified*	89%	76%	70%	94%	100%							
% SI's closed on STEIS within 6 months of SI being reported	50%	0%	0%	0%	0%							
Number of Negligence Claims	11	14	16	15	21							
* this is currently under discussion via the 'exceptions log'												

Monthly Quantitative Information Report

York Teaching Hospital NHS
NHS Foundation Trust

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Pressure Ulcers**												
Number of Category 2	43	40	37	22								
Number of Category 3	12	9	10	5								
Number of Category 4	1	0	0	0								
Total number developed/deteriorated while in our care (care of the organisation) - acute	35	27	24	15								
Total number developed/deteriorated while in our care (care of the organisation) - community	32	29	27	19								
Falls***												
Number of falls with moderate harm	10	8	7	3								
Number of falls with severe harm	8	6	4	1								
Number of falls resulting in death	0	0	0	0								
Safeguarding												
% of staff compliant with training (children)			45%	45%	47%							
% of staff compliant with training (adult)			39%	40%	43%							
% of staff working with children who have review CRB checks												
Prevent Strategy												
Attendance at the HealthWRAP training session	3 in total	3 in total	3 in total	3 in total	3 in total							
Number of concerns raised via the incident reporting system	nil	nil	nil	nil	nil							

** Revised data for April due to data validation

*** 13 falls uncoded for April, 1 for May and 2 for June being followed up

Blank page

F3

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors - 24 September 2014

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 31 August 2014.

At the end of August the Trust is reporting an Income and Expenditure (I&E) deficit of £1.1m against a planned balanced position for the period. The Income & Expenditure position places the Trust behind its Operational plan.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes.

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

Briefing Note for the Finance & Performance Committee Meeting 16 September 2014
Briefing Note for the Board of Directors Meeting 24 September 2014

Subject: August 2014 (Month 5) Financial Position

From: Andrew Bertram, Finance Director

Summary Reported Position for August 2014

Between the July Board meeting and the September meeting our I&E position has remained in deficit. The current latest reported position for August being an actual deficit of income against expenditure of £1.1m. This results in a variance of £1.2m against our planned position of a £0.04m surplus.

Of note in August is that our operational plan predicted a £0.76m deterioration in our cumulative I&E position from a planned surplus of £0.8m to a planned surplus of £0.04m. This primarily related to low activity and income expectations for the month. These expectations have been exceeded and our actual I&E position has improved from a £1.4m deficit to a £1.1m deficit.

Assumptions remain in our reported position for both ambulance turnaround penalties and for receipt of financial support in relation to costs incurred by the Trust as a result of delayed or failed investment of the 70% marginal non-elective rate savings and readmission savings by our CCGs.

The reported position assumes reinvestment of all current ambulance turnaround penalties. These total £477k. The original assumption around receipt of CCG support related to the marginal rate non-elective tariff and readmissions savings remains in our reported position.

Both main CCGs have indicated that, coupled with improvement plans for ambulance turnaround performance, they would be willing to consider reinvestment of the penalties. Discussions continue with both CCGs over the availability of funds to support our claims in relation to marginal rate non-elective tariff and readmissions savings.

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

CIP performance is £2.9m (year-to-date) behind the required savings level. Whilst this is materially impacting on our reported I&E position this does represent better performance than this time last year, when set against last year's delivery trajectory. This issue is dealt with in detail in the efficiency report.

Income Analysis

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

Contract penalties (excluding ambulance turnaround) have increased to £552k. Details are provided in the finance report and performance report.

Expenditure Analysis

Pay budgets and provisions are £1.6m overspent for August. Operational budgets are under spending but locum and agency medical staff and nursing staff expenditure is running at an unaffordable premium level. The agency spend to date totals £3.7m. Clearly there are substantive funded vacant posts offsetting this position but the premium cost on the use of agency is placing significant pressure on our finances. Pressure areas include: medical agency staff in Scarborough for Elderly, Acute Medicine and Ophthalmology and medical staff agency spend at York in ED. There is also considerable nursing agency expenditure in General Medicine, specifically AMU/SSW and Ward 33.

Pay spend (including agency) totalled £24.5m in June. This is in line with the year to date average of £24.6m per month but continues to place pressure on our finances due to the miss-alignment to budget associated with agency costs. Concerted attempts to recruit substantively must continue as an annual agency expenditure bill of around £8m represents a significant premium on costs.

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

The report shows that the CIP programme is impacting adversely on the position by £2.9m. This is the most material adverse issue impacting on our expenditure and is dealt with in the CIP report.

2013/14 Contract Reconciliation

All 2013/14 contract issues have now been resolved, with a final position agreed with H&RD CCG some £0.1m better than recorded in our 2013/14 accounts.

Contracting Matters

Since my last report we have agreed and signed a contract with NHSE for specialised services. This has allowed the final reconciliations to be completed with our CCGs and, although CCG contracts remain unsigned, all acute service elements are agreed and work is drawing to a close in terms of finalising schedules for signature. There remains a single outstanding issue with VOY CCG in relation to our community contract and negotiations continue.

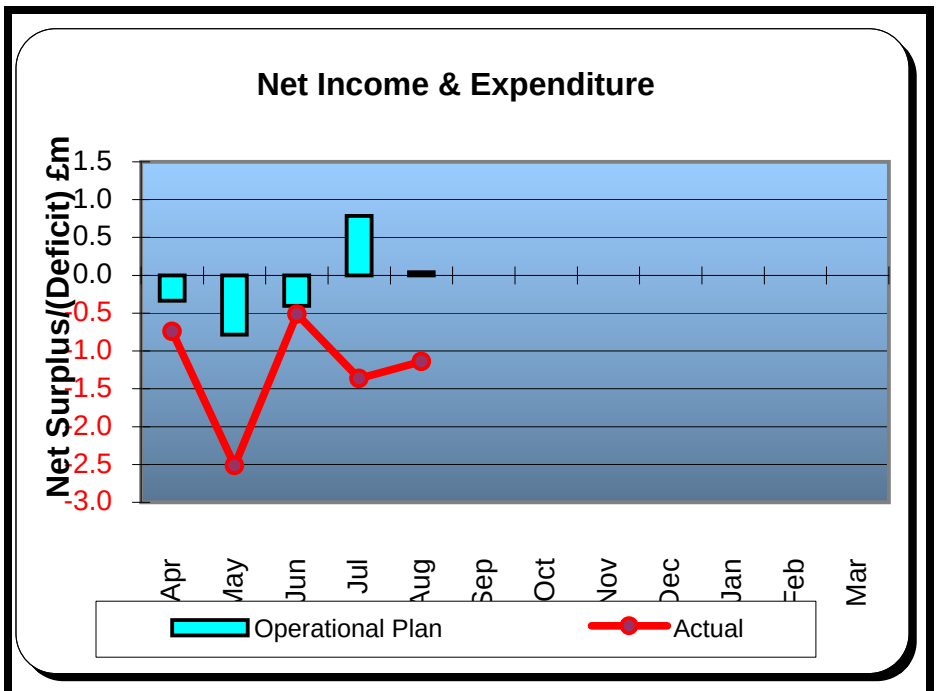
Other Issues

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

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
Financial Report for the Period 1 April 2014 to 31st August 2014

High Level Overview

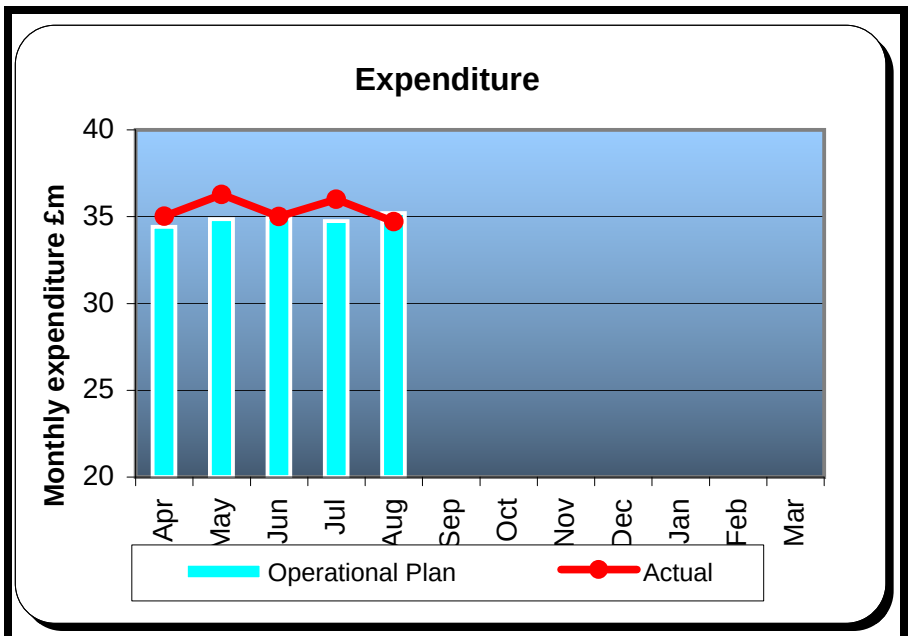
* A net I&E deficit for the period of £1.1m means the Trust is £1.2m behind plan.
* CIPs achieved at the end of August total £10.6m. The CIP position is running £2.9m behind plan.
* Contracts are currently unsigned (with the exception of NHS England), however the estimated overall actual activity value is forecast to be under contract by £0.8m.
* Cash balance is £37.8m, and is £10m ahead of plan.
* Capital spend totalled £9.39m, and is slightly ahead of the plan.
* The Continuity of Service Risk Rating is 4.



Key Period Operational Variances

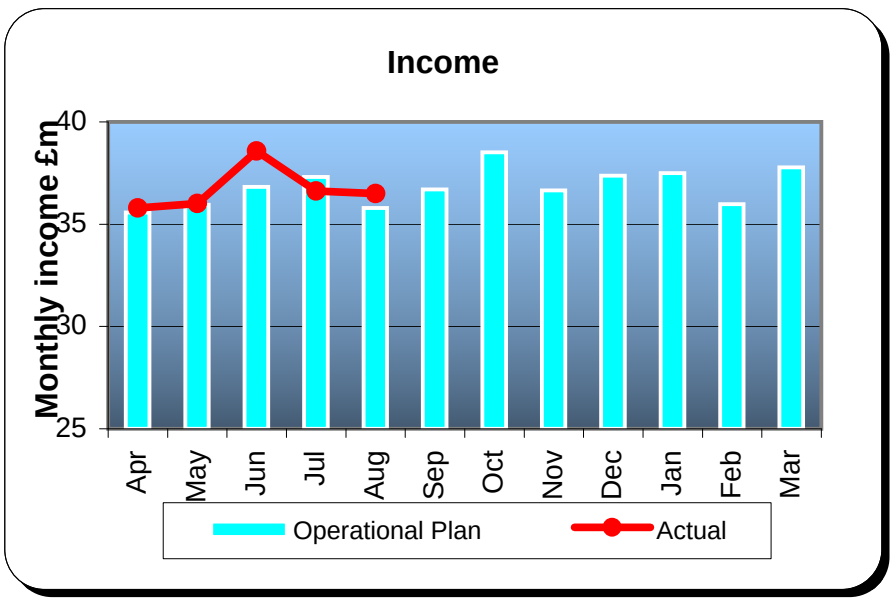
	Plan £m	Act.£m	Var. £m
Clin.Inc.(excl. VET)	154.9	156.1	1.2
Clin.Inc.(VET))	6.1	5.6	-0.5
Other Income	20.8	21.9	1.1
Pay	-121.3	-122.9	-1.6
Drugs	-17.4	-17.2	0.3
Consumables	-18.6	-18.1	0.5
Other Expenditure	-24.4	-26.5	-2.1
	0.0	**-1.1**	**-1.2**

(VET = Vitreous Eye Treatments)



At the end of August there is an adverse variance against operational expenditure budgets of £2.9m. This comprises:-

- Operational pay being £1.6m overspent, predominantly due to a premium paid for agency staff covering vacant posts
- Drugs £0.3m underspent
- Clinical supplies £0.5m underspent.
- Other costs are £0.9m underspent
- Restructuring costs are £0.1m overspent
- CIPs are £2.9m behind plan

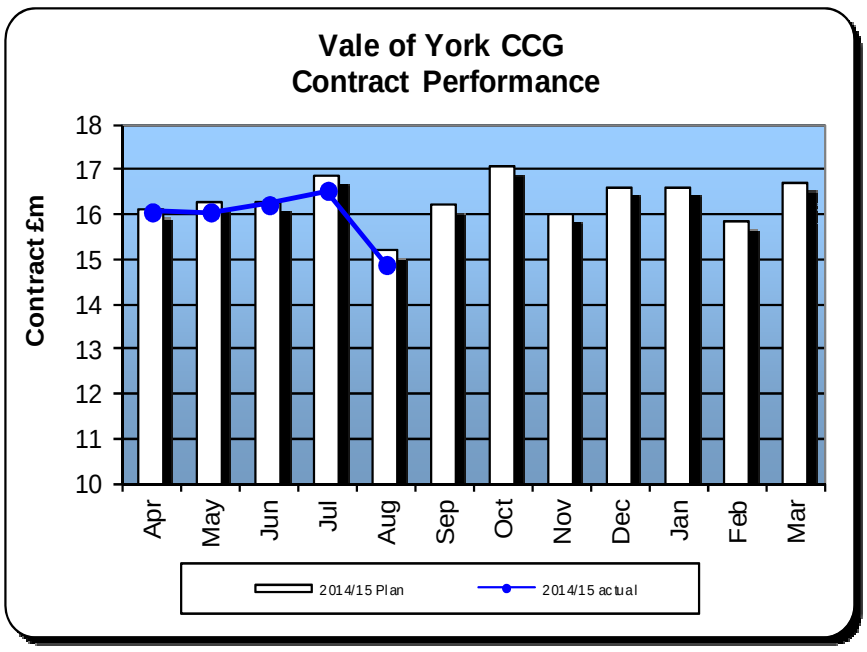


At the end of August income is ahead of plan by £1.7m. This comprises:

- Elective and day case income are behind plan by £1.3m.
- Non elective is ahead of plan by £2.4m.
- Out patient income is behind plan by £1.3m
- A&E income is behind plan by £0.2m
- Other clinical income is ahead of plan by £1.1m.
- Other income is £1.0m ahead of plan

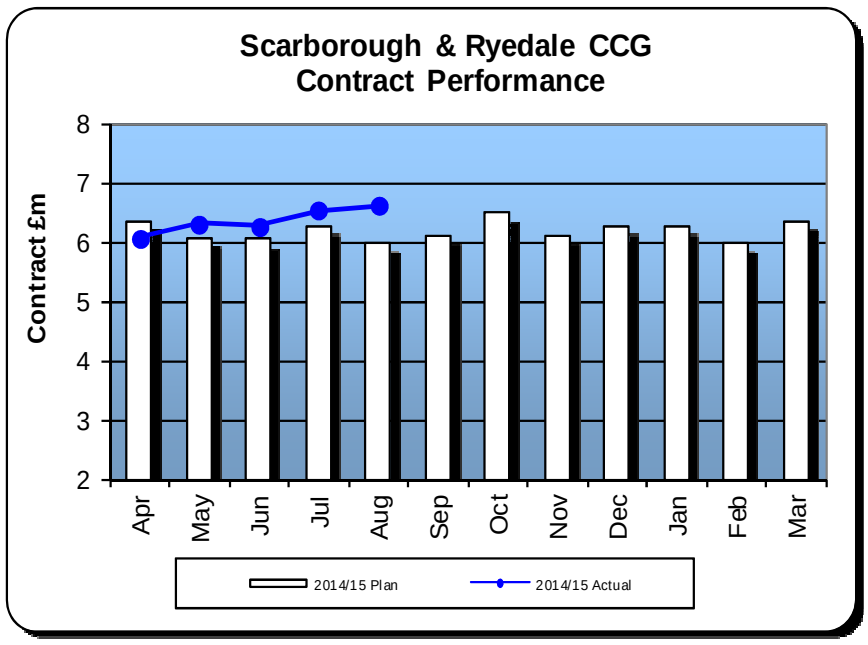
- Potential contract penalties and fines are estimated at £0.5m, included within the lines above.

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
Financial Report for the Period 1 April 2014 to 31st August 2014



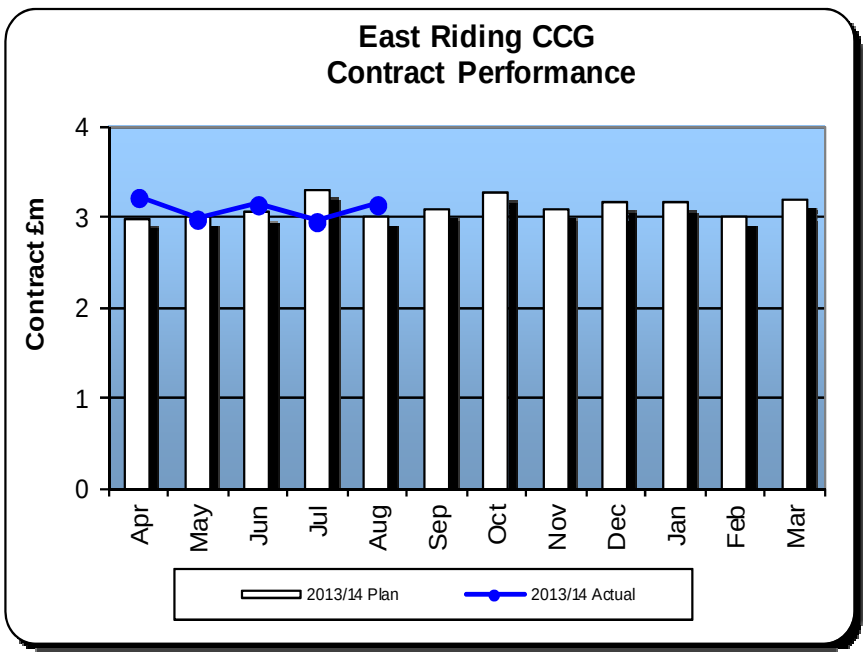
The contract value is estimated to be £195.1m.

The contract is not signed yet, however the estimated actual value to date is forecast to be under contract by £1.0m. This position includes estimates for August and the plan is adjusted for the provisional contract plan for the period.



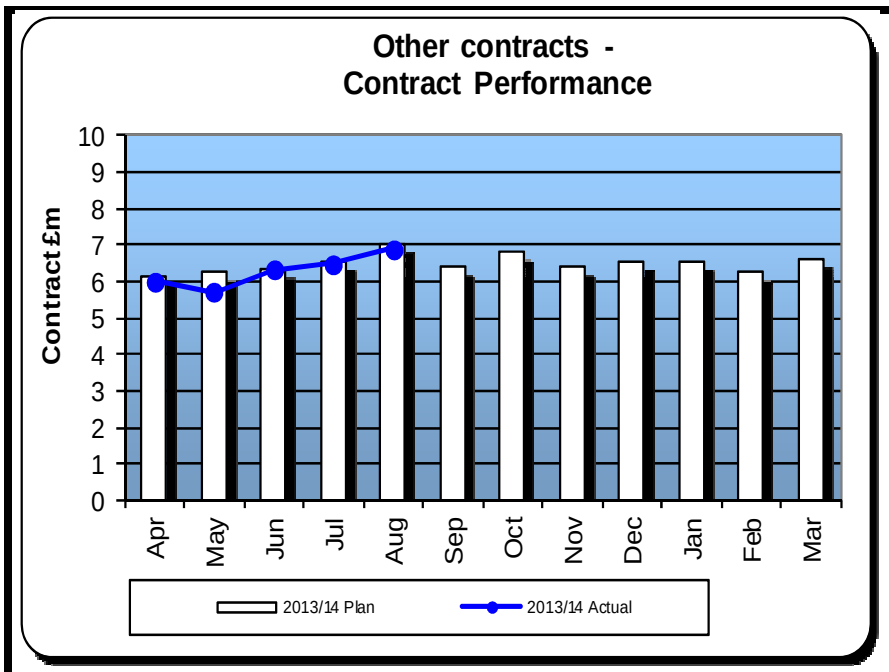
The contract value is estimated to be £73.7m.

The contract is not signed yet, however the estimated actual value to date is forecast to be ahead of contract by £1.1m. This position includes estimates for August and the plan is phased in twelfths until finalised.



The contract value is estimated to be £36.9m.

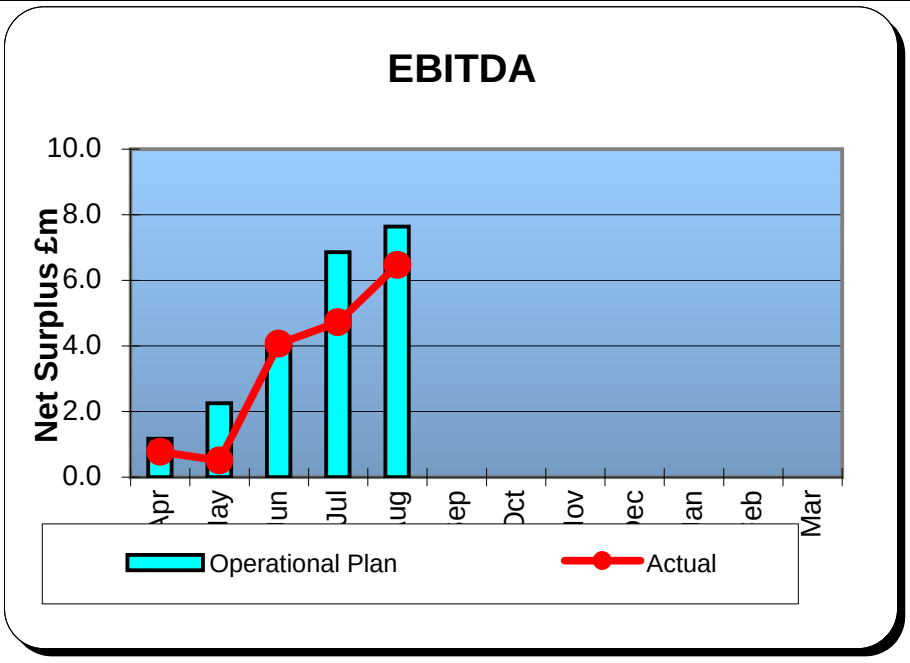
The contract is not signed yet, however the estimated actual value to date is forecast to be on balance. This position includes estimates for August.

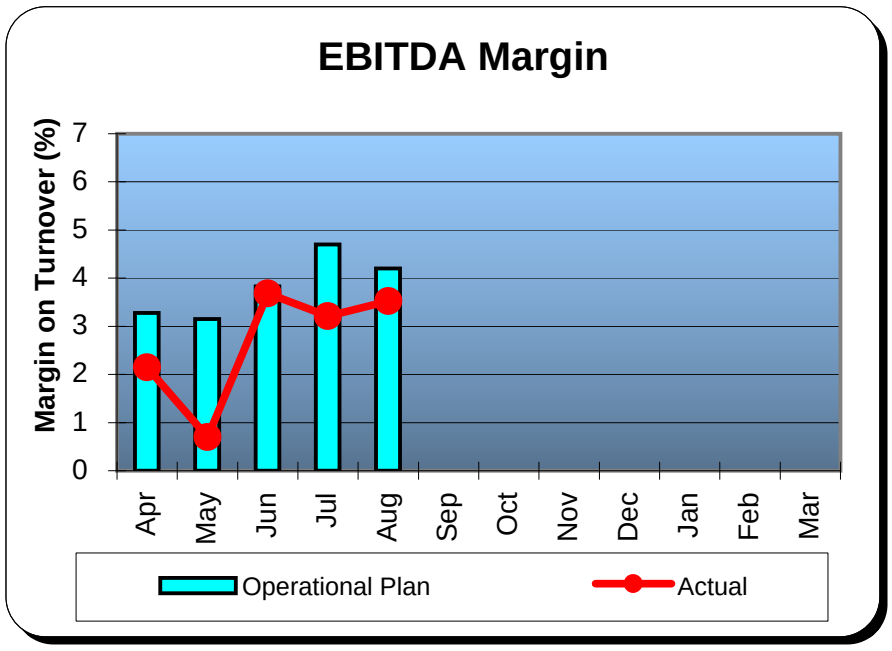


The contract value is estimated to be £77.7m.

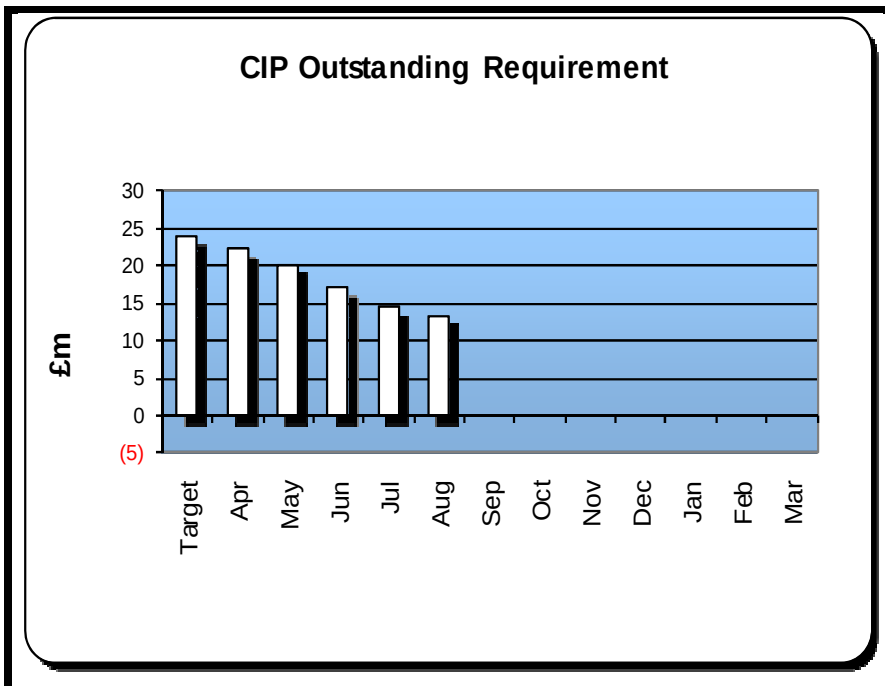
These include the smaller CCGs, NHS England, and Local Authority contracts. Overall, the actual position is estimated to be behind contract by £0.9m. Other than for NHS England the other contracts are not yet signed, and the actual value is estimated at this stage. A high volume of uncoded data may affect the allocation of income against individual contracts, and particularly the undertrade on the prescribed specialist services of £0.4m.

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
Financial Report for the Period 1 April 2014 to 31st August 2014

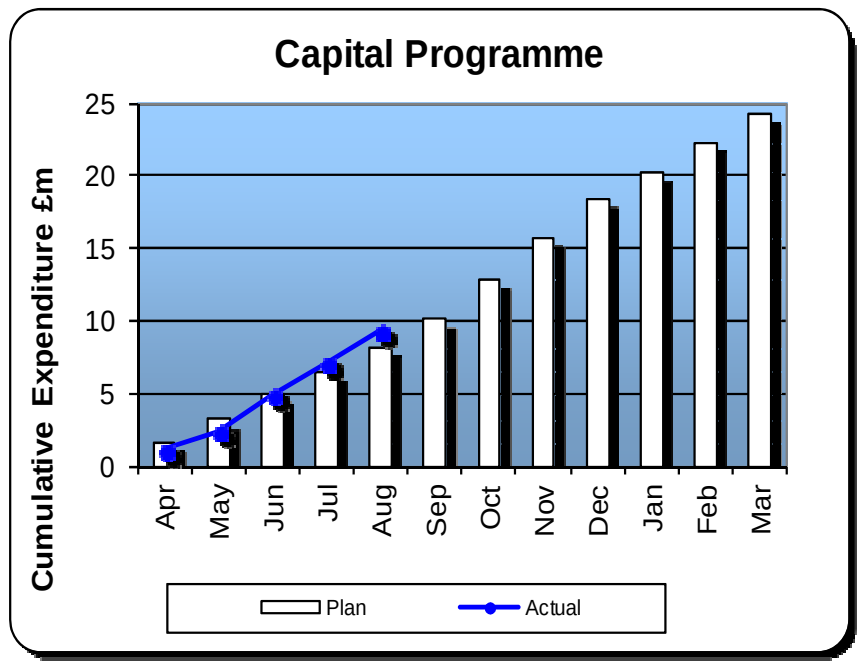




Actual EBITDA at the end of August is £6.467m (3.52%), compared to operational plan of £7.635m (4.20%), and is reflective of the overall I&E performance.



The full year efficiency requirement is £24.0m. At the end of August £10.6m has been cleared.



Capital expenditure to the end of August totalled £9.39m and is slightly ahead of plan.

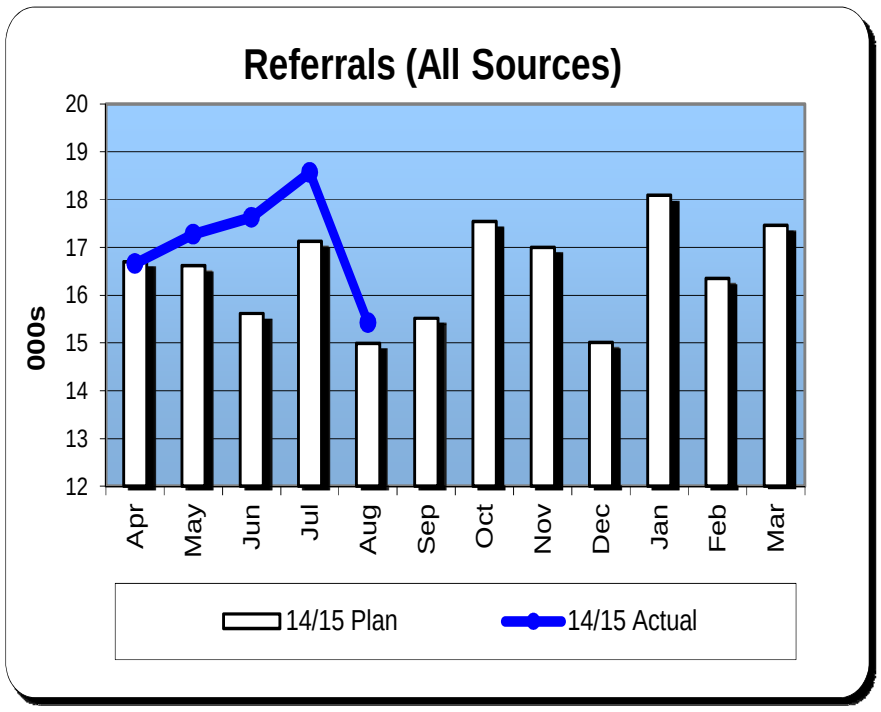
Capital schemes with significant in year spend to date include the on going upgrade of the York Hospital restarurant and kitchens, Endoscopy decontamination expansion and the nearly completed carbon & energy scheme. In Scarborough phase 1 of the new carpark is completed and significant progress on Maple 2(Lilac ward) new build.

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
Financial Report for the Period 1 April 2014 to 31st August 2014

Continuity of Service Risk Rating (CoSSR):

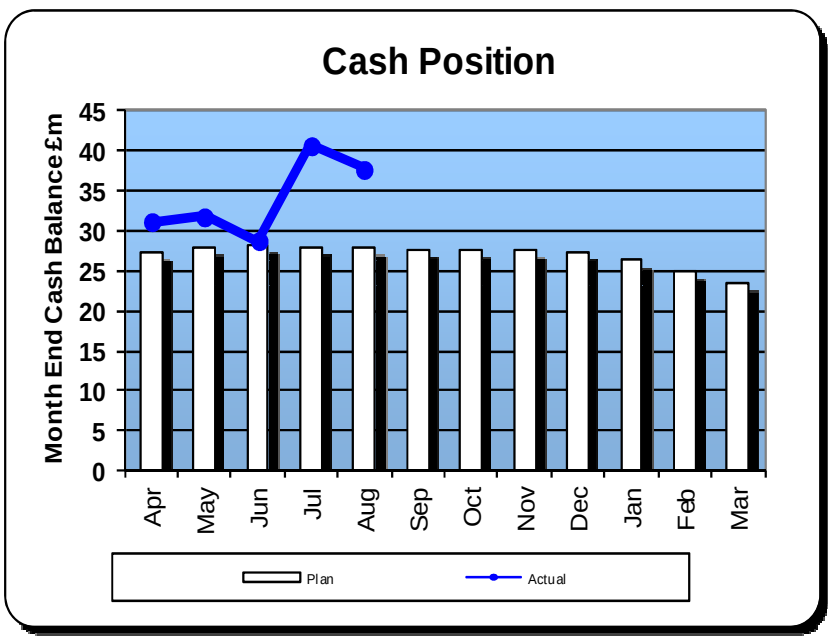
Debt Service Cover rating	3
Liquidity rating	4
Overall CoSSR	**4**

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



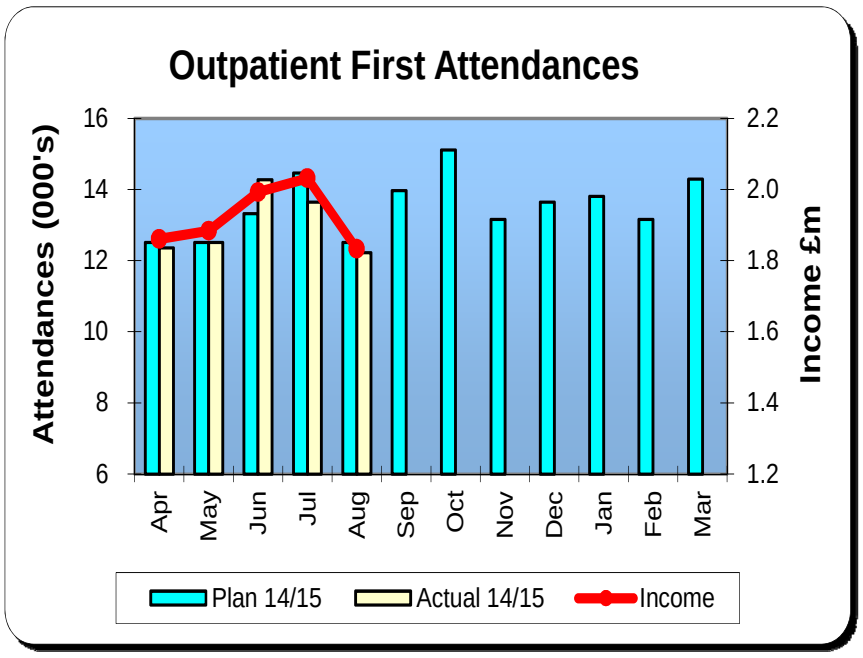
Annual plan 198,057 referrals (based on full year equivalent of 2013/14 outturn)

Variance at end of August: +4,477 referrals (+5.5%)
GP referrals +2,400 (+5.1%)
Cons to Cons referrals -829 (-6.9%)
Other referrals +2,906 (+13.4%)



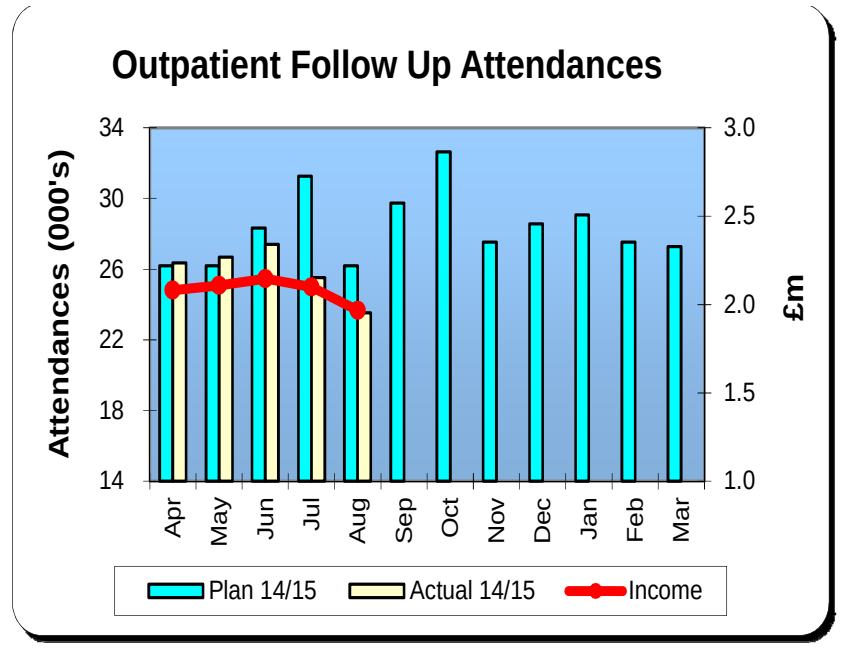
The cash balances at the end of August totalled £37.8m, this is £10m ahead of plan due to the transitional funding received for Scarborough.

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
Financial Report for the Period 1 April 2014 to 31st August 2014



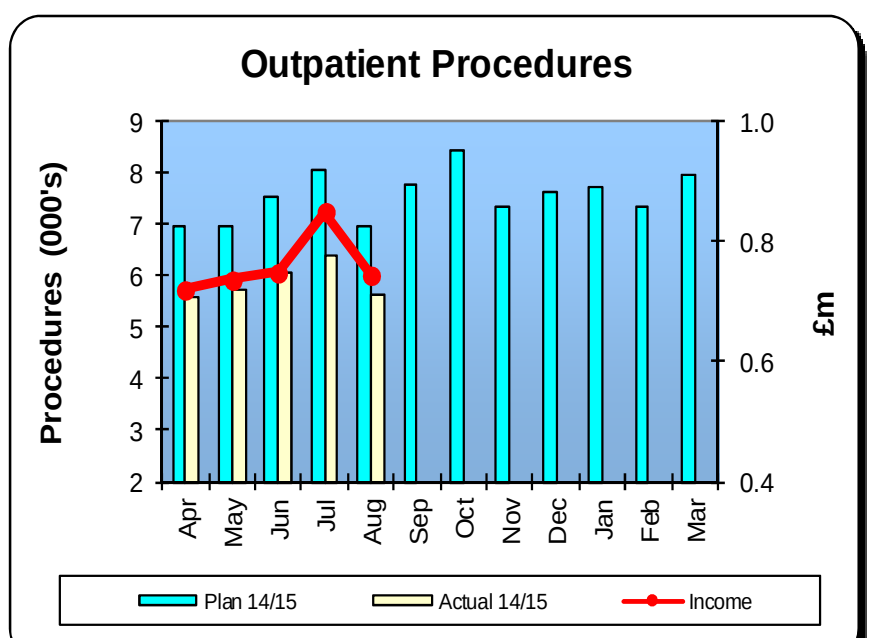
Annual Plan (Attendances) 162,401
Variance at end of August: -582 attendances (-0.9%).

Main variances: Opthalmology +173 (+3%), Obstetrics Zero Tariff +453 (+16%), General Medicine -419 (-91%), Cardiology -348 (-6%), Gastroenterology -382 (-18%)



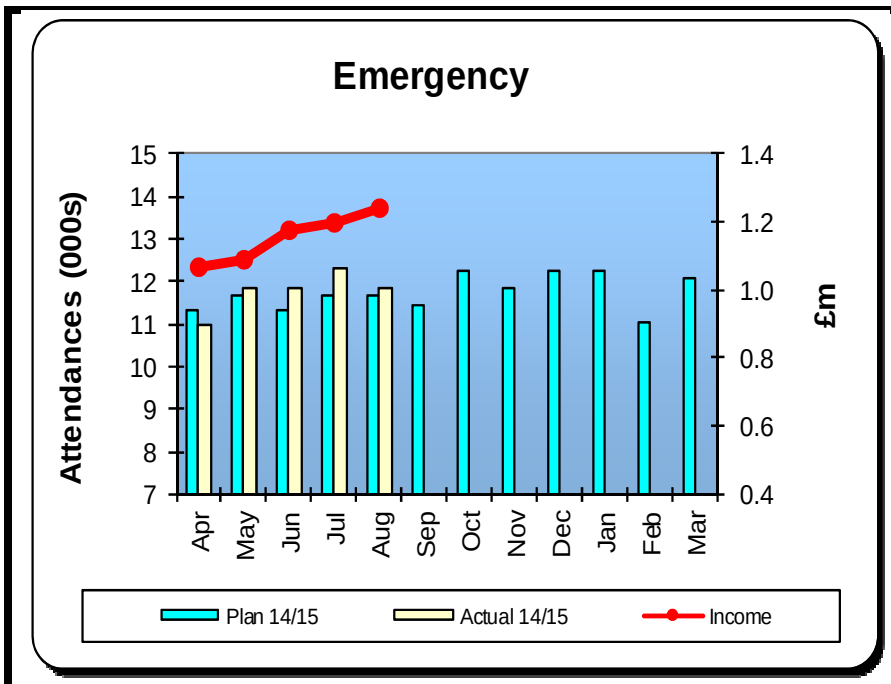
Annual Plan (Attendances) 340,039
Variance at end of August: -7,863 attendances (-5.7%).

Main variances: Pallative Medicine +1,730 (+168%), Paediatrics -1,510 (-33%), Thoracic Medicine -621 (-15%), Gynaecology -1,067 (-32%), and Obstetrics and Midwifery Zero Tariff -5,915 (-27%)



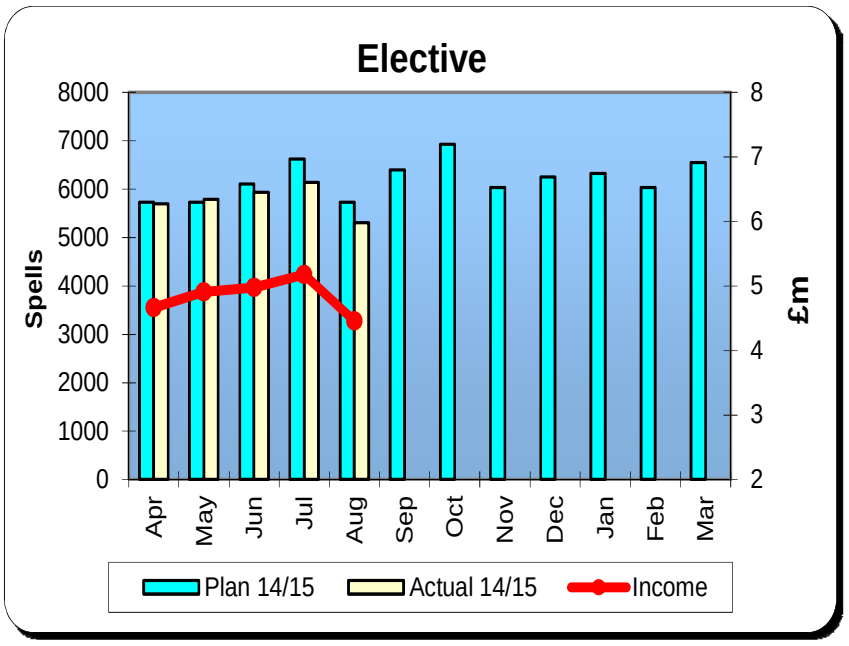
Annual Plan (Procedures) 90,710
Variance at end of August: -7,176 procedures (-19.6%).

Main variances: Dermatology -856 (-11%), Opthalmology -3,950 (-45%), Trauma and Orthopaedics -1,068 (-73%), Restorative Dentistry -350 (-53%), and ENT -781 (-19%).



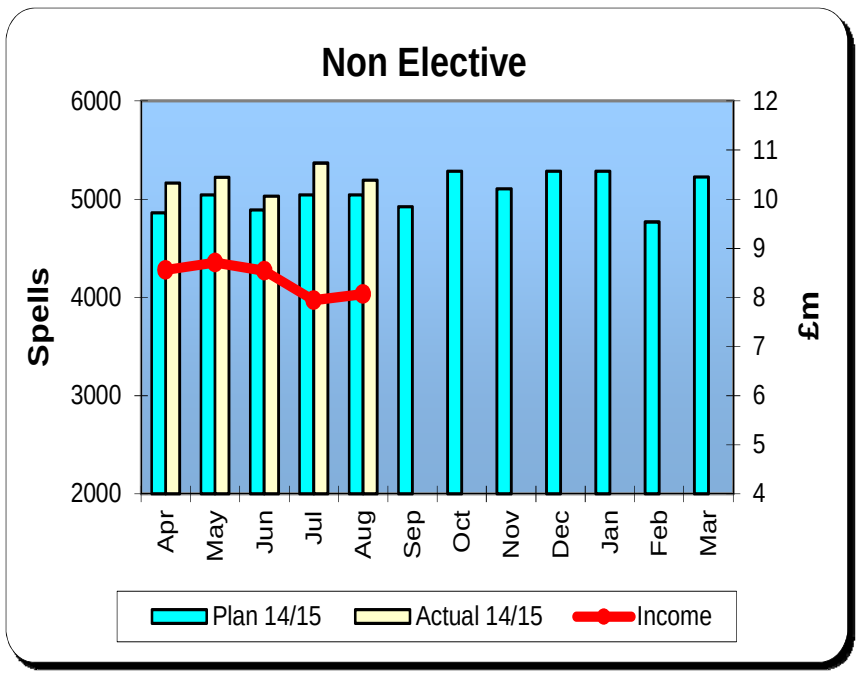
Annual Plan (Attendances) 140,831
Variance at end of August: +1,063 attendances (+1.8%).

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
Financial Report for the Period 1 April 2014 to 31st August 2014



Annual Plan (Spells) 74,445
Variance at end of August: -1,205 spells (-3.1%): inpatient +170; daycase -1,375

Main variances: General Medicine +207 (+29%), General Surgery -243 (-5%), Haematology -311 (-18%), Medical Oncology -399 (-12%), Urology -316 (-7%)



Annual Plan (Spells) 60,765
Variance at end of August: +1,065 spells (+4%).

Main variances: Gastroenterology +370 (+23%), General Surgery +211 (+8%), Endocrinology +312 (+27%), Obstetrics +796 (+38%), General Medicine -501 (-79%)

Contract Penalties

Penalties	YTD Actual	Penalty £000	Comments
52 week breaches		0	£5k penalty per breach per month. Agreement reached to recind penalties following review of cases.
18 week breaches:			Figures include estimates in early months.
- Admitted (90% target, weighting 37.5%)	n/a	26	GenSur £3k; T&O £19k; ENT £5k:
- Non-admitted (95% target, weighting 12.5%)	n/a	11	Cardiology £1.0k; resp. medicine £2.7k; Rheumatology £5.2k.
- Incomplete pathways (92% target, w'ting 50%)	n/a	30	T&O £8k; Gastro £ 5k; ENT £4k, Gastro 5.3k.
Cancer waits		143	Cancer 2 week waits/ Breast symptom two week waits.
NHS Numbers			
A&E 4 hr performance	n/a	261	Faliure to admit, transfer or discharge patients within 4 hours of arrival. Target 95%. Fine is £200 per breach.
Ambulance handover		0	Ambulance handover exceding 30 (£200 each) and 60 minutes (£1,000 each).value assumed at £477k Attempts being made to recover from CCG's.
Diagnostics		81	6 weeks target 99%. relates to tests including radiology, NPU, cardiology tests and endoscopies.
		552	

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
SUMMARY INCOME & EXPENDITURE POSITION
FOR THE PERIOD 1st APRIL 2014 to 31st AUGUST 2014

	ANNUAL PLAN	PLAN FOR PERIOD	ACTUAL FOR PERIOD	PERIOD VARIANCE
	£000	£000	£000	£000
INCOME				
NHS Clinical Income				
Elective Income				
Tariff income	27,474	11,044	9,901	-1,143
Non-tariff income	169	68	56	-12
Planned same day (Day cases)				
Tariff income	35,029	14,081	14,025	-56
Non-tariff income	651	262	194	-68
Non-Elective Income				
Tariff income	94,313	38,664	41,027	2,363
Non-tariff income	1,840	754	791	37
Outpatients				
Tariff income	58,825	23,634	22,613	-1,021
Non-tariff income	4,688	1,885	1,603	-282
A&E				
Tariff income	14,059	5,764	5,589	-175
Non-tariff income	490	201	186	-15
Community				
Tariff income	1,112	456	520	64
Non-tariff income	34,034	14,120	14,035	-85
Other				
Tariff income	0	0		0
Non-tariff income	121,827	50,089	51,154	1,065
				0
	394,511	**161,022**	**161,694**	**672**
				0
	394,511	**161,022**	**161,694**	**672**
Non-NHS Clinical Income				
Private Patient Income	976	407	445	38
Other Non-protected Clinical Income	1,722	718	760	42
	2,698	**1,124**	**1,204**	**80**
Other Income				
Education & Training	14,026	5,844	6,046	202
Research & Development	2,005	835	1,323	488
Donations & Grants received of PPE & Intangible Assets	0	0	0	0
Donations & Grants received of cash to buy PPE & Intangible Assets	600	250	250	0
Other Income	17,573	7,626	7,883	257
Transition support	12,218	5,091	5,091	0
	46,422	**19,646**	**20,593**	**947**
Total Income	**443,631**	**181,792**	**183,491**	**1,699**
EXPENDITURE				
Pay costs	-298,124	-121,320	-122,943	-1,623
Drug costs	-42,202	-17,438	-17,152	286
Clinical Supplies & Services	-45,244	-18,645	-18,141	504
Other costs (excluding Depreciation)	-49,802	-19,616	-18,673	943
Restructuring Costs	0	0	-115	-115
CIP	13,433	2,862	0	-2,862
Total Expenditure	**-421,939**	**-174,157**	**-177,024**	**-2,867**
EBITDA (see note)	**21,692**	**7,635**	**6,467**	**-1,168**
Profit/ Loss on Asset Disposals	0	0	0	0
Fixed Asset Impairments	-300	0	0	0
Depreciation	-10,854	-4,523	-4,523	0
Interest Receivable/ Payable	100	42	71	29
Interest Expense on Overdrafts and Working Capital Facilities	0	0	0	0
Interest Expense on Bridging loans	0	0	0	0
Interest Expense on Non-commercial borrowings	-270	-112	-154	-42
Interest Expense on Commercial borrowings	0	0	0	0
Interest Expense on Finance leases (non-PFI)	0	0	0	0
Other Finance costs	0	0	0	0
PDC Dividend	-7,204	-3,002	-3,002	0
Taxation Payable	0	0	0	0
NET SURPLUS/ DEFICIT	**3,164**	**40**	**-1,141**	**-1,180**

Blank page

F4

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 24 September 2014

Efficiency Programme Update – August 2014

Action requested/recommendation

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

Summary

This report provides a detailed overview of progress to date regarding delivery of the Trust's Efficiency Programme. The 2014/15 target is £24m and full year delivery in August 14 is £10.6m, leaving a gap to be delivered of (£13.4m). There is a significant planning gap of (£2.6m) following a review of all in year plans.

The Monitor variance is (£2.9m) behind plan.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes.

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

Board of Directors – 24 September 2014

Efficiency Programme Update – August 2014

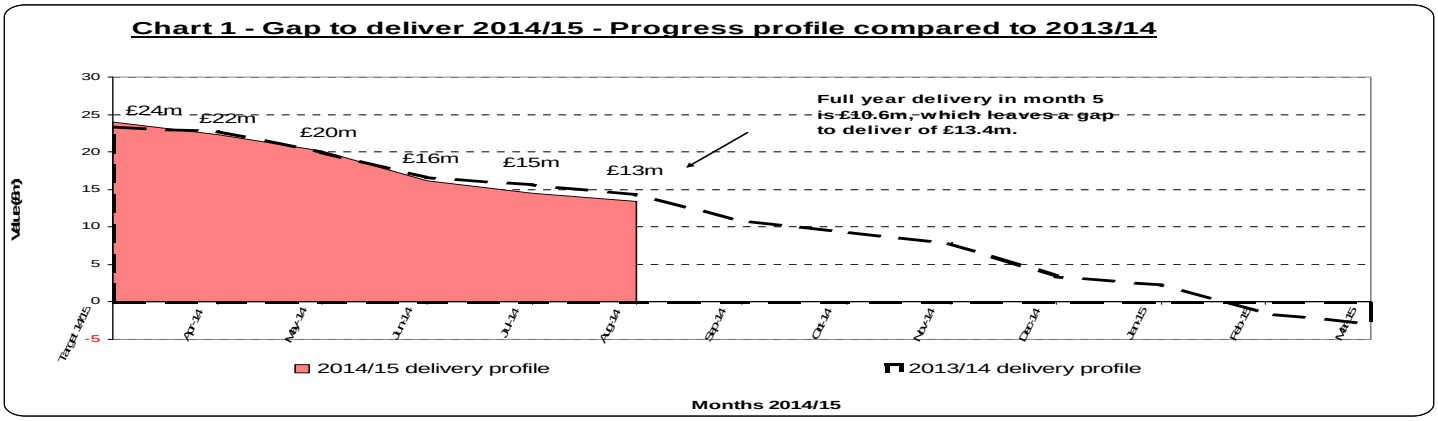
1. Executive Summary

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

See table 1 and chart 1 below.

Table 1 – Executive Summary – August 2014	Total
	£'m
TARGET	
In year target	**24.0**
DELIVERY	
In year delivery	**10.6**
In year delivery shortfall	**(13.4)**
Part year delivery shortfall - Monitor variance	**(2.9)**
PLANNING	
In year planning surplus/(gap)	**(2.6)**
FINANCIAL RISK SCORE	
Overall Trust financial risk score	**(2 Red/Amber)**

Position – current year vs. 2013/14



Governance	Risk to delivery
Current month Of the 32 Directorates and Corporate HQ functions 9 are now green. Work has started on reviewing new schemes.	**Current month** The current planning gap is (£2.6m), which is comparable to last month and remains a concern. Full year delivery in August 2014 is £10.6m which has improved by £1.1m from July 2014. The Monitor variance is (£2.9m) adverse.
Last Month Of the 32 Directorates and Corporate HQ functions 5 remain as green. Work has started on reviewing new schemes.	**Last month** The current planning gap is (£2.5m), which is a significant improvement but still of concern. Full year delivery in July 2014 is £9.5m which has improved by £1.7m from June 2014. The Monitor variance is (£2.2m) adverse.

2. Introduction and background

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

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

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

2.1 Trust plan to Monitor

The combined position is (£2.9m) behind the Trust plan to Monitor as at August 2014; see Tables 2 & 3 and chart 2 below.

Table 2	July YTD 2014	August 2014	Total YTD
	£m	£m	£m
Trust plan	8.0	2.0	**10.0**
Achieved	5.8	1.3	**7.1**
Variance	(2.2)	**(0.7)**	**(2.9)**

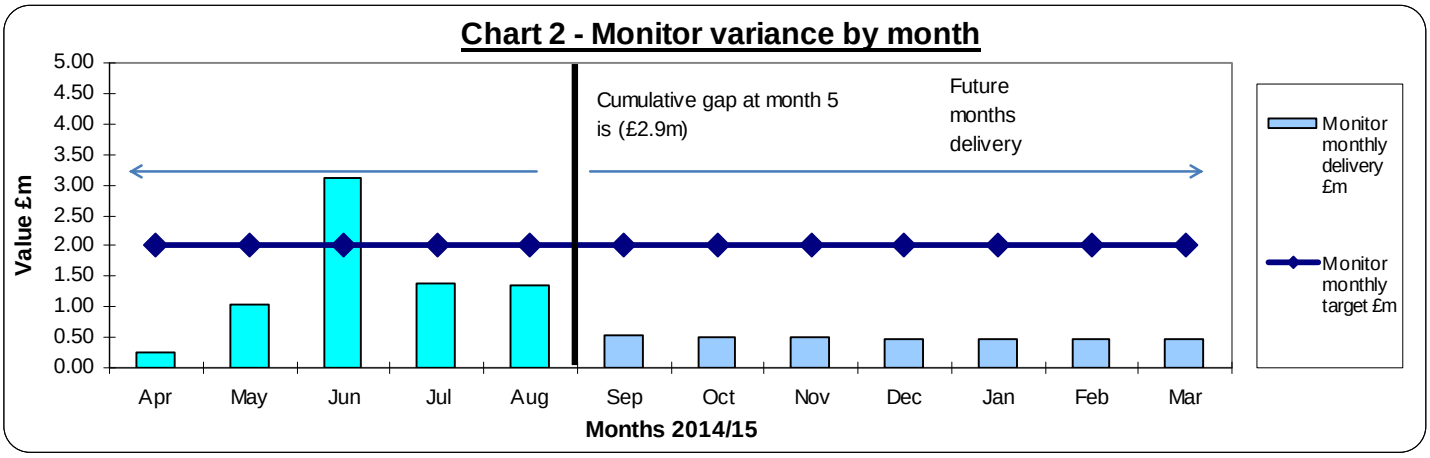


Table 3 – Monitor variance by month and cumulative variance

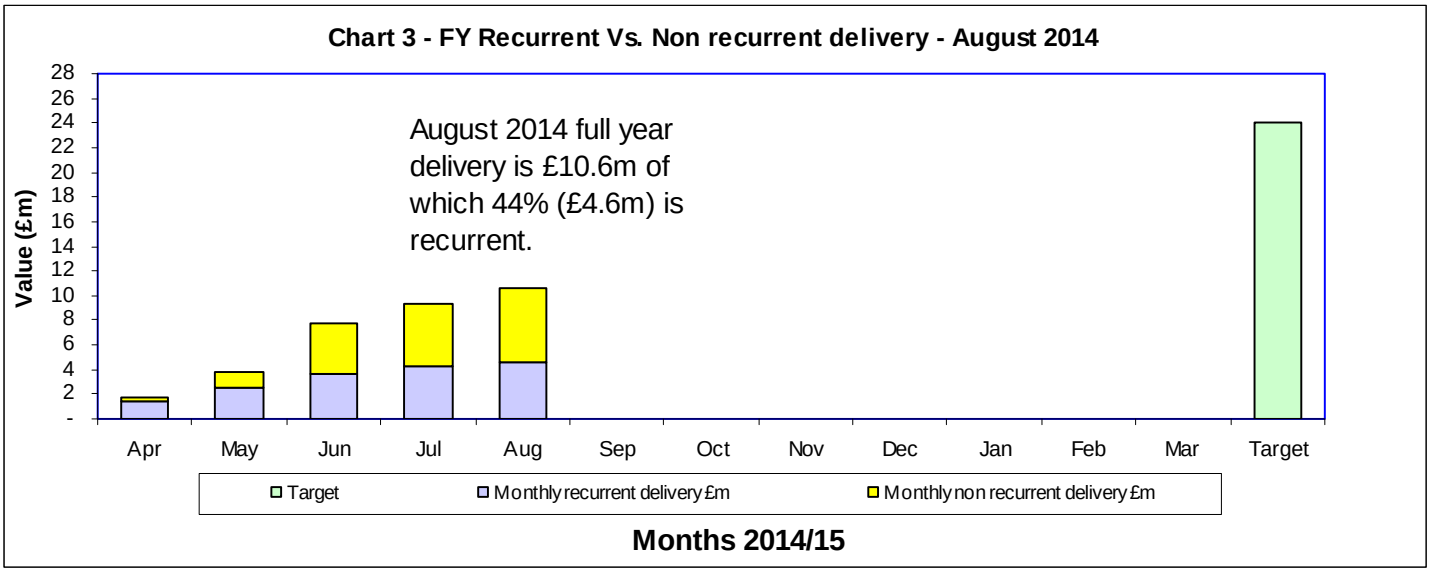
Months	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total 14/15
Monthly delivery £m	0.3	1.0	3.1	1.4	1.3	0.5	0.5	0.5	0.5	0.5	0.5	0.5	**10.6**
Monthly target £m	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	**24.0**
Variance £m	-1.8	-1.0	1.1	-0.6	-0.7	-1.5	-1.5	-1.5	-1.5	-1.5	-1.5	-1.5	-13.4
Cumulative variance	-1.8	-2.7	-1.6	-2.2	-2.9	-4.3	-5.8	-7.3	-8.8	-10.4	-11.9	-13.4	

2.2 Full year position summary

As at August 2014, **£10.6m** has been achieved in full year terms against the plan of £24.0m (see Table 4 below).

Table 4	July 2014	August 2014	Change
	£m	£m	£m
Expenditure plan – 14/15	24.0	24.0	0
Target – 2014/15	**24.0**	**24.0**	**0**
Achieved - recurrently	4.3	4.6	0.3
Achieved - non-recurrently	5.1	5.9	0.8
Total achieved	**9.4**	**10.6**	**1.1**
Shortfall	14.5	13.4	**1.1**
Further plans	12	10.8	**(-1.2)**
(Gap)/Surplus in plans	**(2.5)**	**(2.6)**	**(-0.1)**

The August 2014 position is made up of £4.6m (44%) of recurrent and £5.9m (56%) non-recurrent schemes. This compares with £3.5m (39%) recurrent and £5.5m (61%) non-recurrent at August 2013 - see chart 3 below.



2.3 Further planning and assessed risk to delivery

Further plans have been formulated amounting to £10.8m, which gives a shortfall in the planning position of (£2.6m). Plans are summarised in Table 5 below.

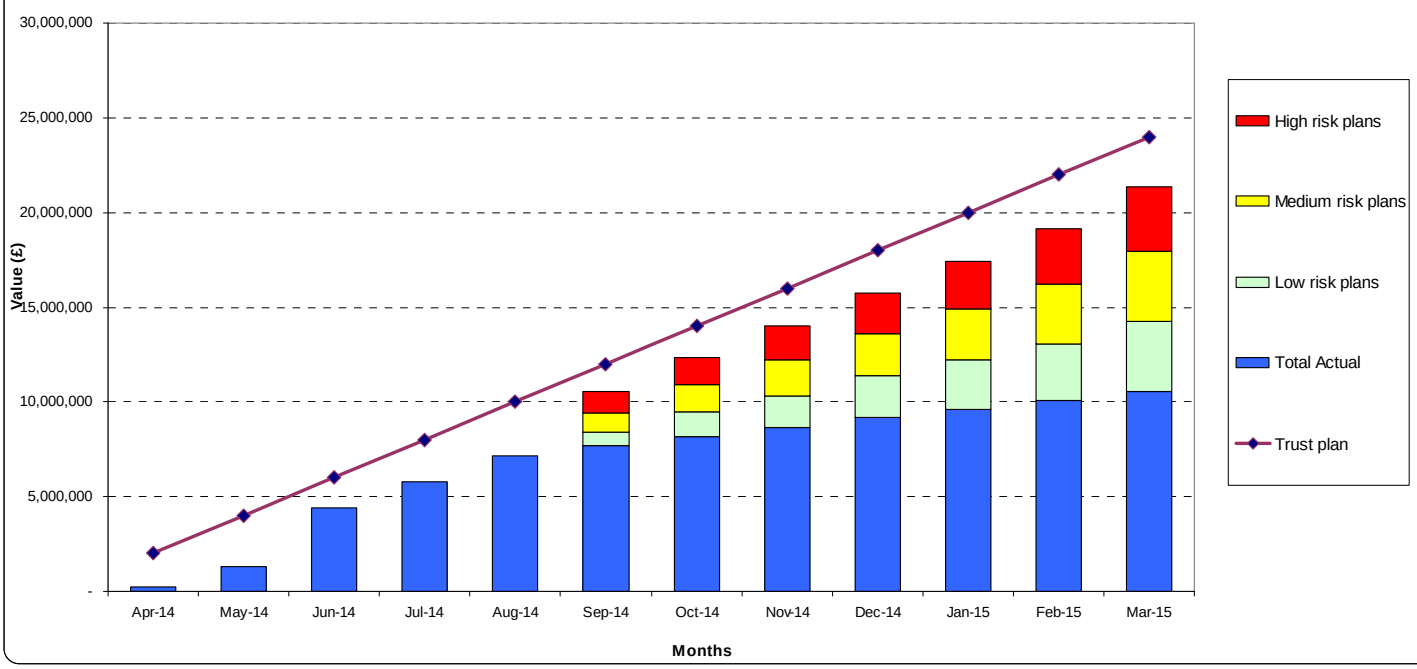
Table 5 – Further plans 2014/15

Risk	Gap Full Year	Plans - Recurrent	Plans - Non Recurrent	**Plans Total**	Gap in plans
	£m	**£m**	**£m**	**£m**	**£m**
Low		2.4	1.2	**3.7**	
Medium		3.3	0.4	**3.7**	
High		2.1	1.3	**3.4**	
Total	**13.4**	**7.9**	**2.9**	**10.8**	**(2.6)**

Directorate plans are each assigned a risk rating.

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

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



Significant work is continually carried out to re-assess, remove or re-profile plans to ensure an up to date position. There is an in year planning gap of **(£2.6m)**, which is comparable to last month, however this remains a high risk position. Work is ongoing to improve this position.

2.4 Four year planning

Directorates are required to develop four year plans and Table 6 below summarises this position. There is currently a shortfall of (£22.2m) over 4 years on the base target; this has improved by £1.6m in the month.

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

Table 6 - 4 Year efficiency plan summary – August 2014

Year	2014/15	2015/16	2016/17	2017/18	Total
	£m	£m	£m	£m	£m
Base target	24.0	16.8	16.8	16.8	**74.4**
Plans	21.4	14.6	10.4	5.9	**52.2**
Variance	**(2.6)**	**(2.2)**	**(6.5)**	**(10.9)**	**(22.2)**

2.5 Finance risk rating

In year delivery is ahead of the same point last year with £10.6m (44%) delivered in August 2014 against £9m (39%) in August 2013.

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

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

2.6 Governance risk rating
A new Quality and Safety report was released this month with a modified assessment matrix. All schemes will be reassessed using this matrix. It is expected all new schemes will have been assessed by the end of September 2014.

3. Conclusion

In August 2014 £10.6m worth of full year schemes has been delivered against the Trust plan of £24.0m, leaving a delivery gap of (£13.4m); this compares with £9m delivery in August 2013. The part year Monitor profile is (£2.9m) behind plan in month 5.

We currently have a planning gap in year of (£2.6m), which remains high risk.

The 4 year planning position highlights a shortfall in base plans of (£22.2m), which has improved from period 4, but also remains high risk. Work is ongoing to improve the overall planning position.

Work is ongoing to reassess all schemes using the new governance risk assessment matrix.

4. Recommendation

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

Author	**Steve Kitching, Deputy Head of Corporate Efficiency**
Owner	**Andrew Bertram, Director of Finance**
Date	**September 2014**

RISK SCORES - AUGUST 2014 - APPENDIX 1

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

RISK SCORES - AUGUST 2014 - APPENDIX 2

DIRECTORATE	Yr1 Target	4Yr Target	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
GEN MED SCARBOROUGH	982	2511	27%	1	5%	1	1%	1	39%	1	4	1
RADIOLOGY	1901	3800	39%	1	16%	1	1%	1	41%	2	5	1
ED YORK	501	1426	68%	2	18%	1	13%	1	26%	1	5	1
SPECIALIST MEDICINE	1850	5345	32%	1	11%	1	10%	1	57%	3	6	1
WOMENS HEALTH	2342	4464	44%	1	23%	1	17%	1	58%	3	6	1
TACC YORK	2421	5768	88%	3	25%	1	19%	1	48%	2	7	1
T&O YORK	789	2331	63%	2	41%	2	11%	1	47%	2	7	1
OPHTHALMOLOGY	875	2667	77%	2	41%	2	40%	2	33%	1	7	1
GS&U	1717	4794	72%	2	43%	2	18%	1	64%	3	8	2
TACC SCARBOROUGH	870	2435	83%	3	57%	2	27%	1	43%	2	8	2
HEAD AND NECK	480	1863	74%	2	47%	2	35%	2	56%	3	9	2
COMMUNITY	1648	4390	60%	2	35%	1	33%	2	97%	5	10	2
ED SCARBOROUGH	404	1329	95%	4	6%	1	0%	1	101%	5	11	2
CHILD HEALTH	1247	2999	65%	4	18%	1	3%	1	74%	5	11	2
GEN MED YORK	1672	5114	93%	4	21%	1	3%	1	89%	5	11	2
THERAPIES	1367	3772	99%	4	37%	1	15%	1	77%	5	11	2
T&O SCARBOROUGH	324	1298	128%	5	78%	4	28%	1	35%	1	11	2
MEDICINE FOR THE ELDERLY SCARBOROUGH	817	1698	107%	5	30%	1	25%	1	91%	5	12	3
MEDICINE FOR THE ELDERLY	174	1717	99%	4	43%	2	23%	1	101%	5	12	3
LAB MED	1672	4022	100%	4	47%	2	27%	1	77%	5	12	3
SEXUAL HEALTH	491	1129	86%	3	54%	2	37%	2	82%	5	12	3
PHARMACY	-188	611	101%	5	101%	5	101%	5	171%	5	20	5
CORPORATE												
MEDICAL GOVERNANCE	77	180	58%	1	41%	2	17%	1	25%	1	5	1
CORPORATE NURSING	334	496	42%	1	42%	2	16%	1	30%	1	5	1
OPS MANAGEMENT SCARBOROUGH	329	638	61%	2	14%	1	2%	1	45%	2	6	1
SNS	1137	2557	76%	2	25%	1	17%	1	49%	2	6	1
ESTATES AND FACILITIES	2878	7804	54%	1	31%	1	19%	1	74%	4	7	1
HR	446	1169	76%	2	48%	2	14%	1	61%	3	8	2
AL&R	185	420	70%	2	57%	2	0%	1	55%	3	8	2
OPS MANAGEMENT YORK	239	419	85%	3	8%	1	0%	1	84%	5	10	2
CHIEF EXEC	75	448	259%	5	243%	5	160%	5	43%	2	17	4
FINANCE	251	1116	126%	5	126%	5	87%	5	87%	5	20	5
TRUST SCORE	**30308**	**80731**	**89%**	**4**	**44%**	**2**	**19%**	**1**	**70%**	**4**	**11**	**2**

F5

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 24 September 2014

Annual Report for the Finance and Performance Committee

Action requested/recommendation

The Board is asked to note the report

Summary

The Committee is required as part of its terms of reference to complete an annual report on the deliberations of the Committee during the year. The attached report fulfils the requirements.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes

Progress of report	The report was presented to the Finance and Performance Committee
Risk	No risk

Resource implications	Resources implication detailed in the report
Owner	Mike Sweet, Chairman of the Finance and Performance Committee
Author	Anna Pridmore, Foundation Trust Secretary
Date of paper	September 2014

York Teaching Hospital NHS
NHS Foundation Trust

Annual Report of the Finance & Performance Committee

Covering the period from 1 April 2013 to 31 July 2014

August 2014

Introduction

The Finance and Performance Committee is a committee of the Board and, as its name suggests, provides assurance to the Board on matters relating to finance and performance. The Committee reviews information in more detail than is possible in a Board Meeting so as to ensure that the numbers are examined in detail and that there is an understanding of the initiatives in place in the organisation to deliver the Trust's financial and performance objectives and ongoing strategies.

This report covers the period from 1 April 2013 to July 2014.

During the period the Committee met 14 times.

Membership

Mr M Sweet, Non-executive Director and Chairman of the Committee.

Mr M Keaney, Non-executive Director.

Mr P Ashton was a member of the Committee until May 2013. He is now a member of the Quality and Safety Committee.

To ensure that the Committee remains quorate when a member of the Committee is unable to attend another Non-executive Director takes their place.

In January and July 2014 Ms L Raper attended in Mr Keaney's absence.

There are a number of officers who attend the Committee on a regular basis. During the period of this report those officers were:

Mr A Bertram, Director of Finance
Mrs L Booth, Director of Operations York (from January 2014).
Mrs D Hollings-Tennant, Head of Resource Management (until June 2014).
Mr S Kitching, Head of Resource Management (from June 2014).
Mr G Lamb, Deputy Director of Finance
Mrs S Lovell, Lead for Clinical Services (until May 2014)
Mrs A Pridmore, Foundation Trust Secretary
Miss L Turner, Deputy Director of Performance

Mrs A McGale, Director of Operations Scarborough, Mr J Hayward, Programme Director – Capital, and Mr M Davison, Finance Project Manager attended the Committee on occasion.

Attendance at the Committee during the period of this report were:

Name	Attendance
Mr M Sweet	14/14
Mr M Keaney	12/14
Mr Ashton	2/2
Mr A Bertram	11/14
Mrs L Booth	4/7
Mrs D Hollings-Tennant	13/14
Mr S Kitching	0/1
Mr G Lamb	13/14
Mrs S Lovell	4/4
Mrs A Pridmore	11/14
Miss L Turner	13/14

The Non-executive Directors met as a group in December 2013 to discuss the relationship between the Quality and Safety Committee, the Finance and Performance Committee, the Workforce Strategy Committee, the Audit Committee and the Nominations Committee. The meeting reflected on shared agenda items and considered the Assurance Framework. The meeting agreed which assurance items would be attached to which committee.

The Terms of Reference require the Committee to consider a number of reports during the year including performance metrics, progress against CQUIN targets, the Finance Report, the Efficiency Report and general performance information at each meeting.

Work of the Committee

During the year the Committee considered the following:

The Finance Report - The Committee considers this report at each meeting and receives a number of supporting papers that provide additional assurance. The Committee provides assurance to the Board by way of the meeting minutes and a verbal report from the Chair on the financial position of the Trust following every meeting of the Committee.

During the period covered by this report the Committee explored in more detail, some of the key concerns and risks that face the Trust. To support this work they received additional information on topics such as:

- Service Line Reporting
- Reports issued by Grant Thornton - the Trust's External Auditors
- Information about the financial position of the commissioners
- Information on key performance indicators, the penalties incurred by the Trust and the Trust's annual set of reference costs.
- The financial performance of Foundation Trusts nationally.

The Efficiency Report – At each meeting the Committee receives the monthly Efficiency Report that reports on progress against the Trust's Cost Improvement Programme (CIP).

In addition to reporting monthly progress at both a Trust and Directorate level, the report also details both in-year and longer terms plans in order that future challenges may be understood.

During this reporting period the Committee explored in considerable detail a number of the key concerns and risks that face the Trust. To support this they received additional information as follows:

- The split between recurrent and non-recurrent savings
- How the impact on the quality and safety is taken into account when developing a cost improvement scheme
- Information on those schemes that are considered to carry a high (red) or medium (amber) risk of achievement
- A regular analysis of performance against the identified schemes
- Details as to how workforce efficiencies are achieved without putting quality and safety at risk and the likely impact on the Cost Improvement Programme should a mandatory level of staffing be put in place
- Details of Directorate performance with a focus on those Directorates that are not achieving their targets
- An Internal Audit report on the CIP process
- The report following the audit / evaluation of our processes by Monitor
- Details of those large cost improvement schemes that have been identified to enable the Trust to achieve the stretching efficiency targets that it will face over the coming years

The Acute Strategy – short and medium term – Initially the Committee reviewed the Trust's overall Acute Strategy. However, it was subsequently agreed between the Board of Directors and Committee that the Finance and Performance Committee would focus on reviewing the short and medium term aspects of the strategy, and that the Board would take responsibility for reviewing the longer term aspects.

Initially the Committee was briefed on the implementation of the Acute Strategy and its work streams on a quarterly basis by Ms Lovell. When Ms Booth (Director of Operations – York) joined the Committee in January 2014 she assumed that responsibility and has provided the Committee with regular updates on progress against the strategy in general and specifically around the challenge of the ambulance turn round times at both York and Scarborough, the development work on the ambulance hand-over bays in the York Emergency Department and the proposed reconfiguration of the wards at York.

When reviewing the strategy the Committee has discussed its impact on the efficiency programme, other performance targets and the financial plans of the Trust. During the period the Committee has also discussed a number of key elements of the strategy including:

- Ambulatory Care for non-admitted ED patients as part of the design work towards the development of an Assessment Centre initially in York
- Future models of working with particular regard to the availability of clinicians to service an Assessment Centre

- Workforce Development and the work that is underway to develop roles and staffing structures
- A Frailty Model and the work that is underway to develop a frailty care service as opposed to the more traditional approach to elderly care
- Community Hub developments and the progress against plan.

Operational Performance – The Committee reviews the Trust's performance report at each meeting. During the period covered by this report the Committee has been involved in the development of a revised and more comprehensive report. Each month Ms Turner updates the Committee on the Trust's performance against numerous key targets including:

- Delivery of the18, 36 and 52 week access targets
- Diagnostics and Radiology
- Expected date of discharge
- The Emergency Department, particularly the 95% in 4 hours target
- Theatre list cancellations at Scarborough
- Ambulance turn round times
- Cancer targets, of which there are many
- Delayed transfers of care
- Rapid improvement events initiated during the year.
- Infection control, in particular C-Diff and MRSA
- The production of discharge letters
- First to follow up ratios
- The annual hospital Flu vaccination programme
- Choose and Book.

Assurance is provided to the Board on these matters through the meeting minutes, which form part of the monthly Board pack, and direct feedback at the Board by the Chair of the Committee when a general overview is presented and attention drawn to matters that the Committee considers require Board discussion.

Commissioning for Quality and Innovation (CQUIN) –The Committee discusses the CQUIN targets at the majority of its meetings. The Committee has been keen to ensure that it has a clear understanding of the potential financial impact on the Trust if targets are not met, and has sought additional assurance from managers where there are concerns that targets will not be achieved and where there are known weaknesses or risks. The Committee also reviews and comments on the new annual targets that are introduced at the beginning of each financial year.

The Committee also commissioned and received a report on the lessons learned from the development, commissioning and delivery of CQUIN in 2012/13 and the challenges that exist around ensuring that the CQUIN targets are defined appropriately with the commissioners.

Capital programme – The Committee reviews the capital programme's progress on a six monthly basis when it receives a presentation from the responsible Programme Director. The Committee also discusses any changes that may be required to the programme during the year.

Tender Register – The Committee has established a register of tenders that sets out both existing contracts that are scheduled for renewal and new business opportunities. This is reviewed on a regular basis to ensure that the Board is aware of any concerns the Committee has identified.

Meetings for the coming year

The Committee will continue to meet before each Board meeting and work closely with the other Board Committees. The Committee will continue to review its work programme at every meeting and request timetabled updates to be provided on a regular basis. The Committee aims to continue challenging any areas where there is an actual or perceived risk to the achievement of the Trust's financial or performance targets and will continue to require assurance on progress on all initiatives. The Committee will also continue to share its thinking with the other Board Committees to ensure that related agendas are considered from a finance and performance perspective.

Conclusion

As it enters its third year the Committee has confirmed its role as a key committee of the Board. It has demonstrated that it is able to both monitor and scrutinise progress against many of the targets (access and financial) that are set for, and by, the Trust in considerable detail. Thereby it is able to provide assurance to the Board and, when appropriate, to elevate specific matters to the full Board and require the responsible Executive Director to provide further detail and set out the proposed remedies when necessary.

The Committee has benefited greatly from the very positive approach that all the participating officers bring to the working of the Committee, and their willingness to help the Committee evolve the manner in which it handles issues and receives reports. The Committee meets for two hours and I consider those two hours to be some of the most productive and effective time that I spend in the hospital.

Having chaired the Committee since its inception two and a half years ago it is appropriate that I step down in October, though I shall remain a member of the Committee, and handover to my colleague Mike Keaney. I hope that he will enjoy the role as much as I have.

Michael Sweet
Chairman of the Finance and Performance Committee
August 2014

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 24 September 2014

Summary of the Audit Committee meeting held on 15th September 2014

Action requested/recommendation

The Board of Directors is asked to note the areas of discussion at the Audit Committee and approve the revised terms of reference.

Summary

The Audit Committee is a Board Committee that meets on a quarterly basis. The last meeting of the Audit Committee was held on 15th September. This paper provides the Board of Directors with a summary of the key issues being addressed by the Committee.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	This paper has only been written for the Board of Directors.
Risk	No risk.
Resource implications	No resource implications.
Owner	Philip Ashton, Non-executive Director
Author	Anna Pridmore, Foundation Trust Secretary
Date of paper	September 2014
Version number	Version 1

Board of Directors – 24 September 2014

Summary of the Audit Committee meeting held on 15th September 2014

1. Summary

The Audit Committee met on 15 September and debated an extensive agenda.

The Committee discussed the results of the recent time out and agreed that the theme throughout the discussions was about the communication between the Audit Committee and the various board committees and other groups across the organisation. The conclusion the time out had come to was that there needed to be a general tightening up of the links so that the Audit Committee could be clear about those possible or actual risks that occur during the year and ensure that they are included as appropriate in any internal audit programme.

As a result of this conclusion the Audit Committee has now included feedback from other board committees in its agenda.

The Audit Committee considered the revised terms of reference and work programme and include the documents for approval by the Board of Directors.

The Audit Committee discussed the annual report from the Counter Fraud Service. The highlights from the report included:

- Fraud Awareness Activity
- Fraud Prevention Activity
- Fraud Detection Exercises
- Reactive Fraud Work
- Quality Assurance of Counter Fraud Work

The Counter Fraud Service also presented the revised draft policy on Anti-Fraud, Bribery and Corruption. The Policy was approved by the Audit Committee and will be presented to the Executive Board in the near future.

The final report presented to the Audit Committee addressed the recent self-assessment tool that had been introduced by NHS Protect. The key principles are:

- Strategic governance, this relates to ensuring that anti-crime measures are embedded at all levels across the organisation.
- Inform and Involve, this relates to raising awareness of crime risks against the NHS.
- Prevent and Deter, this relates to discouraging individuals who may be tempted to commit crime against the NHS.
- Hold to Account, this relates to detecting and investigating crime.

A review has been undertaken by the Local Counter Fraud Manager and showed, for strategic governance and hold to account the Trust was green, for inform and involve and prevent and deter the Trust was amber. This gave an overall rating of amber for the organisation. The Audit Committee reviewed an action plan and agreed that it would keep the action plan under review.

Internal Audit presented an audit report with recommendations from the audit on being open. The report received a low assurance rating and as a result the Quality and Safety Committee have agreed to receive the report at its next meeting and discuss the work with the Medical Director. Management of the recommendations will follow the normal route through the Corporate Directors.

2. Recommendation

The Board of Directors is asked to note the areas of discussion at the Audit Committee and approve the revised terms of reference.

Author	**Anna Pridmore, Foundation Trust Secretary**
Owner	**Philip Ashton, Chairman of the Audit Committee**
Date	**September 2014**

York Teaching Hospital NHS
NHS Foundation Trust

AUDIT COMMITTEE:
Summary of Governance

Version 7
15 September 2014

York Teaching Hospital NHS Foundation Trust

AUDIT COMMITTEE:
Summary of Governance

Table of Contents

AUDIT COMMITTEE

Terms of Reference

1	**Status**
1.1	The Audit Committee ('The Committee') is a formal committee of the Board of Directors ('The Board') and has no executive powers other than those specifically delegated in these Terms of Reference.
1.2	The business of the Committee meetings shall be formally recorded. Due to the frequency of the Audit Committee meeting the formal minutes shall be distributed to the committee members for any immediate comments and presented to the next Board of Directors meeting marked as 'draft'. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure or require Executive action.
1.3	The Council of Governors will receive an annual report from the Audit Committee on the work it has completed during the year.
1.4	The Committee will report to the Board annually on its work in support of the Annual Governance Statement.
2	**Purpose of the Committee**
2.1	The Committee supports the Board by critically reviewing governance and assurance processes on which the Board places reliance and supports the achievement of the Trust's activities. At the corporate level, this will include a Risk Management System and a Performance Management System, underpinned by an Assurance Framework and Corporate Risk Register. The Committee also has a pivotal role to play in reviewing disclosure statements that flow from the organisation's assurance processes.
3	**Authority**
3.1	The Committee is authorised by the Board to investigate any activity within its Terms of Reference and take appropriate action.
3.2	The Committee is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.
3.3	The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers it necessary.
3.4	The Committee is authorised by the Board to establish and develop working groups as required by the activities of the Committee and the business needs of the Trust.

4	**Legal requirements of the committee**
4.1	The Committee must ensure that all legal requirements with regard to any new or amended legislation are reviewed on behalf of the Trust and addressed accordingly. Key documents include, but not exclusively: • NHS Audit Committee Handbook 2011 • Monitor's Governance and Audit Codes for NHS Foundation Trusts • The Department of Health The Code of Conduct: Code of Accountability 2004 • Code of Governance published by Monitor 2010 • **Have due regard to the equality duties**
5	**Roles and functions**
5.1	**Governance, Risk Management and Internal Control** The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal and external control, across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievement of the Trust's objectives. In particular, the Committee will review the adequacy of: • All risk and control related disclosure statements in particular the Annual Governance Statement, and any declarations of compliance, together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board. • The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements. • The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements. • The policies and procedures for all work related to **counter fraud and security as required by NHS Protect.** • In carrying out this work the committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the use of an effective Assurance framework. • The Committee will have effective relations with other key committees so that it understands processes and linkages.
5.2	**Internal Audit** The Committee shall ensure there is an effective internal audit function established that meets mandatory NHS internal Audit standards and provides appropriate assurance to the Committee, Chief Executive and Board of Directors and will also: • Consider the provision of the internal audit service, and the cost involved the

	• Review the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework. • Consider the major findings of internal audit and management response and ensure co-ordination between the Internal and External auditors. • Review the annual report of the internal auditors. • Receive the Head of Internal Audit Statement on the effectiveness of Internal Controls. • Ensure that the Internal Audit function is adequately resourced and has appropriate standing within the organisation. • Discuss problems and reservations arising from Internal Auditor's work and any matters Internal Audit wishes to discuss (in the absence of Executive Directors and other management where necessary). • Meet with the Head of Internal Audit at least once a year without the presence of management. • Monitor and assess the role and effectiveness of the internal audit function in the overall context of the Trust's risks management systems.
5.3	**External Audit** The Committee shall review the work and findings of the External Auditor and consider the responses to their work. The Committee will also: • **Consider the appointment of the external auditors, providing support to the appointment made by the Council of Governors** • Review all External auditors' reports and any work carried out outside of the annual audit plan including agreement of the annual audit plan. • Discuss the nature and scope of the External Audit plan with the External Auditor prior to commencement of the audit and agree the extent of reliance to be placed on internal audit. Where the timing of the Committee meetings makes this impractical, work may proceed with the approval of the Executive Director of Finance which will be subject to later consideration for approval by the next Committee. • Discuss with External Auditors their local evaluation of Audit risk and how the Audit plan addresses these risks. • Discuss issues and reservations arising from External Auditor's work and any matters External Audit wish to discuss (in the absence of Executive Directors, internal auditors and other management where necessary). • Review the performance of the External Auditor, annually.
5.4	**Financial Reporting** The Committee will: • **Monitor the integrity of the financial statements of the organisation and any formal announcements relating its financial performance** • **Ensure that the systems for financial reporting to the Board of Directors and the Council of Governors including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided** • Review the annual financial statements before submission to the Board,

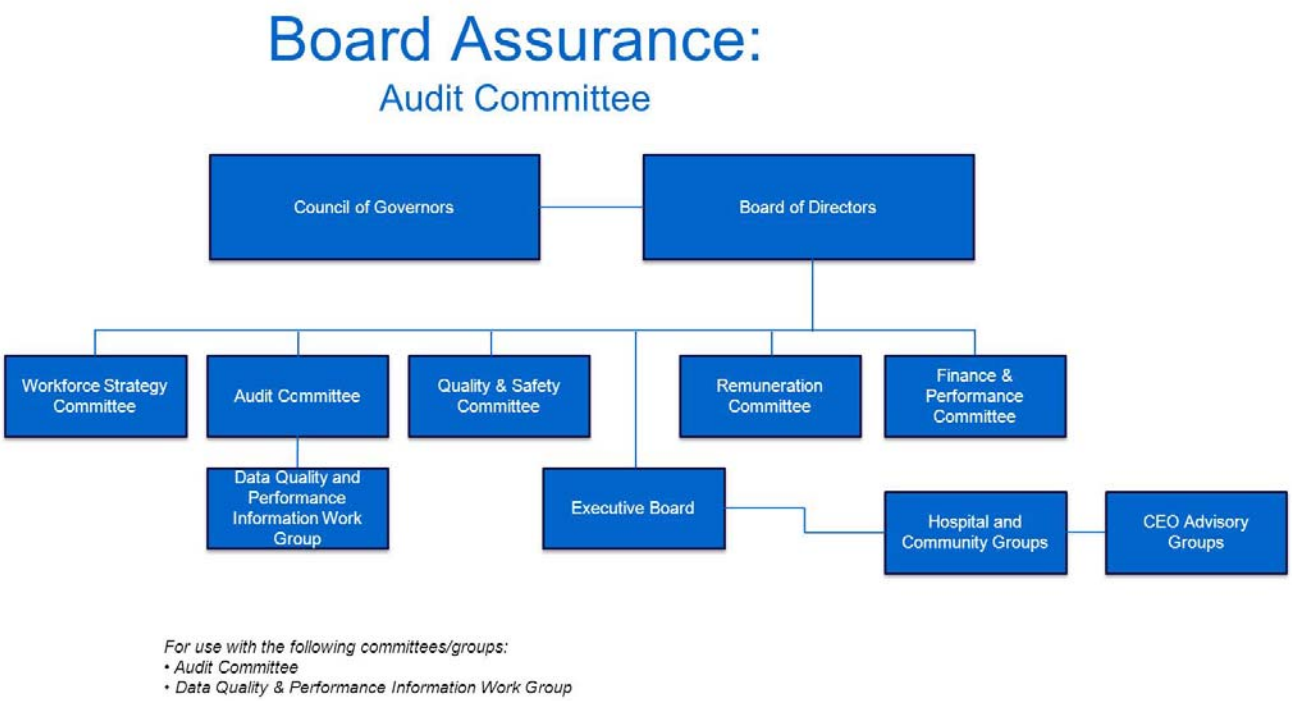
	- the wording in the Annual Governance Statement and other disclosures relevant to these Terms of Reference - changes in, and compliance with, accounting policies and practise - major judgemental areas - **Significant adjustments in preparation for the financial statements** - Significant adjustments resulting from the audit and any material unadjusted mis-statements in the financial statements - Letter of representation - **Explanation for significant variances** • Consider the Trust's in year financial position. • Review the Trust's annual financial plan. • Approve changes to Accounting policy and practice.
5.5	**Other Assurance Duties** The Committee shall review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications to the governance of the organisation: • These will include, but will not be limited to, any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g. Healthcare Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc). • In reviewing the work of the other Committees and work groups, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function. • **The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently**
5.6	**Other Duties** The Committee will: • Review the Trust's Standing Orders, Standing Financial Instructions and Schemes of Delegation. • Receive details of waivers to standing orders approved by the Executive Director of Finance. • Review the schedule of Losses and Compensations and approve write-offs as appropriate. • **The Committee will satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS Protect standards and shall review the Annual Fraud report and other Fraud updates and any outcomes from the work.** • **The Committee shall request and review reports, evidence and assurance from directors and managers on the overall arrangements for governance, risk management and internal audit.** • Receive reports from other groups of the Committee as appropriate. • Receive investment reports and agree investment limits. • **The Committee will support and advise the Council of Governors and any**

	• Escalate any areas of concern identified to the BoD for further discussion and resolution. • The Audit Committee will submit a highlight return report and minutes to the Board of Directors following each of the Audit Committee's meetings (at least 4 times per year). • **The Committee will prepare an annual report for presentation to the Board of Directors and the Council of Governors on its work in support of the annual governance statement, specifically commenting on:** **-The fitness for purpose of the assurance framework** **- the completeness and embeddedness of risk management in the organisation** **- The integration of governance arrangements** **- the appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business** **- the robustness of the processes behind the quality accounts** **The annual report will also describe how the committee has fulfilled its terms of reference and give details of significant issues that the Committee considered in relation to the financial statements and how they were addressed.**
6	**Membership**
6.1	The Committee members shall be appointed by the Board from amongst the Non-executive Directors of the Trust (excluding the Chairman of the Board) and shall consist of not less than four members. One of the members of the Board will be appointed Chair of the Committee and will have a financial qualification or background in finance.
6.2	The following, or their nominated deputies, shall normally attend meetings: • Executive Director of Finance • Foundation Trust Secretary • Head of Corporate Finance • Head of Internal Audit • Manager of Internal Audit • Partner for the External Auditor • Audit Manager for the External Auditor
6.3	The Chief Executive will be invited to attend annually to discuss with the Committee the process for assurance that supports the Annual Governance Statement.
7	**Quoracy**
7.1	The Committee will be quorate with 2 members attending. The Chair of the meeting will ensure that a deputy is appointed to preside over a meeting when the Chair is unavailable or has a conflict of interest (if required).
8	**Meeting arrangements**

8.1	The Committee will meet as a minimum 4 times per year and all supporting papers will be circulated 7 days in advance of the meeting.
8.2	The Foundation Trust Secretary will supply the Secretariat service to the meeting.
8.3	Copies of all agendas and supplementary papers will be retained by the Foundation Trust Secretary in accordance with the Trust's requirements for the retention of documents.
8.4	The Chair of the Committee has the right to convene additional meetings should the need arise and in the event of a request being received from at least 2 members of the group.
8.5	Where members of the Committee are unable to attend a scheduled meeting, they should provide their apologies, in a timely manner, to the secretary of the group and provide a deputy, the deputy does not form part of the quorate group unless agreed with the Chair.
9	**Review and monitoring**
9.1	The Committee will maintain a register of attendance at the meeting. Attendance of less than 50% will be brought to the attention of the Chair of the Committee to consider the appropriate action to be taken. The attendance record will be reported as part of the annual report. The annual report will be presented to the Board and shared with the Risk and Assurance Committee and the Executive Board.
9.2	The terms of reference will be reviewed annually.

Author	**Anna Pridmore, Foundation Trust Secretary**
Owner	**Philip Ashton, Non-executive Director (Chair)**
Date of Issue	**September 2014**
Version	**1**
Approved by	**Board of Directors**
Review date	**October 2015**

Governance Structure



For use with the following committees/groups:
- *Audit Committee*
- *Data Quality & Performance Information Work Group*

Work Programme

Quarter 4/15 (January – March) 16 March 2015

Standing items

- Review of EA work programme/progress reports
- Review of IA work programme/progress reports
- To receive for review the audit recommendations status report
- **Review and approve the annual work plan for counter fraud and security activity**
- **Review counter fraud and security progress reports**
- Review Data Quality and Performance Work Group feedback
- **Report from Quality and Safety Committee**
- **Report from Finance and Performance Committee**
- **Report from Workforce Strategy Committee**
- Review Patient Safety Group feedback
- Review Assurance Framework and Corporate Risk Register
- Single Tender approvals
- Review losses and special payments
- Monitor quarterly return quarter 3 (October – December)

Additional items

- Draft Annual Governance Statement
- Monitor 6 month review (if available)
- Annual review of general compliance – Code of Governance
- Interim Report to those Charged with Governance
- Approve Internal Audit Plan (2013/14) and fee
- Security Annual Report
- Treasury Management Report
- **Review any changes to corporate governance documents**
- External Audit Plan and fee
- Alliance Board minutes
- FD briefing on annual accounts
- **Plan the discharge the committee's duties**
- **Produce the annual committee report**

Quarter 1/15 (Apr-Jun) meeting May 2015

Standing items

- Review of EA work Programme/progress reports
- Review of IA work programme/progress reports
- **Review Trust's annual self-review against NHS Protect standards**
- **Receive the annual report on counter fraud and security activity**
- **Review clinical audit progress reports**
- Review Data Quality Work Group feedback
- Review Assurance framework and Corporate Risk Register
- Review Clinical Quality and Safety Committee feedback
- Review of Losses and Compensation Report (up to period ending 30 April)
- Debtors and Creditors (up to period ending 30 April)
- Single tender waiver (up to period ending 30 April)
- Monitor quarterly return quarter 4 (January – March)

Additional items

- Draft Annual Governance Statement
- Draft HIA opinion and Annual Report
- SO, SFI, Scheme of Delegation
- Report on sealing of documents.
- Report on register of gifts
- **Any third party assurances that are available related to the year end**
- Compound indicators declaration
- Alliance Board Minutes (March).

2014/15 End of Year Accounts meeting May 2015	Quarter 2/15 (July-September) meeting June 2015
Prior to the meeting there will be a private discussion with Internal and External Audit held by the members of the Audit Committee to establish if there are any issues either Internal or External audit wish to draw to the attention of the members of the Audit Committee **Standing items** ➢ Review of EA work programme (anything affecting year end) ➢ Review of IA work programme (anything affecting year end) ➢ Review of CF programme (anything affecting year end) ➢ Review of Losses and Compensation Report (anything affecting year end) **Additional items** ➢ Annual Counter Fraud Report ➢ Internal Audit progress report ➢ Internal Audit Annual Report ➢ Board Assurance Framework ➢ Head of Internal Audit Opinion ➢ ISA 260 report ➢ Letter of Representation; ➢ Annual Governance Statement ➢ Note in relation to going concern ➢ Summarisation schedules and annual accounts for adoption by the Board of Directors ➢ Directors statement to the accounts ➢ YTHFT Annual Report ➢ External Assurance Report on the Quality Report ➢ Private discussion with External/Internal Audit	This meeting is used as a time out and workshop session to explore developments and plan formulation around the functioning of the Audit Committee or specific pieces of business related to the responsibilities of the Audit Committee.

Quarter 2/15 (July-September) meeting September 2015	Quarter 3/12 (October - December) meeting 1 December 2014
Standing items ➢ Review of EA work programme/progress reports ➢ Review of IA work Programme/progress reports ➢ Review of CF work programme/progress reports ➢ **Report from Quality and Safety Committee** ➢ **Report from Finance and Performance Committee** ➢ **Report from Workforce Strategy Committee** ➢ Review Data Quality and Performance Work Group ➢ Review Assurance Framework and Corporate Risk Register ➢ Review Clinical Quality and Safety Committee feedback ➢ Monitor quarterly return quarter 1 report (April – June) **Additional items** ➢ Accounting policy amendments ➢ Review of Terms of Reference, Work Programme and dates for next year ➢ Alliance Board Minutes (June) ➢ **Review any other third party assurances received by the Trust** ➢ **Review risks and controls around financial management** ➢ **Losses and special payments** ➢ **Review clinical audit progress** ➢ **Review of effectiveness of Clinical Audit** ➢ **Review of effectiveness of External Audit**	**Standing items** ➢ Review of EA work Programme/progress reports ➢ Review of IA work programme/progress reports ➢ Review of CF work programme/progress reports ➢ Review Data Quality and Performance Work Group feedback ➢ Review Assurance Framework and Corporate Risk Register ➢ Review Patient Safety Group feedback ➢ **Monitor quarterly return quarter 2 report (July – September)** ➢ Single Tender Waiver ➢ **Review losses and speical payments** **Additional items** ➢ Agree final accounts timetable and plans ➢ Alliance Board Minutes (Nov) ➢ **Review the Risk Mangement System** ➢ **Self assessment of the Audit Committee** ➢ **Review the effectiveness of Internal Audit including counter fraud**

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 24 September 2014

Governance Documents

Action requested/recommendation

The Board of Directors is asked to consider and approve the amendments made to the documents. The Audit Committee considered the documents at their meeting on 15 September and agreed to recommend that the Board of Directors should approve the documents.

Summary

The Trust annually reviews the Standing Orders, Standing Financial Instructions and the Powers Reserved for the Board and Scheme of Delegation. These documents have been reviewed and the track changed documents are included in the pack.

In terms of the Standing Financial Instructions there have been a number of changes made to the documents including:

- Adjustments to the definitions included in the terminology section
- Adjustments to the description of how the Audit Committee provides independent assurance on internal controls
- Changes to the preparation and approval of business plans and budgets
- Adjustments to the budget and control section
- Adjustments to the Annual report and accounts section so that it reflects updated guidance from Monitor and other updated guidance.

With regard to the Standing Orders there have been no significant changes made to the document this year.

With regard to Reservation of Powers and Scheme of Delegation, the key changes are as follows:

- Governor responsibilities have been updated to ensure they are in line with legislation.
- The references have been updated to ensure they are clearer.
- More detail has been given in some areas to improve understanding.
- For business cases (capital only) there has been an increase in the financial authority given to the Capital Planning Board and the Executive Board has been included.
- Expenditure variation on capital schemes has been amended and reduced for the Capital Programme Management Group and increased in the Executive Board.

During 2014/15 some further review work will be undertaken in preparation for the further review of the documents during 2015.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	The document has been presented to the Audit Committee at the meeting on 15 September 2014
Risk	The documents are core governance document for the organisation. Not having the in place would create a significant risk to the organisation. There is no direct reference to the Corporate Risk Register, but indirectly there is a link with the financial risks identified on the register. There are a number of indirect links to the Assurance Framework around the organisation being a well controlled organisation.
Resource implications	There are no direct resource implications from the amendments included in these documents.
Owner	Patrick Crowley, Chief Executive
Author	Anna Pridmore, Foundation Trust Secretary
Date of paper	September 2014

Version number	Version 1

York Teaching Hospital NHS
NHS Foundation Trust

Standing Orders

(For the regulation of proceedings and business of the Board of Directors)

Author:	**Foundation Trust Secretary**
Owner:	**Chief Executive**
Publisher:	**Foundation Trust Secretary**
Date of Issue:	**September 14**
Version:	**10**
Approved By:	**Trust Board**
Review date:	**September 15 (annually, along with SFIs and Scheme of Delegation)**

Deleted: April 13

Deleted: April 14

Foreword

Within the Licence issued by Monitor, the Sector Regulator, NHS Foundation Trusts are required to demonstrate appropriate arrangements to provide comprehensive governance arrangements in accordance with the National Health Service Act 2006 amended by Health and Social Care Act 2012.

Standing Orders (SOs) regulate the proceedings and business of the Trust and are part of its corporate governance arrangements. In addition, as part of accepted Codes of Conduct and Accountability arrangements, boards are expected to adopt schedules of reservation of powers and delegation of powers. These schedules are incorporated within the Trust's *Scheme of Delegation.*

These documents, together with Standing Financial Instructions, Standards of Business Conduct, Budgetary Control Procedures, the Fraud and Corruption Policy and the procedures for the Declaration of Interest provide a regulatory framework for the business conduct of the Trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from possible accusation that they have acted less than properly.

The Standing Orders, Scheme of Delegation, Standing Financial Instructions and Budgetary Control Procedures provide a comprehensive business framework that can be applied to all activities, including those of the charitable Foundation. Members of the Board of Directors and all members of staff should be aware of the existence of and work to these documents.

Contents

Introduction

Statutory Framework

York Teaching Hospitals NHS Foundation Trust (the Trust) is a Public Benefit Corporation, which came into existence on 1 April 2007 pursuant to authorisation of Monitor under the Health and Social Care (Community Health and Standards) Act 2003 ("the 2003 Act") now superseded by the National Health Service Act 2006 (“the 2006 Act”) and amended by Health and Social Care Act 2012.

The principal place of business of the Trust is:

York Hospital
Wigginton Road
YORK
YO31 8HE

For administrative purposes, York Hospital is the Trust Headquarters

NHS Foundation Trusts are governed by the National Health Service Act 2006 amended by the Health and Social Care Act 2012

The functions of the Trust are conferred by this legislation and the Licence.

As a statutory body, the Trust has specified powers to contract in its own name.

The Trust also has statutory powers under Chapter 5 of the National Health Service Act 2006, to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

The Code of Accountability requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals.

The business of the Trust is to be managed by the Board of Directors, who shall exercise all the powers of the Trust, subject to any exception in the National Health Service Act 2006 amended by the Health and Social Care Act 2012 or the Trust’s Constitution. In accordance with the National Health Service Act 2006 amended by the Health and Social Care Act 2012, the following are set out in detail in the constitution:

- The composition of the Board of Directors
- Appointment, removal and terms of office of the Chairman, other Non-executive Directors and the Chief Executive
- Eligibility and disqualification of Directors and Governors
- Meetings of the board of directors
- Conflicts of interest of the directors
- Registers

- Public Documents

- Expenses

These Standing Orders add clarity and detail where appropriate. Nothing in these Standing Orders shall override the Trust's constitution and the 2006 Act amended by 2012 Act.

.

The Regulatory Framework requires the Board of Directors of the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust's Standing Orders and wider governance arrangements are further supported by various policies and procedures and for financial matters, by the Standing Financial Instructions and associated finance procedures. Certain powers are reserved to be exercised by the Board only, and these are covered by the Reservation of Powers and Scheme of Delegation for the Board. All other matters are delegated via the Chief Executive and Executive Directors to other Directors or Officers throughout the Trust, in accordance with the detailed Scheme of Delegation.

NHS Framework

The Code of Accountability requires that, inter alia, Boards of Directors draw up a schedule of decisions reserved to that Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated appropriately.

The constitution requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals.

Monitor's Code of Governance requires that Boards draw up a schedule of decisions reserved to the Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to staff. The Schedule of Decisions reserved to the Board and the Scheme of Delegation form part of the Standing Orders. Audit and Remuneration Committees with formally agreed terms of reference are established under the constitution.

The Code of Practice on Openness in the NHS sets out the requirements for public access to information on the NHS subject for example to the Freedom of Information Act 2000.

1. Interpretation

Save as otherwise permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which he/she should be advised by the Chief Executive).

Any expression to which a meaning is given in the National Health Service Act 2006 amended by the Health and Social Care Act 2012 or in the Financial or other Regulations made under the Acts or in the Authorisation or constitution shall have the same meaning in this interpretation and in addition:

"the 2006 Act" means the National Health Service Act 2006 as may be amended or replaced from time to time;

"the 2012 Act" means the Health and Social Care Act 2012 which amends the 2006 Act and may be amended or replaced from time to time;

"Accountable Officer" means the Officer responsible and accountable for funds entrusted to the Trust. He/she shall be responsible for ensuring the proper stewardship of public funds and assets. In accordance with the 2006 Act, this shall be the Chief Executive.

"Board of Directors" means the Chair, non-executive directors and the executive directors appointed in accordance with the Trust's constitution.

"Budget" means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

"Chair" is the person appointed in accordance with the constitution to lead the Board of Directors and the Council of Governors The expressions "the Chair" shall be deemed to include the Vice-Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

"Chief Executive" means the chief officer of the Trust.

"Commissioning" means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.

"Committee" means a committee appointed by the Board of Directors.

"Committee members" means a person formally appointed by the Board of Directors to sit on or to chair specific committees.

"Constitution" means the constitution of the Trust as approved from time to time by the Council of Governors.

"Contracting and procuring" means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

“Council of Governors” means the Council of Governors as constituted in accordance with the constitution.

“Corporate Director” means the group of Directors who form the Corporate Director team.

.

"Finance Director" means the Executive Director of Finance who is the chief finance officer of the Trust.

“**Foundation Trust Secretary”** means a person who may be appointed to act independently of the Board to provide advice on corporate governance issues to the Board and York Teaching Hospital NHS Foundation Trust

"Executive Director" means a director who is an officer of the Trust appointed in accordance with the constitution. For the purposes of this document, “director” shall not include an employee whose job title incorporates the word director but who has not been appointed in this manner.

"Funds held on Trust" shall mean those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under Chapter 5 of the National Health Service Act 2006. Such funds may or may not be charitable.

“Licence” means the NHS Provider Licence issued by Monitor the Sector Regulator

"Motion" means a formal proposition to be discussed and voted on during the course of a meeting.

"Nominated officer" means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

"Non-Executive Director" means a director who is not an officer of the Trust and who has been appointed in accordance with the constitution or under the previous system. This includes the Chair of the Trust.

"Officer" means employee of the Trust or any other person who exercises functions for the purposes of the Trust other than solely as a Staff Governor or non-executive director of the Trust

"SFIs" means Standing Financial Instructions.

"SOs" means Standing Orders.

“SID” means the Senior Independent Director

"Trust" means York Teaching Hospitals NHS Foundation Trust.

"Vice-chair" means the non-executive director appointed by the Board of Directors in consultation with the Council of Governors to take on the duties of Chair if the Chair is absent for any reason.

2. The Board of Directors

All business shall be conducted in the name of the Trust.

The powers of the Trust established under statute shall be exercised by the Board of Directors except as otherwise provided for in Standing Order 4.

Directors acting on behalf of the Trust as a corporate trustee are acting as quasi-trustees. .

The Board of Directors has resolved that certain powers and decisions may only be exercised or made by that Board in formal session. These powers and decisions are set out in the Scheme of Delegation.

2.1 Composition of the Trust

In accordance with the Trust's constitution, the composition of the Board of Directors shall be:

A Chairman

6 other non-executive directors (one of whom is the Vice Chair)

A minimum of 6 executive directors including:

- the Chief Executive (the Chief Officer)
- the Finance Director (the Finance Director)
- the Executive Medical Director (who shall be a registered medical or dental practitioner)
- the Chief Nurse(who shall be a registered nurse or midwife)
- two other Executive Direcr.

2.2 Appointment of the Chair and Non-Executive Directors

The Chair and Non-executive Directors are appointed by the Council of Governors. Non-executive Directors (including the Chairman) are to be appointed by the Council of Governors using the procedure set out in the constitution.

2.3 Terms of Office of the Chair and Non-executive Directors

The Chair and the Non-executive Directors are to be appointed for a period of office in accordance with the constitution and Code of Governance. The terms and

conditions of the office are decided by the Council of Governors at a General Meeting.

2.4 Appointment of Vice Chair of the Board of Directors

For the purpose of enabling the proceedings of the Trust to be conducted in the absence of the Chair, the Board of Directors will appoint in consultation with the Council of Governors a Non-executive Director to be Vice-Chair for such a period, not exceeding the remainder of their term as Non-executive Director of the Trust, as they may specify. 3.11 sets out the provision if the Chair and Vice-Chair are absent.

Any Non-executive Director so elected may at any time resign from the office of Vice Chair by giving notice in writing to the Chair. The Board of Directors may thereupon appoint another n]Non-executive Director as Vice-Chair in accordance with paragraph 2.8.

The Board of Directors should appoint one of the independent Non-executive Directors to be the Senior Independent Director, in consultation with the Council of Governors. The Senior Independent Director should be available to Members and Governors if they have concerns which contact through the normal channels of Chairman, Chief Executive or Finance Director has failed to resolve or for which such contact is inappropriate. The Senior Independent Director cannot be the Vice Chairman

2.5 Powers of Vice Chair

Where the Chair of the Trust has ceased to hold office, or has been unable to perform duties as Chair owing to illness, absence or any other cause, references to the Chair shall, so long as there is no Chair able to perform those duties, be taken to include reference to the Vice Chair.

3. Meetings of the Board of Directors

Meetings of the Board of Directors are to be held in public. . Members of the public may be excluded from a meeting for special reasons as determined by the Chairman in discussion with the Foundation Trust Secretary.

The Foundation Trust Secretary on the instruction of the Chairman shall give such direction as seen fit in regard to arrangements for meetings to accommodate presenters of papers and information to the Board of Directors and will ensure that business will be conducted without interruption and without prejudice. The Chairman has the power to exclude visitors on grounds of the confidential nature of the business to be transacted.

3.1 Calling Meetings

3.2 Notice of Ordinary Meetings – The Foundation Trust Secretary shall give to all Board Members at least fourteen days written notice of the date and place of every meeting of the Board of Directors. The Chairman may exclude any member of the public from a meeting of the Board of Directors if they are interfering with or preventing the proper conduct of the meeting.

3.3 **Notice of Extraordinary Meetings** – At the request of the Chairman or four Board Members, the Foundation Trust Secretary shall send a written notice to all Board Members as soon as possible after receipt of such a request. The Foundation Trust Secretary shall give to all Board Members at least fourteen days written notice of the date and place of every meeting of the Board of Director. If the Foundation Trust Secretary fails to call such a meeting, then the Chairman or four Board Members shall call such a meeting.

3.4 **Notice of Urgent Meetings**

At the request of the Chairman, the Foundation Trust Secretary shall send a written notice to all Board Members as soon as possible after receipt of such a request. The Foundation Trust Secretary shall give Board Members as much notice as is possible in light of the urgency of the request. If the Trust Secretary
fails to call such a meeting, then the Chairman or four Board Members shall call such a meeting.

Before each meeting of the Board of Directors, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair or by an officer of the Trust authorised by the Chair to sign shall be delivered to every member of the Board, or sent electronically or by post to the agreed address of such director, so as to be available at least seven clear days before the meeting. A postal notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post. Save in the case of emergencies, for each meeting of the Board of Directors a public notice of the time and place of the meeting, and the public part of the agenda, shall be available from the Trust and displayed on the Trust's website at least three clear days before the meeting. (Required by the Public Bodies (Admission to Meetings) Act 1960 S.I. (4)(a).)

Lack of service of the notice on any Director shall not affect the validity of a meeting.

Agendas will be sent to Board of Directors and the Council of Governors no less than seven days before the meeting.

3.5 Setting the Agenda

The Board of Directors may determine that certain matters shall appear on every agenda for a meeting.

A director who requires an item to be included on the agenda should advise the Foundation Trust Secretary prior to the agenda being agreed with the Chairman and no less than ten days before a meeting.

3.6 Chair of Meeting

At any meeting of the Board of Directors the Chair, if present, shall preside. If the Chair is absent from the meeting the Vice-Chair shall preside. If the Chair and Vice-Chair are absent such Non-executive Director as the directors present shall choose shall preside.

If the Chairman is absent from a meeting temporarily on the grounds of a declared conflict of interest the Vice-Chair, if present, shall preside. If the Chairman and Vice-Chairman are absent, or are disqualified from participating, such Non-executive Director as the directors present shall choose shall preside.

3.7 Petition

Where a petition has been received by the Trust, the Chairman of the Board shall include the petition as an item for the agenda of the next Board meeting**.**

3.8 Annual General Meeting

The Trust will publicise and hold an Annual General Meeting.

3.9 Notices of Motion

A director desiring to move or amend a motion should advise the Foundation Trust Secretary prior to the agenda being agreed with the Chairman and no less than 10 days before a meeting. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda.

3.10 Withdrawal of Motion or Amendments

A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

3.11 Motion to Rescind a Resolution

Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding 6 calendar months shall bear the signature of the director who gives it and also the signature of 4 other directors. When any such motion has been disposed of by the Board of Directors, it shall not be competent for any director other than the Chairman to propose a motion to the same effect within 6 months.

3.12 Motions

The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

When a motion is under discussion or immediately prior to discussion it shall be open to a director to move:

- An amendment to the motion.
- The adjournment of the discussion or the meeting.
- That the meeting proceed to the next business.
- The appointment of an ad hoc committee to deal with a specific item of business.

- That the motion be now put.

- A motion under Section 1 (2) of the Public Bodies (Admission to meetings) Act 1960 resolving to exclude the public (including the press).

No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

3.13 Chair's Ruling

Statements of directors made at meetings of the Board of Directors shall be relevant to the matter under discussion at the material time and the decision of the Chairman of the meeting on questions of order, relevancy, regularity, and any other matters shall be observed at the meeting.

3.14 Voting

Every question put to a vote at a meeting shall be determined by a majority of the votes of the Chairman of the meeting and directors present and voting on the question and, in the case of the number of votes for and against a motion being equal, the Chairman of the meeting shall have a second or casting vote.

All questions put to the vote shall, at the discretion of the Chairman of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the directors present so request.

If at least four of the directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each director present voted or abstained.

If a director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

In no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.

An officer who has been appointed formally by the Board of Directors to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director. An officer attending to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An officer's status when attending a meeting shall be recorded in the minutes.

3.15 Minutes

The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person Chairman of the meeting.

No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

In line with the 2012 Act the minutes of the public meeting of the Board of Directors will be circulated to the Council of Governors in advance of the next Board of Directors meeting.

Minutes shall be circulated in accordance with directors' wishes.

3.16 Suspension of Standing Orders

Except where this would contravene any statutory provision or any provision of the Licence or of the Constitution, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board of Directors are present, including two executive directors and two non-executive directors, and that a majority of those present vote in favour of suspension.

A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the directors.

No formal business may be transacted while Standing Orders are suspended.

The Audit Committee shall review every decision to suspend Standing Orders.

3.17 Variation and Amendment of Standing Orders

These Standing Orders shall be amended only if:

- a notice of motion under Standing Order 3.12 has been given; and
- no fewer than half of the Trust's total Non-executive Directors in post vote in favour of amendment; and
- at least two-thirds of the directors are present; and
- the variation proposed does not contravene a statutory provision or provision of the Licence or of the Constitution

3.18 Record of Attendance

The names of the Chairman and directors present at the meeting shall be recorded in the minutes.

3.19 Quorum

No business shall be transacted at a meeting of the Board of Directors unless at least seven members of the whole number of the directors are present including at least two

Executive Directors and two Non-executive Directors, one of whom is the Chairman or Vice Chairman and as such has a casting vote.

An officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

If the Chairman or a director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SO 6 or 7) they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least two Executive Directors to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting.

4. Arrangements for the exercise of functions by delegation

Subject to a provision in the Licence or the Constitution, the Board of Directors may make arrangements for the exercise, on its behalf of any of its functions

- by a committee or sub-committee or group.
- appointed by virtue of SO 5.1 or 5.2 below or by a director or an officer of the Trust in each case subject to such restrictions and conditions as the Board of Directors thinks fit.

4.1 Emergency Powers

The powers which the Board of Directors has retained to itself within these Standing Orders may in emergency be exercised by the Chief Executive and the Chairman after having consulted at least two Non-executive Directors. The exercise of such powers by the Chief Executive and the Chairman shall be reported to the next formal meeting of the Board of Directors for ratification.

4.2 Delegation to Committees

The Board of Directors shall agree, as and when it deems appropriate, to the delegation of executive powers to be exercised by committees, sub-committees or groups, which it has formally constituted. The constitution and terms of reference of these committees, sub-committees or groups, and their specific executive powers shall be approved by the Board of Directors.

4.3 Delegation to Officers

Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to an executive committee or sub-committee shall be exercised on its behalf by the Chief Executive. The Chief Executive shall determine which functions shall be delegated to officers to undertake.

The Chief Executive shall prepare a Scheme of Delegation (which is set out in the Standing Financial Instructions) identifying proposals which shall be considered and approved by the Board of Directors, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the Board of Directors as indicated above.

Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors or the Director of Finance or other Executive Director (this is because the Scheme of Delegation does not discharge accountability to NEDs to provide information and advise the Board of Directors in accordance with any statutory requirements. Outside these statutory requirements the roles of the Director of Finance shall be accountable to the Chief Executive for operational matters.

The arrangements made by the Board of Directors as set out in the Scheme of Delegation shall have effect as if incorporated in these Standing Orders.

4.4 Overriding Standing Orders

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board of Directors for action or ratification. All members of the Board of Directors, Council of Governors and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

5. Committees

5.1 Appointment of Committees

Subject to the Licence and the Constitution and any direction given by Monitor, the Board of Directors may and, if directed by Monitor shall, appoint committees of the Trust, consisting wholly (or partly) of directors of the Trust. The Board of Directors may only delegate its powers to such a committee if that committee consists entirely of board directors.

A committee or joint committee appointed under this regulation may, subject to such directions as may be given by the regulator, and in accordance with the Constitution, appoint sub-committees consisting wholly or partly of members of the committee (whether or not they are directors of the Trust); or wholly of persons who are not directors of the Trust.

The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committees established by the Board of Directors. In which case the term “Chairman” is to be read as a reference to the Chairman of the committee or sub-committee as the context permits, and the term “director” is to be read as a reference to a member of the committee also as the context permits. (There is no requirement to hold meetings of committees established by the Trust in public.)

Each such committee, sub-committee or group shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide and shall be in accordance with any legislation and regulation [or direction issued by the regulator] Such terms of reference shall have effect as if incorporated into the Standing Orders.

The Board of Directors shall approve the appointments to each of the committees, sub-committees or group, which it has formally constituted. Where the Board of Directors determines, and regulations permit, that persons, who are neither directors nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board of Directors as defined by the Licence and Constitution. The Board of Directors shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with its constitution.

The committees and sub-committees established by the Trust are:

- Audit Committee
- Remuneration Committee
- Quality and Safety Committee
- Finance and Performance Committee
- Workforce Strategy Committee

Such other committees may be established, as required, to discharge the Board's responsibilities.

5.2 Confidentiality

A member of a committee, sub-committee or group shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board of Directors or shall otherwise have concluded on that matter.

A director of the Trust or a member of a committee or sub-committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee or sub-committee, notwithstanding that the matter has been reported or action has been concluded, if that Board or committee shall resolve that it is confidential.

6. Declarations of Interest

The Constitution requires members of the Board of Directors to declare interests, which are relevant and material to the Board of Directors. All existing directors should declare such interests. Any directors appointed subsequently should do so on appointment.

Interests, which should be regarded as “relevant and material”, are:

a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).

b) Ownership or part-ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.

d) A position of authority in a charity or voluntary organisation in the field of health and social care.

e) Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services.

f) 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.

The register of directors' interests will include as appropriate all interests of directors and their close family members where they have control, joint control or a significant influence, regardless of whether this is in relation to healthcare

If Board Members have any doubt about the relevance of an interest, advice should be sought from the Foundation Trust Secretary, who has a duty to report and discuss such matters with the Chairman. Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

A register of directors' interests will be maintained and held by the Foundation Trust Secretary and presented monthly to the Board of Directors. This will be formally recorded in the minutes. Any changes in interests should be officially declared to the Foundation Trust Secretary where an appropriate amendment will be made and the updated register presented at the next Board of Directors meeting following the change occurring.

Directors' directorships of companies in 6.2.a above likely or possibly seeking to do business with the NHS (6.2.b above) should be published in the Annual Report. The information should be kept up to date for inclusion in succeeding Annual Reports.

During the course of a Board of Directors meeting, if a conflict of interest is established, the director concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt, this includes voting on such an issue where a conflict is established. If there is a dispute as to whether a conflict of interest does exist, majority will resolve the issue with the Chair having the casting vote.

7. Disability of Chairman and Directors in procedures on account of pecuniary interest

Subject to the following provisions of this Standing Order, if the Chair or a director of the Trust has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

The Board of Directors may exclude the Chairman or a director of that Board from a meeting of that Board while any contract, proposed contract or other matter in which he has a pecuniary interest, is under consideration.

Any remuneration, compensation or allowances payable to the Chairman or a Non-executive Director in accordance with the Constitution shall not be treated as a pecuniary interest for the purpose of this Standing Order.

For the purpose of this Standing Order the Chairman or a director shall be treated, subject to SO 7.2 and SO 7.6, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

(a) he, or a nominee of his, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration;

or

(b) he is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;

and in the case of married persons living together the interest of one spouse shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

The Chairman or a director shall not be treated as having a pecuniary interest in any, proposed contract or other matter by reason only:

(a) of membership of a company or other body, if there is no beneficial interest in any securities of that company or other body;

(b) of an interest in any company, body or person with which he is connected as mentioned in SO 7.5 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

Where the Chairman or a director:

(a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

(b) the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

(c) if the share capital is of more than one class, the total nominal value of shares of any one class in which he/she has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class.

This Standing Order shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to his/her duty to disclose his/her interest.

This Standing Order applies to a committee or sub-committee as it applies to the Board of Directors and applies to any member of any such committee or sub-committee (whether or not he/she is also a director of the Trust) as it applies to a director.

8. Standards of Business Conduct

8.1 Policy

Staff must comply with the national guidance contained in HSG(93)5 “Standards of Business Conduct for NHS staff” and contained in the Trust policy Standards of Business Conduct. Reference must be made to the Standards of Business Conduct policy for further guidance.

9. In-House Services

In all cases where the Board of Directors determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a purchasing officer and a Director of Finance representative. For services having a likely annual expenditure exceeding £500,000, a Non- executive Director should be a member of the evaluation team.

All groups should work independently of each other and individual officers may be a director of more than one group but no director of the in-house tender group may participate in the evaluation of tenders.

The evaluation team shall make recommendations to the Board of Directors.

The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

10. Custody of Seal and Sealing of Documents

10.1 Custody of Seal

The Common Seal of the Trust shall be kept by the Foundation Trust Secretary in a secure place,

10.2 Sealing of Documents

The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board or a committee thereof or where the Board of Directors has delegated its powers. The affixing of the Seal shall be attested and signed by the Chairman (or in his/her absence a Non-executive Director) and the Chief Executive (or in his/her absence his/her deputy).

Before any building, engineering, property or capital document is sealed it must be approved and signed by the Director of Finance (or an officer nominated by him/her) and authorised and countersigned by the Chief Executive (or an officer nominated by him/her who shall not be within the originating directorate).

10.3 Register of Sealing

An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the Audit Committee annually. (The report shall contain details of the seal number, the description of the document and date of sealing and the value of the contract). The book will be held by the Foundation Trust Secretary.

11. Signature of documents

Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board of Directors shall have given the necessary authority to some other person for the purpose of such proceedings.

The Chief Executive or nominated officers shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board of Directors or committee or sub-committee to which that Board has delegated appropriate authority.

12. Miscellaneous

12.1 Standing Orders to be given to Directors and Officers

It is the duty of the Chief Executive to ensure that existing directors and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and SFIs. Updated copies shall be issued to staff designated by the Chief Executive. New designated officers shall be informed in writing and shall receive copies where appropriate of Standing Orders.

12.2 Documents having the standing of Standing Orders

Standing Financial Instructions and the Reservation of Powers and Scheme of Delegation shall have effect as if incorporated into Standing Orders.

12.3 Review of Standing Orders

Standing Orders, and all documents having effect as if incorporated in Standing Orders, shall be reviewed annually by the Audit Committee on behalf of the Board of Directors.

York Teaching Hospital NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

Author:	**Sheila Wilson, Head of Corporate Finance**
Owner:	**Andrew Bertram, Finance Director**
Publisher:	**Andrew Bertram, Finance Director**
Date of Issue:	**April 2013**
Version:	**6.4**
Approved By:	**Board of Directors**
Review date:	**March 2014 (annually, along with Standing Orders and Reservation of Powers and Scheme of Delegation)**

1. INTRODUCTION

1.1 General

1.1.1 The Code of Accountability requires that each NHS Foundation Trust shall give, and may vary or revoke, Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. These Standing Financial Instructions (SFIs) are issued in accordance with the Code. They shall have effect as if incorporated in the Standing Orders (SOs).

1.1.2 These Standing Financial Instructions detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board of Directors and the Scheme of Delegation adopted by the Trust.

1.1.3 These Standing Financial Instructions identify the financial responsibilities that apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. **All financial procedures must be approved by the Finance Director.**

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Finance Director **must be sought before acting**. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

1.1.5 **FAILURE TO COMPLY WITH STANDING FINANCIAL INSTRUCTIONS AND STANDING ORDERS IS A DISCIPLINARY MATTER WHICH COULD RESULT IN DISMISSAL.**

1.1.6 Overriding Standing Financial Instructions - if for any reason these Standing Financial Instructions are not complied with full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board of Directors and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Finance Director as soon as possible.

1.2 Terminology

1.2.1 Any expression to which a meaning is given in the National Health Service Act 1977, National Health Service and Community Care Act 1990, the Health and Social Care (Community Health and Standards) Act 2003 and other Acts relating to the National Health Service or in the Financial or other Regulations made under the Acts or in the Authorisation or Constitution shall have the same meaning in this interpretation and in addition:

"**Accountable Officer**" means the Officer responsible and accountable for funds entrusted to the Trust. He/she shall be responsible for ensuring the proper stewardship of public funds and assets. In accordance with the Act, this shall be the Chief Executive.

"Authorisation" means the authorisation of the Trust by Monitor, the Independent Regulator of NHS Foundation Trusts

Formatted: Font: Bold

"**Board of Directors**" means the Chair, non-executive directors and the executive directors appointed in accordance with the Trust's Constitution.

"**Budget**" means a resource, expressed in financial terms, proposed by the Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

"**Budget Holder**" means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

"**Chair**" is the person appointed in accordance with the Constitution to lead the Board of Directors and the Council of Governors. The expression "the Chair" shall be deemed to include the Vice-Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

"**Chief Executive**" means the chief officer of the Trust.

"**Commissioning**" means the process for determining the need for and for obtaining the supply of healthcare and related services from the Trust

"**Committee**" means a committee appointed by the Board of Directors.

"**Committee Member**" means a person formally appointed by the Board of Directors to sit on or to chair specific committees.

"**Constitution**" means the constitution of the Trust as approved from time to time by the Council of Governors.

"**Contracting and Procuring**" means the system for obtaining the supply of goods, materials, manufactured items, services, building and

engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

"**Executive Director**" means a director who is an officer of the Trust appointed in accordance with the Constitution. For the purposes of this document, "Director" shall not include an employee whose job title incorporates the word Director but who has not been appointed in this manner.

"**Finance Director**" means the chief finance officer of the Trust.

"**Funds Held on Trust**" shall mean those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under the National Health Services Act 2006. Such funds may or may not be charitable.

Deleted: Sch 2 Part II para 16.1c NHS & Community Care Act 1990

"**Legal Adviser**" means the properly qualified person appointed by the Trust to provide legal advice.

"**Monitor**" means the Independent Regulator of NHS Foundation Trusts.

"**Nominated Officer**" means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

"**Non-Executive Director**" means a director who is not an officer of the Trust and who has been appointed in accordance with the Constitution. This includes the Chair of the Trust.

"**Officer**" means employee of the Trust or any other person who exercises functions for the purposes of the Trust other than solely as a Staff Governor or Non-executive Director of the Trust.

"**Provider Licence**" means the licence issued by Monitor.

"**Secretary of State Directions**" means the Directions to NHS Bodies on Counter Fraud Measure issued in 1999, and subsequently revised in 2004. Each NHS body is required to take necessary steps to counter fraud in the NHS in accordance with these Directions and the Chief Executive and Finance Director are mandated to monitor and ensure compliance with these Directions

"**SFIs**" means Standing Financial Instructions.

"**SOs**" means Standing Orders.

"**Trust**" means York Hospitals NHS Foundation Trust.

"**Vice-Chair**" means the non-executive director appointed by the Council of Governors to take on the duties of Chair if the Chair is absent for any reason.

1.2.2 Wherever the title Chief Executive, Finance Director, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

1.2.3 Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

1.3 Responsibilities and Delegation

1.3.1 The Board of Directors exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

(d) defining specific responsibilities placed on members of the Board of Directors and employees as indicated in the Reservation of Powers and Scheme of Delegation document.

1.3.2 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These are set out in the Reservation of Powers and Scheme of Delegation document.

1.3.3 The Board of Directors will delegate responsibility for the performance of its functions in accordance with the Reservations of Powers and Scheme of Delegation document adopted by the Trust.

1.3.4 Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board of Directors, and as Accountable Officer for ensuring that the Board of Directors meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chairman and the Board of Directors for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.3.5 The Chief Executive and Finance Director will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

1.3.6 It is a duty of the Chief Executive to ensure that existing members of the Board of Directors and employees and all new appointees are notified of, and understand, their responsibilities within these Instructions.

1.3.7 The Finance Director is responsible for:

(a) implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time.

and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Finance Director include:

(d) the provision of financial advice to other members of the Board of Directors and employees;

(e) the design, implementation and supervision of systems of internal financial control; and

(f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.3.8 All members of the Board of Directors and employees, severally and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources; and

(d) conforming to the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

1.3.9 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.3.10 For any and all members of the Board of Directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board of Directors and employees discharge their duties must be to the satisfaction of the Finance Director.

2 AUDIT

2.1 Audit Committee

2.1.1 In accordance with Standing Orders the Board of Directors shall formally establish an Audit Committee, with clearly defined terms of reference, which will provide an independent and objective view of internal control by:

(a) overseeing Internal and External Audit services;

(b) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;

(c) review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives

(d) monitoring compliance with Standing Orders and Standing Financial Instructions;

(e) reviewing schedules of losses and compensations and making recommendations to the Board of Directors;

2.1.2 Where the Audit Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wish to raise, the Chairman of the Audit Committee should raise the matter at a full meeting of the Board of Directors. Exceptionally, the matter may need to be referred Monitor.

2.1.3 It is the responsibility of the Finance Director to ensure an adequate internal audit service is provided and the Audit Committee shall be involved in the selection process when there is a proposal to review the provision of internal audit services.

2.2 Finance Director

2.2.1 The Finance Director is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;

Formatted: Indent: Left: 0 pt, Hanging: 85.05 pt

Deleted: c

Deleted: d

Deleted: (e) reviewing the establishment and maintenance of an effective system of internal control and risk management, and advising the Board of Directors accordingly.¶
¶
(f) monitoring of clinical systems

(b) ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities;

(d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board of Directors. The report must cover:

(i) a clear opinion on the effectiveness of internal control in accordance with current controls assurance guidance, including for example compliance with control criteria and standards,

(ii) major internal financial control weaknesses discovered,

(iii) progress on the implementation of internal audit recommendations,

(iv) progress against plan over the previous year,

(v) strategic audit plan covering the coming three years,

(iv) a detailed plan for the coming year.

2.2.2 The Finance Director and designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises, members of the Board of Directors or employees of the Trust;

(c) the production of any cash, stores or other property of the Trust under a member of the Board of Directors or employee's control; and

(d) explanations concerning any matter under investigation.

2.3 Role of Internal Audit

2.3.1 Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the suitability of financial and other related management data;

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences,

(ii) waste, extravagance, inefficient administration,

(iii) poor value for money or other causes.

(e) Internal Audit shall also independently verify the controls assurance statements in accordance with relevant guidance.

2.3.2 Whenever a matter arises that involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Finance Director must be notified immediately.

2.3.3 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

2.3.4 The Head of Internal Audit shall be accountable to the Finance Director. The reporting system for internal audit shall be agreed between the Finance Director, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Manual. The reporting system shall be reviewed at least every 3 years.

2.3.5 The reporting process agreed is that the Internal Audit department will issue a formal written audit report to the appropriate Directors of Clinical and Functional Directorates at the conclusion of each piece of audit work, within an appropriate timescale. Outstanding audit reports will be reviewed by the Finance Director who will initiate immediate remedial action.

2.3.6 Managers in receipt of audit reports referred to them have a duty to take appropriate remedial action within the timescales specified in the report. The Director of Finance shall identify a formal review process to monitor the extent of compliance with audit recommendations. Changes implemented must be maintained in the future and not viewed as merely satisfying an immediate audit point.

2.3.7 A summary of reports and an annual report will be presented to the Audit Committee.

Deleted: 6

2.3.8 The Head of Internal Audit has the right to report directly to the Chief Executive of the Board of Directors if, in his/her opinion, the circumstances warrant this course of action.

Deleted: 7

2.4 Fraud and Corruption

2.4.1 In line with their responsibilities, the Trust Chief Executive and Finance Director shall monitor and ensure compliance with NHS Protect Directions on fraud and corruption.

Deleted: Secretary of State (SofS)

2.4.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the Department of Health Fraud and Corruption Manual and guidance.

2.4.3 The Local Counter Fraud Specialist shall report to the Trust Finance Director and shall work with staff in the NHS Counter Fraud Services and the Counter Fraud Operational Service in accordance with the Department of Health Fraud and Corruption Manual.

2.5 External Audit

2.5.1 The external auditor is appointed by the Board of Governors from an approved list recommended by the Board of Directors and paid for by the Trust. The Audit Committee must ensure a cost-efficient service. Should there appear to be a problem then this should be raised with the external auditor and referred on to the Council of Governors. If the issue cannot be resolved by the Council of Governors it should be reported to Monitor.

3 BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

3.1 Preparation and Approval of Business Plans and Budgets

3.1.1 The Chief Executive will compile and submit to the Board of Directors an annual business plan which takes into account Foundation Trust financial requirements, including compliance with forecast income and expenditure plans and cash resources. The annual business plan will contain:

Deleted: the Prudential Borrowing Code, and

(a) a statement of the significant assumptions and risks on which the plan is based;

(b) details of major changes in workload, delivery of services or resources required to achieve the plan.

3.1.2 Prior to the start of the financial year the Finance Director will, on behalf of the Chief Executive, ensure annual budgets are prepared. Such budgets will:

(a) be in accordance with the aims and objectives set out in the annual business plan as submitted to Monitor;

(b) accord with workload and manpower plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available funds; and

(e) identify potential risks.

3.1.3 The Finance Director shall monitor financial performance against budget and business plan, periodically review them, and report to the Board of Directors.

3.1.4 All budget holders must provide information as required by the Finance Director to enable budgets to be compiled and monitoring reports to be prepared.

3.1.5 The Finance Director has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

3.2 Budgetary Delegation

3.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be

in writing, reflecting the Scheme of Delegation, and be accompanied by a clear definition of:

(a) the amount of the budget;

(b) the purpose(s) of each budget heading;

(c) individual and group responsibilities;

(d) authority to exercise virement;

(e) achievement of planned levels of service; and

(f) the provision of regular reports.

3.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total set by the Board of Directors.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive.

3.3 Budgetary Control and Reporting

3.3.1 The Finance Director will devise and maintain systems of budgetary control. These will include:

(a) regular financial reports to the Board of Directors in a form approved by the Board of Directors containing:

(i) income and expenditure to date showing trends and forecast year-end position;

(ii) movements in working capital;

(iii) movements in cash;

(iv) capital project spend and projected outturn against plan;

(v) explanations of any material variances from plan;

(vi) details of any corrective action where necessary and the Chief Executive's and/or Finance Director's view of whether such actions are sufficient to correct the situation;

(vii) an updated assessment of financial risk;

Formatted: List Paragraph, Left, No bullets or numbering, Hyphenate, Tabs: Not at -36 pt + 0 pt + 35.45 pt + 82.8 pt + 115.8 pt + 144 pt

Formatted: Numbered + Level: 1 + Numbering Style: i, ii, iii, ... + Start at: 1 + Alignment: Left + Aligned at: 82.8 pt + Tab after: 0 pt + Indent at: 118.8 pt

Formatted: Numbered + Level: 1 + Numbering Style: i, ii, iii, ... + Start at: 1 + Alignment: Left + Aligned at: 82.8 pt + Tab after: 0 pt + Indent at: 118.8 pt

Formatted: Numbered + Level: 1 + Numbering Style: i, ii, iii, ... + Start at: 1 + Alignment: Left + Aligned at: 82.8 pt + Tab after: 0 pt + Indent at: 118.8 pt

Formatted: Numbered + Level: 1 + Numbering Style: i, ii, iii, ... + Start at: 1 + Alignment: Left + Aligned at: 82.8 pt + Tab after: 0 pt + Indent at: 118.8 pt

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and manpower budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers.

3.3.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board of Directors;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

(c)no employees are appointed without the approval of the Chief Executive via the Vacancy Control process.

Formatted: Indent: Left: 0 pt, First line: 0 pt

Deleted: . (c) .

Deleted: permanent

Deleted: other than those provided for within the available resources and manpower establishment as approved by the Board of Directors: and¶

3.3.3 The Chief Executive is responsible for identifying and implementing cost improvements, cost reductions and efficiencies and income generation initiatives in accordance with the requirements of the Annual Business Plan.

3.4 Capital Expenditure

3.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI Section 10.)

3.5 Monitoring Returns

3.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation e.g. Monitor.

4 ANNUAL ACCOUNTS AND REPORTS

4.1 The Finance Director, on behalf of the Trust, will prepare financial returns and reports in accordance with the accounting policies and guidance laid down within International Financial Reporting Standards, as modified by the guidance given by Monitor with the approval of HM Treasury.

Deleted: :

Deleted: (a) prepare financial returns in accordance with the accounting policies and guidance given Monitor, the Trust's accounting policies, and generally accepted accounting practice;¶
¶
(b) prepare and submit annual financial reports to Monitor, certified in accordance with current guidelines; and¶
¶
(c) submit financial returns to Monitor for each financial year in accordance with the timetable prescribed Monitor.

4.2 The Trust's annual accounts must be audited by the external auditor appointed by the Council of Governors. The Trust's audited annual accounts must be approved by the Board of Directors and presented to a public meeting of the Council of Governors and made available to the public.

4.3 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with Monitor's FT Annual Reporting Manual (FT ARM).

5 BANK AND GBS ACCOUNTS, INVESTMENT AND EXTERNAL BORROWING

5.1 General

5.1.1 The Finance Director is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account Monitor's guidance/directions.

5.1.2 The Board of Directors shall approve the banking arrangements.

5.2 Bank and GBS Accounts

5.2.1 The Finance Director is responsible for:

(a) the operation of bank accounts;

(b) establishing separate bank accounts for the Foundation Trust's non-exchequer/charitable funds;

(c) ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made; and

(d) reporting to the Board of Directors all instances where bank accounts may become or have become overdrawn, together with the remedial action taken.

5.3 Banking and Investment Procedures

5.3.1 The Finance Director will prepare detailed instructions on the operation of bank accounts that must include:

(a) the conditions under which the bank accounts are to be operated;

(b) the limit to be applied to any overdraft; and

(b) those authorised to sign cheques or other orders drawn on the Trust's accounts.

5.3.2 The Finance Director must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.4 Investments

5.4.1 The Finance Director will comply with the Treasury Management Policy, as approved by the Board of Directors, when borrowing and investing surplus funds.

5.5 External Borrowing

5.5.1 The Finance Director will advise the Board of Directors concerning the Trust's ability to pay interest on, and repay, both Public Dividend Capital and any proposed new borrowings.

Deleted: , within the limits set by Monitor

5.5.2 Any application for a loan or overdraft will only be made by the Finance Director or by an employee so delegated by him/her.

5.5.3 All short term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position.

5.5.4 All long term borrowings must be consistent with the plans outlined in the current Business Plan and be approved by the Board of Directors.

5.6 Tendering and Review

5.6.1 The Finance Director will review the commercial bank arrangements of the Foundation Trust at regular intervals to ensure that they reflect best practice and represent best value for money.

6 INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 Income Systems

6.1.1 The Finance Director is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 The Finance Director is also responsible for the prompt invoicing and banking of all monies received.

6.2 Fees and Charges

6.2.1 The Trust shall follow the Department of Health's guidance on Payment by Results when entering into contracts for patient services.

6.2.2 The Finance Director is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health's "Commercial Sponsorship – Ethical standards in the NHS" shall be followed.

6.2.3 The Finance Director shall determine the appropriate charges or fees for the provision of non-clinical services provided to other organisations and staff.

6.2.4 It is the responsibility of all employees to inform the Finance Director promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.3 Debt Recovery

6.3.1 All staff have an overriding responsibility to collect fees due for the provision of chargeable services thus ensuring the minimisation of debts.

6.3.2 The Finance Director is responsible for the appropriate recovery action on all outstanding debts.

6.3.3 Income not received should be dealt with in accordance with losses procedures. (See section 12.)

6.3.4 Overpayments should be detected (or preferably prevented) and recovery initiated.

6.4 Security of Cash, Cheques and other Negotiable Instruments

6.4.1 The Finance Director is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

6.4.2 Official money shall not under any circumstances be used for the encashment of private cheques.

6.4.3 All cheques, postal orders, cash etc., shall be banked promptly and intact. Disbursements shall not be made from cash received, except under arrangements approved by the Finance Director.

6.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

6.4.5 Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be monitored and recorded within the Finance Department. Any significant trends should be reported to the Finance Director and Internal Audit via the incident reporting system. Where there is prima facie evidence of fraud or corruption this process should follow guidance provided by NHS Protect (previously known as the NHS Counter Fraud and Security Management Service). Where there is no evidence of fraud or corruption the loss should be dealt with in line with the Trust's Losses and Special Payments procedures.

7 NHS SERVICE CONTRACTS FOR PROVISION OF SERVICES

7.1 The Chief Executive, as the accountable officer, is responsible for ensuring the Trust enters into suitable legally binding service contracts with service commissioners for the provision of NHS services.

7.2 All service contracts should aim to implement the agreed priorities contained within the Integrated Business Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- the Provider Licence from Monitor
- the standards of service quality expected;
- the relevant national service framework (if any);
- the provision of reliable information based on national and local tariffs, and underlying reference costs
- the National Institute of Clinical Excellence Guidance
- the National Standard Local Action – Health and Social Care Standards and Planning Framework
- that service contracts build where appropriate on existing partnership arrangements;
- that service contracts are based on integrated care pathways.

7.3 A good service contract will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The service contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

7.4 The Chief Executive, as the accountable officer, will need to ensure that regular reports are provided to the Board of Directors detailing actual and forecast income from the service contract. This will include information on costing arrangements, which increasingly should be based upon case mix adjusted measures including Healthcare Resource Groups (HRGs). The service contract will also meet the minimum standards of the Payment by Results requirements.

8 TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE BOARD OF DIRECTORS AND EMPLOYEES

8.1 Remuneration and Terms of Service

8.1.1 In accordance with Standing Orders the Board of Directors shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

8.1.2 The Remuneration Committee will:

(a) advise the Board of Directors about appropriate remuneration and terms of service for the Chief Executive, other Executive Directors employed by the Trust and other senior employees including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars; and

(iii) arrangements for termination of employment and other contractual terms

(b) make such recommendations to the Board of Directors on the remuneration and terms of service of officer members of the Board of Directors (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust – having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate; and

(c) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking accounts of such national guidance as is appropriate.

8.1.3 The Committee shall report in writing to the Board of Directors the basis for its recommendations. The Board of Directors shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of executive directors. Minutes of the Board of Directors' meetings should record such decisions.

8.1.4 The Board of Directors will after due consideration and amendment if appropriate approve proposals presented by the Chief Executive for

Formatted: Indent: Left: 85.05 pt, Hanging: 21.3 pt

Formatted: Indent: Left: 106.35 pt, No bullets or numbering

Formatted: Indent: Left: 85.05 pt, Hanging: 21.3 pt

Formatted: List Paragraph, Left, No bullets or numbering, Hyphenate, Tabs: Not at -36 pt + 0 pt + 35.45 pt

Formatted: Indent: Left: 85.05 pt, Hanging: 21.3 pt

Formatted: No bullets or numbering

Deleted: ¶
. (ii) . provisions for other benefits, including pensions and cars;¶
¶
<#>arrangements for termination of employment and other contractual terms;¶

Formatted: Indent: Left: 37.8 pt, Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 2 + Alignment: Left + Aligned at: 82.5 pt + Tab after: 129.75 pt + Indent at: 129.75 pt, Tabs: 85.05 pt, Left + Not at 129.75 pt

setting of remuneration and conditions of service for those employees not covered by the Committee.

8.1.5 The Trust will pay allowances to the Chairman and Non-Executive Directors of the Board of Directors and said allowances will be approved by the Council of Governors.

Deleted: ,

Deleted: in accordance with instructions issued by Monitor.

8.2 Funded Establishment

8.2.1 The workforce plans of the Trust will be reconciled with the funded establishments on expenditure budgets, to ensure affordability of appropriate staffing levels.

8.2.2 The funded establishment of any department may not be varied recurrently without the approval of the Chief Executive, on the advice of the HR Director.

8.3 Staff Appointments

8.3.1 No officer may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Executive; and

(b) within the limit of his approved budget and funded establishment.

8.3.2 The Board of Directors will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees.

8.4 Processing Payroll

8.4.1 The Finance Director is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances (in conjunction with the Director of HR);

(c) making payment on agreed dates; and

(d) agreeing method of payment.

8.4.2 The Finance Director will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of payment available to various categories of employee and officers;

(h) procedures for payment by cheque or bank credit to employees and officers;

(i) procedures for the recall of cheques and bank credits;

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) separation of duties of preparing records; and

(m) a system to ensure the recovery from leavers of sums of money and property due by them to the Trust.

8.4.3 Appropriately nominated managers have delegated responsibility for:

(a) Submitting a signed copy of the notification of starter/variation in contract forms and other such documentation as may be required immediately upon an employee commencing duty;

(b) submitting time records and other notifications in accordance with agreed timetables;

(c) completing time records and other notifications in accordance with the Finance Director's instructions and in the form prescribed by the Finance Director; and

(d) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that

Formatted: Indent: Left: 30.5 pt, Hanging: 54.55 pt, Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 72 pt + Tab after: 0 pt + Indent at: 90 pt, Tabs: 85.05 pt, Left + Not at 92.15 pt + 115.8 pt

Deleted: a

Deleted: b

Deleted: c

suggest they have left without notice, the Finance Director must be informed immediately.

(e) taking responsibility for managing staff costs within the available resources and engaging staff in accordance with Trust policies and procedures.

Deleted: d

8.4.4 Regardless of the arrangements for providing the payroll service, the Finance Director shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

8.5 Contracts of Employment

8.5.1 The Board of Directors shall delegate responsibility to managers

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board of Directors and which complies with employment legislation; and

(b) dealing with variations to, or termination of, contracts of employment.

9 NON-PAY EXPENDITURE

9.1 Delegation of Authority

9.1.1 As part of the approval of annual budgets, the Board of Directors will approve the level of non-pay expenditure and the Chief Executive will determine the level of delegation to budget managers as part of the budget management framework.

9.1.2 The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services; and

(b) the maximum level of each requisition and the system for authorisation above that level (See Reservation of Powers and Scheme of Delegation document)

9.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

9.1.4 The Chief Executive will determine the level of delegation in respect of entering into contracts (refer to Reservation of Powers and Scheme of Delegation for delegated limits).

9.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

9.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Estates or Purchasing department shall be sought. Where this advice is not acceptable to the requisitioner, the Finance Director (and/or the Chief Executive) shall be consulted.

9.2.2 The Finance Director shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

9.2.3 The Finance Director will:

(a) advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; current thresholds are set out in 9.5 below;

(b) prepare procedural instructions on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of Board Directors/employees (including specimens of their signatures) authorised to certify invoices.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

(iii) A timetable and system for submission to the Finance Director of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts (where providing good value for money) or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

9.2.4 Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%);

(b) the appropriate Executive Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) the Finance Director will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold); and

(d) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or Chief Executive if problems are encountered.

9.2.5 Official orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Finance Director;

(c) state the Trust's terms and conditions of trade; and

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

9.2.6 Managers and officers must ensure that they comply fully with the guidance and limits specified by the Finance Director and that:

(a) all contracts, leases, tenancy agreements and other commitments which may result in a liability are notified to the Finance Director in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU regulations on public procurement (thresholds and regulations together with the consequences of breaching these regulations are attached at Appendix 1).

Deleted: Procurement Directive 2004/18/EC and the World Trade Organisation Plurilateral Agreement on Government Procurement (GPA)

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health/Monitor

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

Refer to the national guidance contained in "Standards of Business Conduct for NHS Staff".

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Finance Director on behalf of the Chief Executive;

(f) all goods, services, or works are ordered on an official order except purchases from petty cash or on purchase cards;

(g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

(h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(j) changes to the list of directors/employees and officers authorised to certify invoices are notified to the Finance Director;

Deleted: (see

Deleted: HSG 1993/5

Deleted: " (contained in Appendix B of the Model Standing Orders at Appendix 1 of the Corporate Governance Framework Manual).¶

Deleted: works and services executed in accordance with a contract,

9.3 Petty Cash

9.3.1 Purchases that will be reimbursed from petty cash are restricted in value and by type, in accordance with instructions issued by the Finance Director.

9.3.2 All reimbursements must be supported by receipt(s) and certified by an authorised signatory.

9.3.3 Petty cash records are maintained in a form as determined by the Finance Director.

9.4 Building and Engineering Transactions

9.4.1 The Finance Director shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE, and Project 21 guidance. The technical audit of these contracts shall be the responsibility of the relevant Director.

9.5 Tendering Quotation and Contract Procedure

9.5.1 The Trust shall ensure the competitive tenders are invited for the supply of goods, materials, manufactured articles and services for the design, construction and maintenance of buildings and engineering works and for disposals.

9.5.2 Formal tendering procedures may be waived by officers for whom powers have been delegated by the Chief Executive through the Scheme of Delegation where one or more of the following applies:

(a) The estimated expenditure or income does not, or is not reasonably expected to, exceed £25,000 (this figure is reviewed annually). It is a breach of the Regulations to spilt contracts to avoid the thresholds. The value used should be the overall contract value for the life of the equipment or service not annual costs;

(b) This is an extension to an existing (or very recently expired) contract which was sourced by competitive selection or via a framework either by the Trust or by agencies such as the Crown Commercial Service, NHS Supply Chain or another commercial procurement collaborative acting on behalf of a NHS organisation;

(c) Where the supply of the proposed goods or service is under special arrangements by any Government Agency (e.g. Procure21+ as it applies to construction contracts).

9.5.3 The negotiated procedure without the prior publication of a contract notice (the STA) may be used in the following circumstances but should not be used to avoid competition or for administrative convenience:

(a) There is an absence of suitable tenders. (i.e. The goods/services/works having been appropriately advertised using the open procedure or the restricted procedure);

(b) For reasons of extreme urgency brought about by events unforeseeable by, and not attributable to, the Trust, e.g. flood, fire or

Deleted: ;

Deleted: ;

Deleted: 9.5.2 . Formal tendering procedures may be waived by officers to whom powers have been delegated by the Chief Executive through the Scheme of Delegation where one or more of the following applies:¶
¶
(a) . The estimated expenditure or income does not, or is not reasonably expected to, exceed £25,000 (this figure should be reviewed annually).¶
¶
(b) . Where ordered under existing contracts which were themselves sourced under competitive selection (either by the Trust itself or by agencies such as NHS Supply Chain, The Government Procurement Service or regional commercial procurement collaboratives acting on behalf of NHS organisations).¶
¶
(c) . Where the supply is proposed under special arrangements negotiated by the DoH (including Procure21 as it applies to construction contracts).¶
¶
9.5.3 . The limited application of the single tender rules should not be used to avoid competition or for administrative convenience, however, formal tendering procedures may also be ... [1]

Formatted: Indent: Hanging: 36 pt

Deleted:

Formatted ... [2]

Formatted: Indent: Left: 53.25 pt, First line: 0 pt, Tabs: 35.45 pt, Left

Formatted ... [3]

Formatted: List Paragraph, No bullets or numbering, Tabs: Not at 35.45 pt

Formatted ... [4]

Formatted: Indent: Left: 0 pt, First line: 0 pt, Tabs: 35.45 pt, Left

Formatted: Indent: Left: 0 pt, Hanging: 35.45 pt, Tabs: Not at 27 pt

Formatted: Indent: Left: 53.25 pt, No bullets or numbering

Formatted ... [5]

system failure. Failure to plan properly is not a justification for single tender;

(c) Specialist expertise / equipment is required and it is only available from one source. (i.e. for technical, artistic reasons or connected to the protection of exclusive rights).

(d) There is clear benefit to be gained from maintaining continuity where:

(i) the goods are a partial replacement for, or in addition to, existing goods or an installation; and

(ii) to obtain the goods from another supplier would oblige the Trust to acquire goods having different technical characteristics which may result in incompatibility and/or disproportionate technical difficulties in the operation or maintenance of the existing. This must be more than familiarity. This continuity must outweigh any potential financial advantage to be gained by competitive tendering.

Where a responsible officer decides that competitive tendering is not applicable and should be waived by virtue of the above details should be recorded on the Single Tender Approval Form and submitted to the Chief Executive for approval. Details of these approvals will be reported to the Audit Committee,

9.5.4 All invitations to tender should be sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than three firms/individuals, having regard to their capacity to supply the goods, materials or undertake the service required.

9.5.5 The firms/individuals invited to tender (and where appropriate quote) should be as set out in the tendering procedures.

9.5.6 Quotations are required where the formal tendering procedures are waived under 9.5.2 above.

9.5.7 All quotations should be treated as confidential and should be retained for inspection.

9.5.8 The Chief Executive or his nominated officer should evaluate the quotations and select the one which gives best value for money. If this is not the lowest, then this fact and the reasons why the lowest quotation was not chosen should be in a permanent record.

9.5.9 Where tenders or quotations are not required, the Trust shall procure goods and services in accordance with procurement procedures approved by the Board of Directors.

9.5.10 The Chief Executive shall be responsible for ensuring the best value for money can be demonstrated for all services provided under contract or

Formatted: List Paragraph, No bullets or numbering, Tabs: Not at 56.7 pt

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 35.25 pt + Tab after: 0 pt + Indent at: 53.25 pt, Tabs: 56.7 pt, Left + Not at 115.8 pt

Formatted: List Paragraph, No bullets or numbering, Tabs: Not at 56.7 pt

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 35.25 pt + Tab after: 0 pt + Indent at: 53.25 pt, Tabs: 56.7 pt, Left + Not at 115.8 pt

Formatted: List Paragraph, No bullets or numbering, Tabs: Not at 56.7 pt

Formatted: Numbered + Level: 2 + Numbering Style: i, ii, iii, ... + Start at: 1 + Alignment: Left + Aligned at: 54 pt + Tab after: 0 pt + Indent at: 72 pt, Tabs: 56.7 pt, Left + Not at 115.8 pt + 144 pt

Formatted: Indent: Left: 72 pt, Tabs: 56.7 pt, Left + Not at 27 pt + 115.8 pt + 144 pt

Formatted: Numbered + Level: 2 + Numbering Style: i, ii, iii, ... + Start at: 1 + Alignment: Left + Aligned at: 54 pt + Tab after: 0 pt + Indent at: 72 pt, Tabs: 56.7 pt, Left + Not at 115.8 pt + 144 pt

Formatted: List Paragraph, No bullets or numbering, Tabs: Not at 56.7 pt

Formatted: Indent: Left: 0 pt, Hanging: 35.45 pt, Tabs: Not at 27 pt

Deleted:

Formatted: Tabs: 35.45 pt, Left + Not at 27 pt

Deleted:

Deleted:

Deleted: (a) or (c)

Deleted: , because expenditure is below £15,000

in-house. The Board of Directors may also determine from time to time that in-house services should be market tested by competitive tendering. (Standing Order 9)

9.5.11 The competitive tendering or quotation procedure shall not apply to the disposal of:

(a) Items with an estimated sale value of less than £15,000;

(b) Any matter in respect of which a fair price can be obtained only by negotiation or sale by auction;

(c) Obsolete or condemned articles and stores; which may be disposed of in accordance with the procurement policy of the Trust;

10 CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

10.1 Capital Investment

10.1.1 The Chief Executive:

a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

c) shall ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges.

10.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; and

(ii) appropriate project management and control arrangements;

(iii) the involvement of appropriate Trust personnel and external agencies; and

(b) that the Finance Director has certified professionally to the costs and revenue consequences detailed in the business case.

10.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issues procedures for their management, incorporating the recommendations of “CONCODE”.

The Finance Director shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

The Finance Director shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

10.1.4 The approval of a capital programme shall not constitute approval for the initiation of expenditure on any scheme.

10.1.5 The Finance Director shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender;

(c) approval to accept a successful tender.

10.1.6 The Chief Executive will issue a scheme of delegation for capital investment management in accordance the Trust's Standing Orders.

Deleted: with the Capital Investment Manual guidance and

10.1.5 The Finance Director shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures will:

(a) be designed to ensure that each project stays within estimated/budgeted costs at each milestone;

(b) be issued to project managers and other employees/persons involved in capital projects;

(c) incorporate simple checklists designed to ensure that important requirements are complied with on each project.

10.2 Private Finance (including leasing)

10.2.1 The Trust may test for PFI when considering a major capital procurement.

10.2.2 When the Trust proposes to use finance the following procedures shall apply:

Deleted: that is to be provided other than through its total borrowing limit set by Monitor,

(a) The Finance Director shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

(b) The proposal must be specifically agreed by the Board of Directors.

(c) Any finance or operating lease must be agreed and signed by the Finance Director.

10.3 Asset Registers

10.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Finance Director concerning the form of any register and the method of updating, and arranging for a physical check of assets.

10.3.2 The Trust shall maintain an Asset Register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the guidance issued by Monitor.

10.3.3 Additions to the Fixed Asset Register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and

(c) lease agreements in respect of assets held under a finance lease and capitalised.

10.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

10.3.5 The Finance Director shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on Fixed Asset Registers.

10.3.6 The value of each asset shall be depreciated using methods and rates in accordance with Monitor's FT ARM.

10.4 Security of Assets

10.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

10.4.2 Asset control procedures, (including both purchased and donated assets) must be approved by the Finance Director. These procedures shall make provision for:

(a) recording of managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

Deleted: Indexation and depreciation should be in line with UK GAAP and guidance issued by Monitor.

Deleted: 10.4 Protected Property¶
¶
10.4.1 A register of protected property must be maintained in accordance with the requirements of Monitor.¶
¶
10.4.2 No protected property may be disposed of without the approval of the Monitor.¶

Deleted: 5

Deleted: 5

Deleted: 5

Deleted: fixed assets, cash, cheques and negotiable instruments, and also including donated

(e) periodic verification of the existence of, condition of, and title to assets recorded;

(f) identification and reporting all costs associated with the retention of an asset.

10.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Finance Director.

10.4.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board Directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS Foundation Trust property as may be determined by the Board of Directors. Any breach of agreed security practices must be reported in accordance with instructions.

10.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Directors and employees in accordance with the procedure for reporting losses.

10.4.6 Where practical, assets should be marked as Trust property.

10.4.7 Equipment and other assets may be loaned to or from the Trust. Employees and managers must ensure that the Trust's management procedure is followed, in particular conditions attaching to the loan are documented and the assets identified. Assets loaned to the Trust must not be entered in the Trust's asset register.

Deleted: 5

Deleted: 5

Deleted: 5

Deleted:

Formatted: No bullets or numbering

Formatted: Indent: Left: 36 pt, No bullets or numbering

11 STORES AND RECEIPT OF GOODS

11.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

11.2 Subject to the responsibility of the Finance Director for the systems of control, overall responsibility for the control of stores shall be delegated to the Trust's Head of Procurement. The day-to-day responsibility may be delegated by him/her to departmental employees and stores managers/keepers. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated Estates Manager.

11.3 A number of principles apply to the operation of all stores; managers of stores and stock are responsible for ensuring that:-

(a) stocks are kept to a minimum, commensurate with delivery and cost effective purchasing;

(b) delegation of responsibility must be clearly defined and recorded. The Finance Director may require access to the record in writing;

(c) the designated manager must be responsible for security arrangements; the custody of keys etc must be clearly defined in writing;

(d) security measures, including marking as Trust property, must be commensurate with the value and attractiveness of the stock;

(e) stocktaking arrangements are agreed with the Finance Director and a physical check undertaken at least once a year;

(f) the system of store control, including receipt and checking of delivery notes etc, is agreed with the Finance Director;

(g) there is a system, approved by the Finance Director, for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods;

(h) any evidence of significant overstocking and of any negligence or malpractice shall be reported to the Finance Director;

(h) losses and the disposal of obsolete stock are reported to the Finance Director

11.4 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Finance Director.

11.5 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store, and issue appropriate guidance for checking receipt of goods.

12 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

12.1 Disposals and Condemnations

12.1.1 The Finance Director must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

12.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Finance Director of the estimated market value of the item, taking account of professional advice where appropriate. The Finance Director shall ensure that the arrangements for the sale of disposable assets maximise the income to the Trust.

12.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Finance Director;

(b) recorded by the Condemning Officer in a form approved by the Finance Director that will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Finance Director.

12.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Finance Director who will take the appropriate action.

12.2 Losses and Special Payments

12.2.1 The Finance Director must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The Finance Director must also prepare a Fraud and Corruption Policy that sets out the action to be taken both by the persons detecting a suspected fraud and those persons responsible for investigating it.

12.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Finance Director or inform an officer charged with responsibility for responding to concerns involving loss confidentially. This officer will then appropriately inform the Finance Director and/or Chief Executive. When an employee discovers or suspects fraud or corruption it must be immediately reported to the Trust's Local Counter Fraud Specialist – phone 01904 725145. Alternatively, employees can contact the NHS Fraud and Corruption

Reporting Line – 0800 028 40 60. Where a criminal offence is suspected, the Finance Director must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies that may indicate fraud or corruption, the Finance Director or Local Counter Fraud Specialist must inform the relevant CFOS regional team in accordance with the Secretary of State's Directions.

12.2.3 The Finance Director or Local Counter Fraud Specialist must notify NHS Protect (previously known as the NHS Counter Fraud and Security Management Service) and both the Internal and External Auditor of all frauds.

Deleted: the NHS Counter Fraud Services

12.2.4 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Finance Director must immediately notify:

(a) the Board of Directors,

(b) the External Auditor, and

(c) the Head of Internal Audit.

12.2.5 The Board of Directors shall approve the writing-off of losses. The delegated limits for approval of all losses and special payments are set out in the Reservation of Powers and Scheme of Delegation document. Authorising officers must undertake fuller reviews of systems to reduce the risk of similar losses occurring in the future and seek advice where they believe a particular case raises issues of principle.

Deleted: Schedule I (Losses and Special Payments)

12.2.6 For any loss, the Finance Director should consider whether any insurance claim could be made.

Deleted: 12.2.6 . The Finance Director shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.¶

Deleted: 7

12.2.8 The Finance Director shall maintain a Losses and Special Payments Register in which write-off action is recorded. This register will be reviewed by the Audit Committee on an annual basis.

12.2.9 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health.

Deleted: advised by the Department of Health

Deleted: Board of Directors.

12.3 Bankruptcies, Liquidation and Receiverships

12.3.1 The Finance Director shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

12.3.2 When a bankruptcy, liquidation or receivership is discovered, all payments should cease pending confirmation of the bankruptcy, etc. As a matter of urgency, a statement must be prepared listing the amounts due to and from the Trust.

13 COMPUTERISED FINANCIAL SYSTEMS

13.1 The Finance Director, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's financial data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

(b) ensure that adequate (reasonable) controls exist over financial data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the financial computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the financial computerised system and that such computer audit reviews as he/she may consider necessary are being carried out.

13.2 The Finance Director shall satisfy him/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

13.3 In the case of computer systems which are proposed General Applications (i.e. including those applications which the majority of NHS bodies in the locality/region wish to sponsor jointly) all responsible directors and employees will send to the Finance Director:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

13.4 The Finance Director shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

13.5 Where another health organisation or any other agency provides a computer service for financial applications, the Finance Director shall periodically seek assurances that adequate controls are in operation.

13.6 Where computer systems have an impact on corporate financial systems the Finance Director shall satisfy him/herself that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that an audit trail exists;

(c) Finance Director staff have access to such data; and

(d) such computer audit reviews are being carried out as are considered necessary.

14 PATIENTS' PROPERTY

14.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

14.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets,
- hospital admission documentation and property records,
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

14.3 The Finance Director must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money.

14.4 Where Department of Health instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the Finance Director.

14.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

14.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

14.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

14.8 Where a deceased patient is intestate and there is no lawful next-of-kin, details of any monies or valuables should be notified to the Treasury Solicitor.

14.9 Any funeral expenses necessarily borne by the Trust in respect of a deceased patient shall be reimbursed from any of the patient's monies held by the Trust.

15 CHARITABLE FUNDS

15.1 Introduction

15.1.1 Charitable funds are those funds which are held in the name of the Trust separately from other funds and which arise principally from gifts, donations, legacies and endowments made under the relevant charities legislation.

15.1.2 Standing Orders state the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust and define how those responsibilities are to be discharged. They explain that although the management processes may overlap with those of the organisation of the Trust, the trustee responsibilities must be discharged separately and full recognition given to its dual accountabilities to the Charity Commission for charitable funds held on trust and to Monitor for all funds held on trust.

15.1.3 The reserved powers of the Board of Directors and the Charitable Funds Scheme of Delegation make clear where decisions regarding the exercise of discretion in terms of the disposal and use of funds are to be taken and by whom. Directors and officers must take account of that guidance before taking action. SFIs are intended to provide guidance to persons who have been delegated to act on behalf of the corporate trustee.

15.1.4 As management processes overlap most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust. This section covers those instructions which are specific to the management of funds held on trust.

15.1.5 The over-riding principle is that the integrity of each trust must be maintained and statutory and trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

15.2 Income

15.2.1 All gifts and donations accepted shall be received and held in the name of the Trust's registered charity and administered in accordance with the Charity's policy, subject to the terms of the specific charitable funds.

Deleted: Trust

15.2.2 All managers/employees who receive enquiries regarding legacies shall keep the Finance Director, or person nominated by him, informed and shall keep an appropriate record. After the death of a benefactor all correspondence concerning a legacy shall be dealt with on behalf of the Trust by the Finance Director.

15.2.3 The Finance Director shall advise the Board of Directors on the financial implications of any proposal for fund raising activities which the Trust may initiate, sponsor or approve.

15.2.4 New charitable funds will only be opened where the wishes of benefactors cannot be accommodated within existing funds and in all cases must comply with the requirements of the Charity Commission.

15.3 Expenditure

All expenditure from charitable funds, with the exception of legitimate expenses of administering and managing those funds and expenditure for research purposes, must be for the benefit of the NHS.

Formatted: Indent: Left: 35.45 pt

Deleted: patients or staff.¶

15.3.1 Expenditure of any charitable funds shall be conditional upon the goods and services being within the terms of the appropriate charitable fund and upon the proviso that the expenditure does not result in further payments by the Trust which have not been agreed and funded.

15.4 Investments

15.4.1 Charitable funds shall be invested by the Finance Director in accordance with the Trust's policy and statutory requirements.

15.4.2 In managing the investments the Trust shall take due account of the written advice received from its duly appointed Investment Advisors.

16 ACCEPTANCE OF GIFTS BY STAFF

16.1 The Finance Director shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. This policy should follow the guidance contained in the Department of Health Standards of Business Conduct for NHS Staff.

17 RETENTION OF DOCUMENTS

17.1 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained in accordance with Department of Health guidelines " Records Management: NHS Code of Practice".

17.2 The documents held in archives shall be capable of retrieval by authorised persons.

17.3 Documents held in accordance with Department of Health guidelines shall only be destroyed at the express instigation of the Chief Executive and records shall be maintained of documents so destroyed. All the above shall be in compliance with the requirements of the Freedom of Information Act and the Trust's policy for document management and retention.

Deleted: a

18 RISK MANAGEMENT

18.1 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with the terms of the licence issued by Monitor. This programme will be approved and monitored by the Board of Directors.

18.2 The programme of risk management shall include:

a) a process for identifying and quantifying principal risks and potential liabilities, existing controls, additional controls as identified in the corporate risk register;

b) engendering among all levels of staff a positive attitude towards the control of risk as described in the Trust Risk Management Strategy;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;

e) review arrangements including; external audit, internal audit, clinical audit, health and safety review;

f) receive and review annual plan at Board of Directors.

Deleted: <#>monitor progress against the better health care standards;¶

The existence, integration and evaluation of the above elements will assist in providing a basis to make a statement on the effectiveness of Internal Control within the Annual Report and Accounts as required by the guidance issued Monitor.

18.3 The Board of Directors shall review insurance arrangements for the Trust.

Deleted: The Finance Director shall ensure that documented procedures cover these arrangements.

APPENDIX 1

THRESHOLDS FOR EU PUBLIC CONTRACTS REGULATIONS 2006 - FROM 1 JANUARY 2014

Formatted: Underline

	SUPPLIES	SERVICES	WORKS
Entities listed in Schedule 1[1]	£111,676 (€134,000)	£111,676[2] (€134,000)	£4,322,012[3] (€5,186,000)
Other public sector contracting authorities	£172,514 (€207,000)	£172,514 (€207,000)	£4,322,012[3] (€5,186,000)
Indicative Notices	£625,050 (€750,000)	£625,050 (€750,000)	£4,322,012 (€5,186,000)
Small lots	£66,672 (€80,000)	£66,672 (€80,000)	£833,400 (€1,000,000)

CONSEQUENCES OF BREACHING THE EU REGULATIONS

Formatted: Underline

A breach of the UK Public Contracts Regulations 2006 (currently being transposed into new legislation), the Public Contracts (Amendment) Regulations 2009 and the EU Public Contracts Directive 2014/24/EU is a serious matter whereby a fine is levied and/or reputational damage is done to the Trust.

When might a breach occur?

A breach may occur if the regulations have not been followed and is likely to be by one of the following happening;

1. **The Trust has directly awarded a contract without placing an OJEU advertisement in circumstances where an OJEU advertisement is required by the legislation. E.g. Inappropriate use of a Single Tender Action Waiver**
2. **The Trust has breached the rules relating to the standstill period and that breach has denied the supplier an opportunity to challenge the contract award.**
3. **A call-off from a contract under a framework agreement for goods or services with a value over the EC procurement threshold has been entered into without following the relevant call-off procedures under that framework.**

What might happen if we do breach?

Any contract will be deemed to be 'Ineffective'. Ineffectiveness is only available for procurements commenced on or after 20 December 2009. In such procurements, the three main circumstances outlined above may mean a remedy may be available to suppliers

What remedies are available to suppliers if we are found to have breached the Regulations?

If a court finds that the Regulations have been breached, it may render the contract ineffective or shorten the contract (possibly due to our requirements being critical and life-saving) and fine the Trust. In addition, a bidder may claim damages for its losses resulting from the breach.

When could we be fined?

A court is required (has no discretion) to impose a fine (described in the legislation as a "civil financial penalty") in any circumstances where the court declares a contract ineffective.

What will the level of fine be?

There is no prescribed "tariff" for fines however, the Regulations do state that fines must be "effective, proportionate and dissuasive". A figure of 10% of revenue has been used as a guide. A 1% (of revenue) fine for our Trust would be £4M.

Formatted: Font: Bold

9.5.2 Formal tendering procedures may be waived by officers to whom powers have been delegated by the Chief Executive through the Scheme of Delegation where one or more of the following applies:

(a) The estimated expenditure or income does not, or is not reasonably expected to, exceed £25,000 (this figure should be reviewed annually).

(b) Where ordered under existing contracts which were themselves sourced under competitive selection (either by the Trust itself or by agencies such as NHS Supply Chain, The Government Procurement Service or regional commercial procurement collaboratives acting on behalf of NHS organisations).

(c) Where the supply is proposed under special arrangements negotiated by the DoH (including Procure21 as it applies to construction contracts).

9.5.3 The limited application of the single tender rules should not be used to avoid competition or for administrative convenience, however, formal tendering procedures may also be waived where one or more of the following applies:

(d) The timescale genuinely precludes competitive tendering (failure to plan the work properly is not a justification for single tender)

(e) Specialist expertise or equipment is required and is available from only one source

(f) There is clear benefit to be gained from maintaining continuity with an earlier project, which might include compatibility or standardisation with existing equipment or consumables. This must be something more than familiarity of potential users with the product or awareness of a good reputation; in particular, the benefits of this continuity must outweigh any potential financial advantage to be gained by competitive tendering.

(g) Where provided for in the Capital Investment Manual.

Where a responsible officer decides that competitive tendering is not applicable and should be waived by virtue of (d) to (g) above, details should be recorded on the Single Tender Approval Form and submitted to the Chief Executive for approval. Details of these approvals will be reported to the Audit Committee.

Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 35.25 pt + Tab after: 0 pt + Indent at: 53.25 pt, Tabs: 35.45 pt, Left

Page 31: [3] Formatted **Harcourt, Jennifer D.** **24/07/2014 11:28:00**

Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 35.25 pt + Tab after: 0 pt + Indent at: 53.25 pt, Tabs: 35.45 pt, Left

Page 31: [4] Formatted **Harcourt, Jennifer D.** **24/07/2014 11:28:00**

Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 35.25 pt + Tab after: 0 pt + Indent at: 53.25 pt, Tabs: 35.45 pt, Left

Page 31: [5] Formatted **Harcourt, Jennifer D.** **24/07/2014 11:35:00**

Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 35.25 pt + Tab after: 0 pt + Indent at: 53.25 pt, Tabs: 56.7 pt, Left + Not at 115.8 pt

York Teaching Hospital NHS
NHS Foundation Trust

RESERVATION OF POWERS

AND

SCHEME OF DELEGATION

Author: Foundation Trust Secretary
Owner: Chief Executive
Publisher: Compliance Unit
Date of Issue: October 2014
Version: 8
Approved By: Audit Committee and Board of Directors
Review date: September 2015

RESERVATION OF POWERS TO THE BOARD OF DIRECTORS AND DELEGATION OF POWERS

Introduction

The Code of Accountability for NHS Boards and Monitor's Code of Governance requires the Board of Directors to draw up a schedule of decisions reserved to it and to ensure that management arrangements are in place to enable the clear delegation of its other responsibilities. This document sets out the powers reserved to the Board of Directors and the Scheme of Delegation including financial limits and approval thresholds. However, the Board of Directors remains accountable for all of its functions, including those which have been delegated, and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

All powers of the Trust which have not been retained as reserved by the Board of Directors or delegated to a Board Committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Scheme of Delegation identifies any functions which the Chief Executive shall perform personally and those delegated to other directors or officers. All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise.

GOVERNORS' LEGAL RESPONSIBLITIES

Introduction

The Trust has a body of elected individuals that make up the Council of Governors. Governors have a number of legal rights and responsibilities. These include:

- The appointment or dismissal of the Chairman and Non-executive Directors
- The approval of the appointment of the Chief Executive
- At a general meeting the Council of Governors will:
    - receive the annual accountsannual report and Quality Report and annual audit letter from the external auditors
    - approve the remuneration and allowances and other terms and conditions of the office of the Chairman and Non-executive Directors
    - appoint or replace the Trust's auditor at a general meeting
- Providing the views of the Council of Governors to the Board of Directors for the purposes of the preparation by the Board of Directors of the document containing information as to the Trust's forward planning in respect of each Financial Year to be given to Monitor
- Receiving and considering the views of the Members on matters of significance to the future plans of the Trust
- Approval of the amended of the constitution
- Hold the Non-executive Directors individually and collectively to account for the performance of the Board of Directors
- Represent the interests of the NHS Foundation Trust members and the public served by the Trust
- Approving significant transactions that fall within the definition
- Appointment and removal of the External Auditors
- Approval of the increase of non- NHS income where it is 5% or more in any one year

FUNCTIONS WHICH ARE RESERVED FOR DECISION BY THE BOARD

1.1 General enabling provision

The Board may determine any matter (for which it has delegated or statutory authority) it wishes in full session within its statutory powers.

1.2 Regulation and controls

- Approval, suspension, variation or amendment of Standing Orders, Reservation of Powers and Scheme of Delegation and Standing Financial Instructions for the regulation of its proceedings and business

- Approval of the Reservation of Powers and Scheme of Delegation from the Board to officers

- Requiring and receiving the Declaration of Directors' Interests which may conflict with those of the Trust and determining the extent to which that director may remain involved with the matter under consideration

- Requiring and receiving declaration of interest from officers which may conflict with those of the Trust.

- Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property

- Approval of the arrangements for dealing with complaints

- Adoption of the organisational structure, processes and procedures to facilitate the discharge of business by the Trust and to agree any modification there to

- To receive reports from committees including those which the Trust is required to provide by the Secretary of State, Monitor or other regulatory body or regulation to establish and to take appropriate action thereon

- To confirm recommendations presented to the Board of Directors by the Trust's Committees

- To establish terms of reference and reporting arrangements of all sub-committees of the Board of Directors

- Ratification of any urgent decisions taken by the Chairman in accordance with Standing Orders

- Approve the Trust's Major Incident Plan

- Prescribe the Financial and Performance reporting arrangement required by the Board of Directors

1.3 Appointments

- The appointment and dismissal of Board Committees
- The appointment of the Vice Chairman
- The appointment of the Senior Independent Director in consultation with the Council of Governors
- Through the Remuneration Committee the appointment and appraisal of Executive Directors and the disciplinary procedures of the Trust
- Ratification of the appointment of senior medical staff
- Approval of all new consultant appointments related to a business case
- The appointment of membership of the Board sub-committees
- The appointment of any representative body outside the organisation

1.4 Policy Determination

- The Board of Directors will approve policies that require specific Board approval including:
  - Management of Risk
  - Fire Safety Policy
  - Health and Safety Policy
  - Security Policy

This is not an exhaustive list.

1.5 Strategy and plans

- Define and approve the strategic aims and objectives of the Trust
- Approve strategic business plans incorporating a programme of investment in respect of the application of available financial resources
- Approve proposals for ensuring quality and safety and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State
- Approve proposals for action on litigation against or on behalf of the Trust
- Review use of NHSLA risk pooling schemes

1.6 General matters

- Acquisition, disposal of land/ or buildings above a value of £1m.
- Change of use of land
- Joint ventures
- To agree actions on litigation against or on behalf of the Trust
- Any investment regardless of size of new activity or any disinvestment

1.7 Financial and performance reporting arrangements

- Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from directors, committees and officers of the Trust
- Consideration and approval of the Trust's Annual Report and Annual Accounts prior to submission to Parliament
- Receive the annual management letter from the external auditor and agree proposed action taking account of the advice, where appropriate, of the Audit Committee

SCHEME OF DELEGATION

Delegated matters in respect of decisions which may have a far reaching effect must be reported to the Chief Executive. The delegation shown below is the lowest level to which authority is delegated. Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Officers as appropriate. All items concerning Finance must be carried out in accordance with Standing Financial Instructions and Standing Orders.

	Delegated Matter	Authority delegated to	Reference document
1	**Accountability**		
1a	Accountable through NHS Accounting Officer to Parliament for stewardship of Trust resources	Chief Executive	Accounting Officer Memorandum
1b	Ensure that expenditure by the Trust complies with Parliamentary requirements	Chief Executive	
1c	To ensure appropriate advice is given to the Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness	Chief Executive Finance Director Foundation Trust Secretary	
2	**Planning & Budgetary Control**		
2a	Prepare and submit an Annual Plan	Finance Director/ Director of Corporate Development and Research	SFI 3.1
2b	Management of budgets for the totality of services	Chief Executive	SFI 3.2
	• At Directorate level Prime budget holders are clinical directors and directors who hold all operating budgets for the Directorate's they manage including, where appropriate, income, activity and expenditure. Directorate Managers who provide professional support to practising Clinical Directors have also been granted Prime budget holder status.	Prime budget holder	Trust Finance Manual section 8
	• At individual budget unit level (pay and non pay) Prime budgets holders can delegate budgetary authority to delegated budget holders. These are typically lead clinicians, senior and other operational managers who control budgets on a day to day basis.	Delegated budget holder	Trust Finance Manual section 8
2c	Virement (planned transfer) of resources between directorate or specialty/department budgets (per	Finance Director	SFI 3.2.3, 3.3.2

	annum):		Trust Finance Manual. Section 8.2.3.
2d	Non pay requisitions - Decisions to rent or lease in preference to outright purchase	Head of Corporate Finance	SFI10.2
2e	Authority to change clinical template activity	Director of Operations/ Finance Director	
2f	Non-pay revenue expenditure within budgets (Note: over £50K the Business Case procedure shall apply)		SFI 9 Trust Finance Manual - section 5.2
	• Orders up to £1,000, except with explicit agreement to a higher limit set by FD	Delegated budget holder (If within available budget resources as agreed with Finance Director)	
	• Orders up to £50K (Except medical equipment – see below)	Prime budget holder (If within available budget resources as agreed with Finance Director)	
	• Medical equipment (i.e. medical, scientific, technical and x-ray equipment) - individual items over £1k and up to £100K	Medical Equipment Resource Group (MERG)	Trust Finance Manual; section 8.2.1
	• Orders over £50k (medical equipment over £100k) up to £500k	Executive Board	
	• Orders over £500K	Board of Directors	
	• Establishment of escalation facilities at short notice and associate costs	Deputy Chief Executive	
2g	Non-pay expenditure for which no specific budget has been established and which is not subject to funding under delegated powers of virement. (Subject to the limits specified above).	Finance Director	SFI 9
2h	Purchasing Cards: Authority to issue purchasing cards and setting of limits	Prime budget holder	
3	**Bank accounts and loans**		
3a	Loan arrangements	Director of Finance	SFI 5
4	**Business Cases**		

4a	Delegated limits relate to capital schemes within the agreed annual programme, annual revenue costs or the combination of capital and revenue cost in the first full year and relates to approval of a business case **Capital only** • up to £100k	Capital Programme Management Group	SFI 10
	• £100k-£500K-	Chief Executive / Finance Director through Capital Planning Board	
	• £500k-£1m	Executive Board	
	• Over £1m (and all PFI proposals)	Board of Directors	
	Capital and revenue, and revenue only		
	• Up to £50k	Prime Budget Holder	
	• £50k - £300k	Chief Executive	
	• £300k - £1m	Executive Board	
	• Over £1m (and all PFI proposals)	Board of Directors	
	• Consider all new consultant appointments and recommend to Board of Directors	Executive Board	
5	**Asset Register**		
5a	Maintenance of the asset register	Chief Accountant	SFI 10.3
6	**Quotations, Tendering and Contracts**		
6a	Obtaining a minimum of 3 written competitive tenders for goods/services over £25K	Head of Procurement	SFI 9
6b	Waiving of quotations and tenders subject to SFIs and SOs (including approval of single tenders)	Chief Executive	SFI 9.5
6c	Opening tenders – manual	An Executive Director and the Foundation Trust Secretary	SFI 9.5

6d	Opening tenders – electronically the system prevents quotes/tenders from being opened before the deadline	Head of Procurement	
6e	Acceptance of quotations/permission to consider late quotations	Head of Procurement	SFI 9.5.4
6f	Acceptance of tenders/permission to consider late tenders – over £25K	Chief Executive	SFI 9.5.4
6g	Accepting contracts and signing relevant documentation up to £25k	Head of Procurement	
6h	Accepting contracts and signing relevant documentation over £25k	Chief Executive / Finance Director	
7	**Expenditure variations on capital schemes**		SFI 10.1
	• Variations up to a value £10k		
	• Variations up to a value of £300k	Capital Programme Management Group Chief Executive / Finance Director through Capital Planning Board	
	• Variations up to the value of £500K	Executive Board	
	• Unlimited	Board of Directors	
8	**Setting of fees and charges**		SFI 6.2
8a	Private patient, overseas visitors, income generation and other patient related services	Finance Director	Provider Licence
8b	Financing content of NHS contracts	Finance Director	
8c	Approval of healthcare contracts and other agreements resulting in income to the Trust	Finance Director	
8d	Approval of variations of healthcare contracts:		
	• Up to £200K	Finance Director	
	• Over £200K	Executive Board	
9	**Property transactions**		SFI 12.1
9a	Disposal and acquisition of land and buildings		
	• Up to £300K	Chief Executive	
	• £300k-£1m	Executive Board	

	• Above £1m	Board of Directors	
9b	Lets and leases:		SFI 10.2
	• preparation and signature of all tenancy agreements/ licenses for all staff subject to Trust Policy on accommodation for staff	Director of Estates and Facilities	
	• extensions to existing leases	Director of Estates and Facilities	
	• Letting of premises to outside organisations, subject to business case limits	Director of Estates and Facilities	
	• Approval of rent based on professional assessment	Director of Estates and Facilities	
10	**Condemning and disposal - Equipment**		
10a	Items obsolete, obsolescent, redundant, and irreparable or cannot be repaired cost effectively (note: For disposal including those for sale the tendering and quotation limits shall apply)	Executive Director responsible for the area	SFI 12.1 Disposal policy
11	**Losses and compensation**		
11a	All losses, compensation and special payments shall be in accordance with current DOH guidance & details of all such payments shall be presented to the Audit Committee		SFI 12.2
11b	Maintain a losses and special payments register	Finance Director	SFI 12
11c	Clinical cases	Settled by NHS Litigation Authority	
11d	Non clinical cases		
	• Up to £50K	Finance Director	
	• £50K-£300k	Chief Executive	
	• £300k-£500k	Executive Board	
	• Over £500K	Board of Directors	
11e	Review schedules of losses and compensations and make recommendations to the Board	Audit Committee	
11f	Special payments	Treasury approval	
12	**Petty cash disbursements**		SFI 9.3
12a	Expenditure up to £50 per item	Petty cash holder	

12b	Expenditure over £50 per item	Finance Director	
12c	Reimbursement of patients monies up to £250	Delegated budget holder	
12d	Reimbursement of patients monies over £250	Prime budget holder	
13	**Maintenance and update of Trust accounting policies**	Finance Director	FRM and Monitor guidance
13a	Approval of updated Trust accounting policies	Audit Committee	
14	**Investment of funds**		SFI 5.4 Treasury Management Policy
14a	Investment of funds	Finance Director	
15	**Provision of services to other organisations**		
15a	Legal and financial arrangements for the provision of services to other organisations	Finance Director	
15b	Signing agreement with other organisations	Finance Director	
16	**Audit and Accounts**		SFI 2.5.1 SFI 4
16a	Approve the appointment and where necessary dismissal of the External Auditors	Council of Governors	
16b	Receive the annual management letter from the External Auditor.	Council of Governors	
16c	Receive the annual management letter from the external auditor and agree proposed action, taking account of the advice, where appropriate, of the Audit Committee	Board of Directors	
16d	Receive an annual report from the Internal Auditors and agree action	Audit Committee	
17	**Annual Report and Accounts**		
17a	Receive and approve the Annual Report and Accounts and Quality Report	Board of Directors	SFI 4
17b	Receive the Annual Report and Accounts and Quality Report and any comments on them at the Annual General Meeting	Council of Governors	
17c	Sign the annual statements including the annual accounts on behalf of the Board of Directors	Chairman, Chief Executive and Finance Director	

17d	Implementation of internal and external audit recommendations	Finance Director	SFI 2.1
18	**Retention of Records**		
18a	Maintaining archives of records to be retained	Chief Executive	SFI 17
19	**Declaration of Interests**		SO 6
19a	The keeping of a declaration of board members and officers' interests	Foundation Trust Secretary	
20	**Receipt or provision of hospitality and gifts**	All Trust employees have a duty to declare	SFI 16
20a	Approve procedures for declaration of hospitality and sponsorship	Board of Directors	Standards of Business Conduct
20b	Maintenance of gifts and hospitality register	Foundation Trust Secretary	
20c	Approval of receipt of both individual and collective hospitality	Prime budget holder	
21	**Attestation of sealings in accordance with Standing Orders**		
21a	Attestation of sealings in accordance with Standing Orders	Chairman or Designated NED and Chief Executive or Designated ED	SO 10
21b	The keeping of the sealings	Foundation Trust Secretary	SO 10
22	**Research and development**		
22a	Approval of research and development contracts (including variations or extensions):		
	• Up to £300K	Medical Director or Director of Finance or Chief Executive	
	• £300k -£1m	Executive Board	
	• £1m and over	Board of Directors	
23	**Personnel and Pay**		SFI 8
23a	Approve management policies including personnel policies incorporating arrangements for the appointment, removal and remuneration of staff	JMSC/LNC and Executive Board	

23b	Authorisation of timesheets (including agency timesheets)	Delegated budget holder	
23c	Authority to fill funded post on the establishment with permanent staff	Chief Executive	SFI 8
23d	Authority to appoint staff to post not on the formal establishment	Chief Executive	SFI 3/8
23e	Granting of additional increments to staff:	All subject to compliance with A4C regulations	SFI 8
	• within budget	Director of Human Resources	
	• in excess of budget	Director of Finance	
	• for Chief Executive and Director posts	Remuneration Committee	
	• for Non-executive Directors and Chairman	Council of Governors	SO 2.3
23f	Upgrading and regarding	Director of Human Resources	SFI 8
23g	Variation to existing Consultant Contracts/job plans	Medical Director Both subject to compliance with regulations	
23h	Authority to authorise overtime	Delegated Budget Holder	SFI 8
23i	Authority to authorise travel and subsistence expenses	Delegated Budget Holder	
23j	Authority to pay clinical excellence awards to Consultants	Board of Directors endorse decision of Committee chaired by the Chief Executive or Director of HR	
23k	Authority to pay discretionary points to staff grade and associate specialist doctors	Medical Director	
23l	Consider and approve recommendations on behalf of the Board on the remuneration and terms of service of corporate directors to ensure they are fairly rewarded for their individual contribution to the Trust, having proper regard to	Remuneration Committee	

	the Trust's circumstances and performance and to the provisions of any national arrangements for such staff		
23m	Approval of annual leave	Delegated budget holder	Annual Leave Policy
23n	Annual leave – approval of carry forward		
	• Up to a maximum of 5 days:	Delegated budget holder	
	• Over 5 days		
	(i) Medical Staff	Medical Director	
	(ii) Other Staff	Prime budget holder	
23o	Approval of compassionate leave		Special Leave Policy
	• Up to 5 days	Delegated budget holder	
	• Up to 10 days	Prime budget holder in consultation with HR	
23p	Special leave		Special Leave Policy
	• Paternity	Delegated budget holder	Paternity leave Policy
	• Other	Delegated budget holder	
	• Maternity leave		Maternity Leave Policy
	• Leave without pay	Delegated budget holder	
	• Medical staff leave of absence – paid and unpaid	Chief Executive	Special Leave Policy
	• Time off in lieu	Prime budget holder	Special Leave Policy
	• Flexible working arrangements	Delegated budgeted budget	Flexible Working Policy
	• Extension of sick leave on half pay up to three months • Return to work part time on full pay to assist recovery	Director of HR delegated where appropriate to Prime budget holder	Managing Sickness Absence Policy

	• Extension of sick leave on full pay		
23q	Study leave		
	• Study leave outside the UK – medical	Clinical Director	Policy on Learning Leave
	• Study leave outside the UK – other	Prime budget holder	
	• Medical staff study leave (UK)	Clinical Director Delegated budget holder	
	All other study leave (UK)	Delegated budget holder	
23r	Rent and House Purchases: Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview)		Relocation Expenses Policy
	• up to £6,000 (non-medical staff)	Prime Budget Holder	
	up to £6,000 (medical staff)	Director of Human Resources or Medical Director	
	• £6,000 - £8,000	Director of Human Resources or Medical Director	
	• Over £8,000	Chief Executive	
23s	Requests for new posts to be authorised as car users or mobile phone users	Prime budget holder	Lease Car and Mobile Phone Policies
23t	Renewal of fixed term contracts	Delegated budget holder	
23u	Authorisation of retirement on the grounds of ill health.	Via the Director of Human Resources (the decision can only be made by the NHS Pensions Agency)	
23v	Authorisation of staff redundancy	Finance Director and Director of Human Resources	Redundancy Policy
23w	Any termination settlement	Finance Director (with HM Treasury approval where required)	

23x	Authorisation of staff dismissal	Director of Human Resources	Disciplinary Policy
23y	Engagement of staff not on the establishment	Corporate Directors	
23z	Booking of Bank or Agency Staff		
	• Medical Locums	Prime Budget Holder	
	• Nursing	Prime Budget Holder	
	• Clerical	Prime Budget Holder	
24	**Facilities for staff not employed by the Trust to gain practical experience** Professional recognition, honorary contracts and insurance of medical staff, work experience students	Director of Human Resources or Medical Director	
25	**Security and risk management**		
25a	Corporate responsibility for implementation of the Security Policy	Director of Estates and Facilities	Security Policy
25b	Overall statutory responsibility for security management within the Trust	Chief Executive	
25c	Where an offence is suspected		
	• Criminal offence of a violent or clinical nature	Head of Security	
	• Where a fraud or theft is involved	Head of Security (theft)/ Local Counter-Fraud Specialist (fraud)	
25d	Authority for the issue of ID and security badges and car park passes	Delegated budget Holder	Security Policy ID Badge policy
26	**Insurance policies**		
26a	Insurance	Head of Corporate Finance	SFI 18/ Claims Handling Policy
26b	Review of all statutory compliance legislation and Health and Safety requirements including Control of Substances Hazardous to Health Regulations	Health and Safety Manager	Health and Safety Policy
27	**Authorisation of new drugs**		
27a	Yearly cost of drugs		

	• Estimated total yearly cost per individual drug up to £25,000	Directorate managers	Pharmaceutical Procurement Policy
	• Estimated total yearly cost per individual drug above £25,000	DTC recommendation, subject to business case procedure and Executive Board approval	Pharmaceutical Procurement Policy
27b	Authority to purchase/contract:		
	• Up to £5K	Senior Technician	
	• £5K - £50K	Countersigned by Principal Pharmacist	
	• £50K - £100K	Countersigned by Chief Pharmacist	
	• £100K to £150K	Director of Finance or Chief Executive	
	• £150K to £300K	Chief Executive	
	• £300K - £1m	Executive Board	
	• Over £1m	Board of Directors	
27c	Approval of nurses and others to administer and prescribe medication beyond the normal scope of practice	Director of Nursing or Medical Director or Chief Pharmacist	Nurse, Midwives, HV Act, Midwives Rules/Codes of Practice, NMC Code of professional Conduct/CSP Rules of Professional Conduct
28	**Patients and relatives' complaints**		
28a	Overall responsibility for ensuring that all complaints are dealt with effectively	Head of Patient Experience	Complaints Policy PALS policy
28b	Responsibility for ensuring complaints relating to a Directorate are investigated thoroughly	Head of Patient Experience	Complaints Policy PALS policy
28c	Agreement of financial compensation	Director of Finance	Losses procedure
29	**Extra Contractual Payment**		
	Authority to undertake and approval to pay waiting list initiatives	Director of Finance or Deputy Chief	

		Executive	
30	**Engagement of Trust's Solicitors**	Chief Executive, Foundation Trust Secretary, Finance Director, Head of Corporate Finance, Director of Estates and Facilities, Director of Human Resources, Head of Risk and Legal Services	

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 24 September 2014

Human Resources Strategy Quarterly Performance Report – 1 April 2014 – 30 June 2014

Action requested/recommendation

The Board of Directors is asked to consider the following recommendations in relation to potential actions and solutions to address current nursing workforce challenges:

- Urgently consider the development of new roles & identify pilot areas where they should be implemented – specifically band 3 & 4 support roles
- Development of opportunities for gaining healthcare experience (short term, e.g. summer contracts) to attract a younger workforce
- Pro active succession planning to minimise potential risks relating to senior and experienced nursing posts becoming vacant through retirements. This may potentially involve the development of an internal talent pool
- Support more open discussions around alternatives when posts (in particular Specialist Nursing posts) become vacant rather than default being to replace like for like

Support the continued exploration of innovative recruitment approaches, potentially including international recruitment

Summary

The attached document provides updated information for the period April - June 2014, relating to key Human Resources indicators including; sickness, recruitment & retention and workforce expenditure.

The main body of the paper demonstrates a shift in focus for this report. The report will focus in each quarter on a different key workforce theme. This report highlights the nursing workforce challenges faced by this organisation and other NHS organisations both regionally and nationally. The intelligence and analysis presented in this report is intended to inform discussion about actions required and potential solutions to address these challenges.

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	Executive Board – 17th September 2014
Risk	No risk
Resource implications	No resource implications
Owner	Sue Holden, Director of Applied Learning & Research
Author	Siân Longhorne, Workforce Information Manager
Date of paper	August 2014
Version number	Version 1

Board of Directors – 24 September 2014

Human Resources Strategy Quarterly Performance Report – 1 April 2014 – 30 June 2014

1. Introduction and background

Appendix A presents information relating to a range of key Human Resources indicators including sickness and temporary workforce expenditure.

Organisational performance against some of these metrics highlight some concerns. In particular, temporary workforce spend in this quarter is higher than in both the previous quarter and the same quarter of the 2013/14 financial year. The number of vacancies as a percentage of establishment and the percentage of the workforce on maternity leave have both increased recently which correlates to the increased demand for temporary staffing.

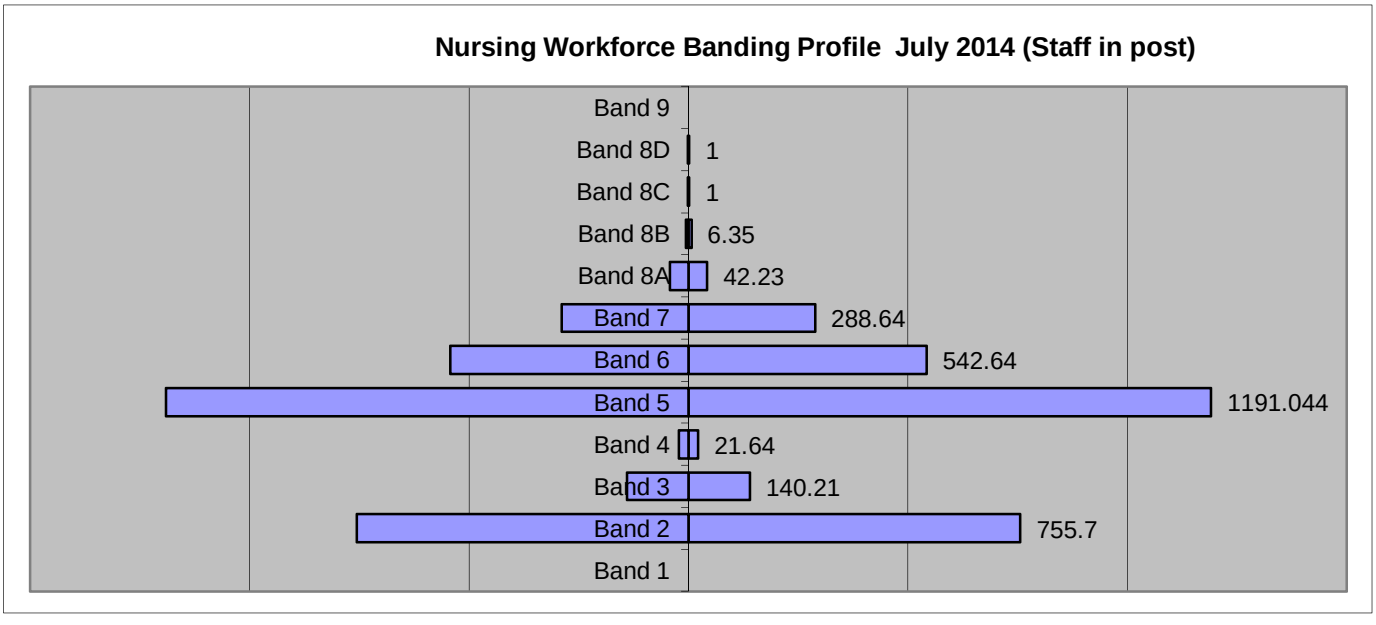
Appraisal rates in the first six months of 2014 have been well below the organisation's target of 95%.

We do however continue to see improvements in the organisation's sickness absence rates and continue to compare favourably with the absence rates of other similar organisations in the region.

The main body of this report focuses on the nursing workforce and the challenges currently facing this organisation and other NHS organisations regionally and nationally including the shortfall in supply of registered nurses to meet demand and the age profile of the current workforce, specifically in relation to experienced and senior nursing staff.

2. Current nursing workforce profile

Staff in post



The above graph shows the banding profile of the nursing workforce (based on staff in post) as at July 2014. This includes both registered nursing and non-registered roles providing support to nursing.

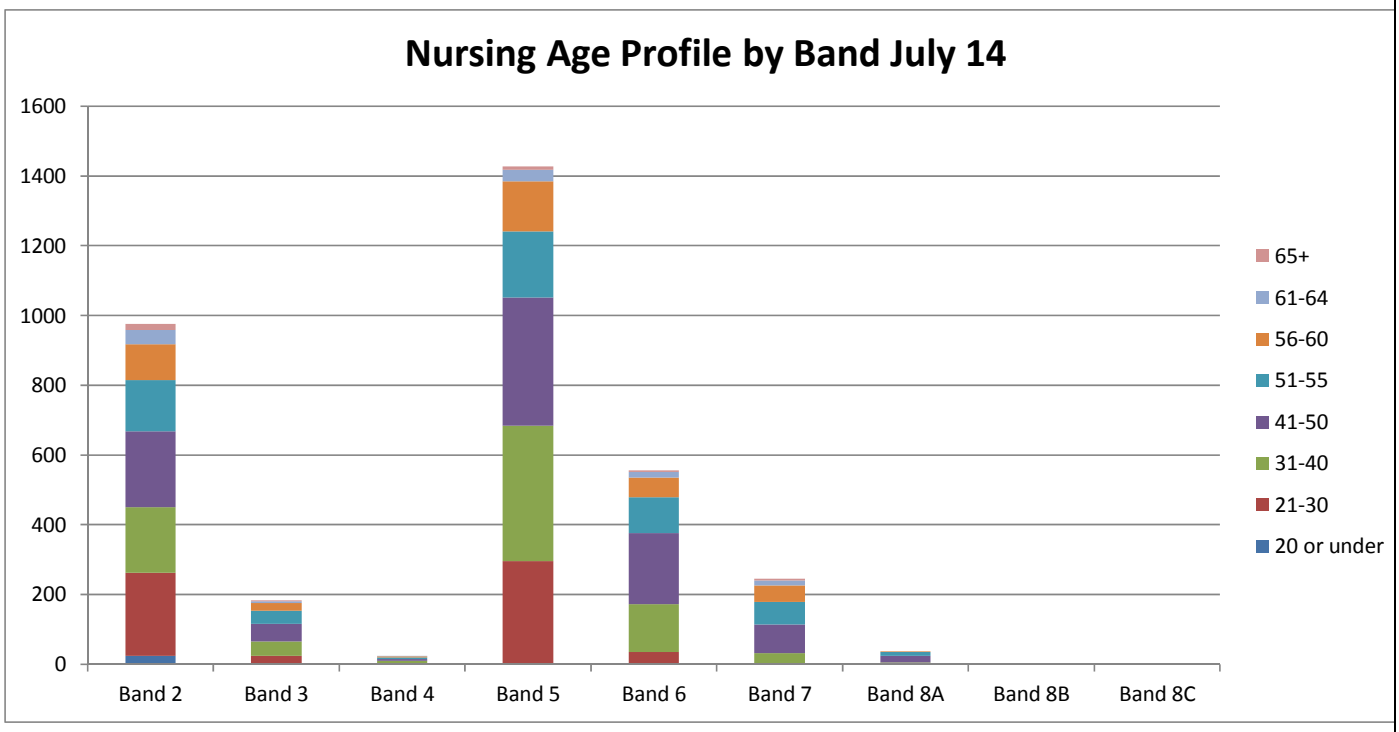
The above clearly demonstrates a gap between band 2 and band 5 in the nursing workforce. There are very real opportunities here to reshape the nursing workforce to provide benefits to the service and our patients but also to provide a more structured career framework for those entering the workforce at HCA level who would welcome the opportunity to progress but who do not want to pursue a nursing degree.

The vast majority of band 3 roles are in the Community setting. There are a very small number of band 3 posts in the acute setting including midwifery, sleep services, dermatology and A&E at Scarborough. The very small number of band 4 support roles that exist are mostly nursery nurses.

It is difficult to quantify an accurate vacancy rate at this point in time due to the way in which the Trust's electronic systems are set up – information contained within the finance general ledger showing budgeted establishment does not easily map to information held on ESR. This issue is also exacerbated by the way in which headroom is built into nursing budgets and therefore the difference between establishment and staff in post is not a true vacancy rate.

Ward/Outpatient/Community Nursing

The majority of our current nursing workforce are based on wards, in outpatient areas or in the community. The following is an age profile analysis of staff working in these settings. This also includes Midwives, Health Visitors, qualified and trainee Advanced Clinical Practitioners, Matrons and Lead Nurses.



Overall, a little less than a third of the nursing workforce are aged 51+. These are the staff who might reasonably be expected to consider retirement or flexible retirement over the next 5-10 years.

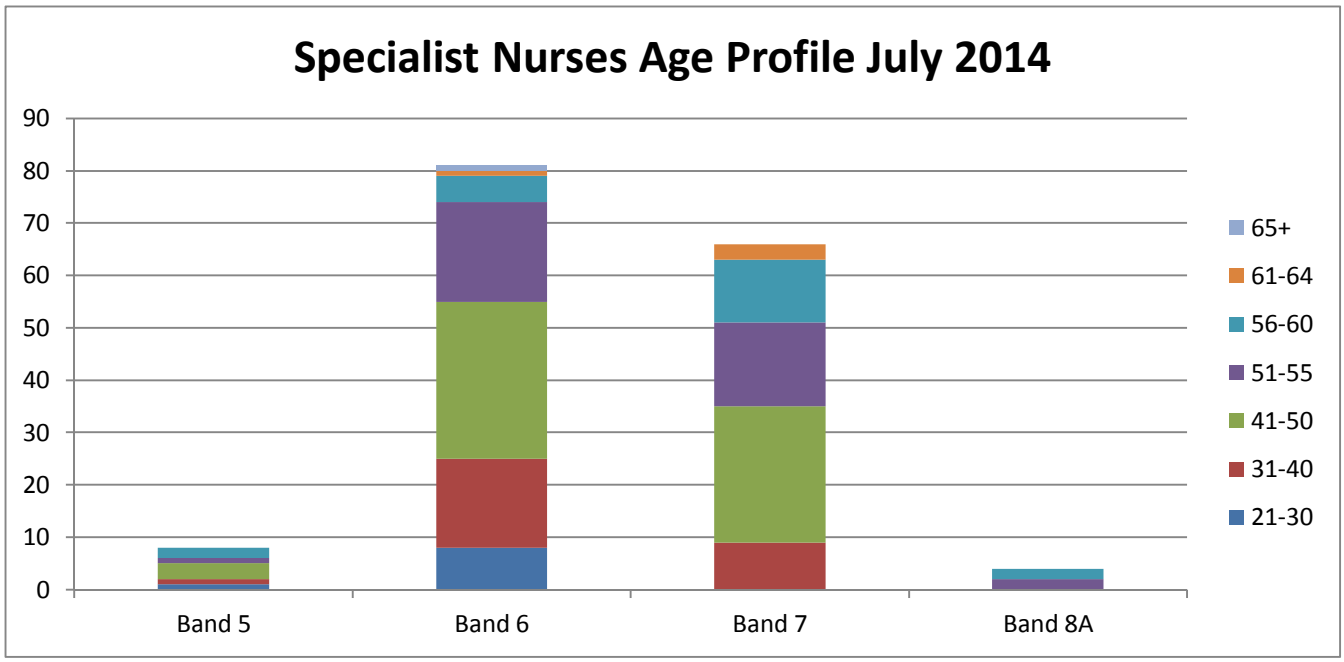
With regards to band 2 & 3 staff, the current age profile does not cause too much concern as there is a fairly even spread across all age bands. Also, as noted in the nursing supply narrative below, recruitment to these roles is currently successful.
The age profile for band 5 nursing in itself is also not of significant concern with a fairly even spread across the bands and approximately a quarter of staff aged 51+.

There is however a concern around the age profile of more senior nursing staff. Whilst it is to be expected that the average age for staff in this group would be higher (due to usual patterns of career progression) it is concerning that more than half of band 7 staff working in these settings are aged 51+. Whilst the proportion of band 8A nursing staff aged 51+ is reflective of the overall nursing profile, it is worthy of note that more than half are aged between 41-50 and some of these staff may have the option of retiring at 50.

This detail does support the need to proactively invest time in succession planning for senior nursing roles as it is likely that a number of vacancies will arise at this level in the short to medium term.

Specialist Nurses

The Trust employs more than 150 Specialist Nurses at bands 5 to 8A in a number of different areas. The age profile for this group of staff is shown below.



Overall, 40% of Specialist Nurses are aged 51+ with an additional 37% aged between 41-50. This current profile and the potential number of retirements in the short to medium term should prompt discussions about how vacancies could be filled as they arise as it may provide opportunities to explore new roles.

Flexible retirees

A piece of work was recently undertaken to identify staff who had drawn their NHS pension and returned to work. Through this exercise it was identified that at least 100 registered nursing staff and almost 40 HCAs have returned to work under these arrangements. The majority of these staff appear to have returned to the same role on the same salary point (in most cases this was the top of the scale).

Whilst the supply of registered nursing staff is certainly a challenge currently and therefore there is an argument for supporting flexible retirement for this group, this needs to be balanced against the risk of the consequences of shifting the age profile of the workforce to the right. Anecdotally, it also seems to be the case that these agreements are made with more consideration for individuals' preferences than for service needs.

Health & Wellbeing

In the Staff Survey 2013, there were a number of key findings relating to the theme of health and wellbeing;

- Key Finding 3 - work pressure felt by staff
- Key Finding 5 - % working extra hours
- Key Finding 11 - % suffering work related stress
- Key Finding 20 - % feeling pressure to attend work when feeling unwell

In the staff survey questionnaire, respondents are required to identify which staff group they belong to. The scores for all four key findings listed above for staff who identified themselves as belonging to either the adult/general nurses or other registered nurses group were worse than the Trust score. Around 80% of nurses who responded to the survey said that they work extra hours every week and around 40% said that in the last year they had suffered with work related stress.

The scores for three of the findings for staff who identified themselves as HCAs were also worse than the Trust score with 40% saying that they had suffered with work related stress in the last year and 34% saying that they felt pressure to attend work when they felt unwell.

Sickness absence rates

The organisation's absence rate for the year to the end of June 2014 was 3.54%.

The absence rate for registered nursing staff 3.80% which was the equivalent of more than 78 FTE staff. The top reason for absence, accounting for more than 4,500 absence days was stress, anxiety and depression.

For HCAs the absence rate was much higher at 5.17% which was the equivalent of almost 48 FTE staff. The top reason for absence for this group was also stress, anxiety and depression accounting for more than 2,700 absence days.

2.1 Nursing supply

Recruitment

In terms of unregistered workforce, the Trust's generic process for recruitment of HCAs continues to be successful. By the end of the year, the team will have coordinated 11 campaigns (five in Scarborough, six in York) and up to now, conversion rates have been strong. There's room for improvement in terms of how the campaigns are executed but as far as the outcomes are concerned, these are positive and don't present us with any concerns at this stage.

As regards registered workforce, specifically in relation to Staff Nurses, the organisation is continuing to experience difficulty in filling vacancies. Through turnover alone, it was forecast that the organisation would need to find somewhere in the region of 200 FTE Staff Nurses in the 2014-15 financial year. Adding in unfilled vacancies, plans for service reconfiguration in Scarborough and Bridlington and winter provision, the figure rose to an estimated 300 FTE.

The recruitment of Staff Nurses is administered locally under the Trust's devolved model of recruitment, and there have been 150 adverts to try and attract experienced and newly qualified candidates to the Trust (January 2014 - to date). In addition to this number, the Recruitment Team have been working to augment the recruitment of nurses through the devolved system by running additional, centrally supported campaigns during 2014. This has required additional resource and been achieved by staff working additional hours and over-time. Through these additional campaigns, different approaches to recruitment have been tried (eg. Glasgow city recruitment, 'One stop shop' style campaign days, interviews based at University of York to coincide with qualification dates).

While supply of candidates is a well-known issue due to the saturation of Staff Nurses vacancies within the Health Service nationally, the Trust has shown an ability to attract reasonable numbers of appointable candidates: in the period from March-May 2014, 94 appointable candidates were identified following interview via the centrally supported campaigns alone. However, this top level figure only tells us so much and there are a number of problems for the Trust to contend with, principally:

Appointable - Appointed conversion rate: Based on centrally supported recruitment activities during this period, the conversion rate is currently running at 62% which is very low for bulk campaigns. Herein lie a number of issues:

- Many candidates are pending registration and therefore unavailable for an immediate start. This has the effect of making them less attractive to wards who have an immediate need and are consequently slower to respond to candidates than they might be in respect of an already registered candidate.
- Time taken to onboard: onboarding is the stage between interview and candidate commencement, and encompasses amongst other things completion of employment checks, communication with the candidate and agreement around their assignment. Onboarding is conducted locally by the department by whom the candidate will be employed. A good onboarding process takes 6-8 weeks. Notwithstanding that many applicants are newly qualified and therefore unavailable to start work in a registered role until September 2014, it's frequently been the case, that beyond an initial Trust generic offer letter sent by Recruitment, some applicants have not even been contacted by their assigned department within this timescale and are therefore choosing to pursue other options. It is the Recruitment department's experience that the Trust is poor at onboarding nurses following bulk campaigns.
- Due to the number of opportunities available nationally, candidates have an unprecedented level of choice of places to work as a Staff Nurse and are therefore exercising their options to find the vacancy that suits them best.
- Due to the way in which vacancies are being advertised individually at the Trust, there are huge amounts of duplication going on with the same candidates going round and round the system seeking their ideal vacancy. This can paralyse the process and leave wards or hospitals which are perceived as being less desirable without candidates - e.g. Newly qualified candidates tend to choose not to take up roles in Scarborough because they know opportunities are available in York; in other cases, offers of appointment to some medical wards are being declined in favour of other available options, creating concentrations of vacancies in particular areas
- There is in some cases a lack of willingness to flex to accommodate candidates. While it may not always be possible to be flexible in relation to working patterns, there have been instances of a few experienced candidates not pursuing their interest because Matrons have been unable to meet their salary expectations (i.e. to be paid at the top of their band).

Supply of newly qualified nursing staff

Health Education England's LETBs (Local Education & Training Boards) use workforce plans submitted by provider organisations each year to support their education commissioning

decisions for the coming years. Within these plans, organisations are required to forecast their requirements for all staff groups. Ultimately, those graduates from the education places commissioned by the LETBs become a significant part of the workforce supply pool.
The table below shows the number of nursing staff in post each year from 2009 to 2014 at this organisation (including Scarborough for the whole period but only including Community from 2012) and the number of nursing education places commissioned from HEIs in Yorkshire & the Humber. The number of places that are commissioned to be provided by the University of York are also shown as this would historically have been expected to provide our primary pool of newly qualified nursing staff.

	2009	**2010**	**2011**	**2012**	**2013**	**2014**
Staff in post FTE	1592.62	1638.30	1665.37	2044.73*	2048.09	2073.11
Education Commssions (Yorks & Humber)	2316	2146	1848	1805**	1815	2010
Education Commissions (University of York)	232	214	184	188	188	227

*There was an increase in staff in post of 380 FTE between 2011 and 2012 of which 300 FTE was staff transferring from the Community.
**In 2012 entry into the registered nursing profession became degree only

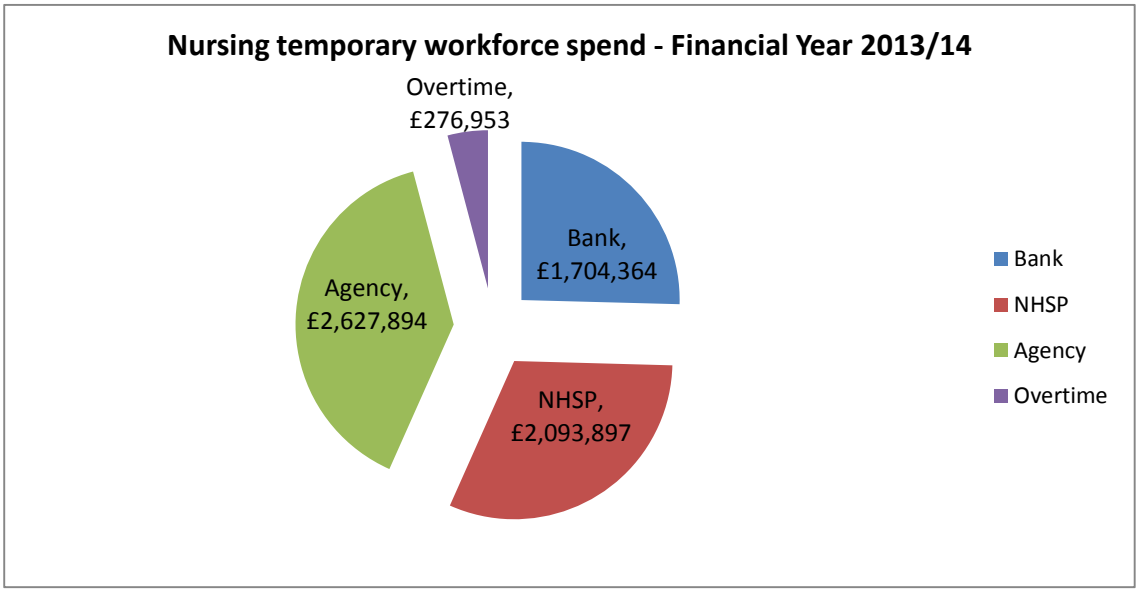
Apart from the transfer of Community staff to this organisation since 2009, there has been an additional increase of 180 FTE nursing staff in post. Whilst the number of commissioned education places has increased for the coming academic year this is still lower than the number of commissions made in 2009 and those who enrol for courses starting 2014 will not enter the supply pool until 2017.

It must be borne in mind that whilst 2010 places are commissioned in the region and 227 from the local university, these figures are not reflective of ultimate supply due to reasons including attrition. Health Education England's 'Workforce Plan for England' reports that attrition rates from nursing education can be in excess of 20%. It is also the case that some of those who do qualify may move out of the area or would be looking to work part time. This clearly demonstrates therefore a significant shortfall in filling a requirement for 300 FTE posts (as mentioned above).
When providers submitted workforce plans in 2012 for the following five years, overall forecasts for nursing staff requirements showed a reduction in numbers. Education commissions were made on this basis, however the workforce actually grew, likely as a result of the issues highlighted through the Francis report and other factors including the assumptions made in plans about reductions in activity which did not occur and that plans were based on affordability.
On the basis of the forecasts in the plans indicating a reduction in nursing workforce requirements, in 2011 and 2012, SHAs reduced the number of education commissions they made. The Workforce Plan for England therefore highlights that outputs may fall for the coming three years unless action is taken to improve attrition and quality of candidates to offset the reduced commissions.

According to information published by the Health & Social Care Information Centre the number of qualified nursing, midwifery and health visiting staff employed (contracted as per ESR, rather than establishment, i.e. actual demand) within the NHS in England increased by almost 6,500 FTE from 307,634 FTE in May 2013 to 314,082 FTE in May 2014. This represented an increase of more than 2%. In the Yorkshire and Humber region over the same period, the number of qualified nursing, midwifery and health visiting staff employed increased by almost 500 FTE to 32,360. This represented an increase of 1.5%.

Supply of temporary staff

In the previous financial year, the organisation spent £6.7 million on temporary nursing workforce as below.



In the first quarter of the current financial year, spend on temporary nursing workforce was £1.8 million.

Bank provision by NHS Professionals (York)

Reports from NHSP who supply bank nurse staff for the York Hospital site highlight a significant increase in demand during the first quarter. More than 70,000 net hours were requested in the period which is the equivalent of approximately 150 FTE staff each week. This was a 15% increase in demand compared to the previous quarter (Jan-Mar 2014) and a 44% increase compared to the same quarter in 2013.

Sickness and vacancies are consistently the top reasons for bank staff demand through NHSP. However, since the end of 2013 there has been a continual rise in demand for temporary staffing for specialing of patients.

In the first quarter of the previous financial year (April – June 2013) there were approximately 5,500 bank hours requested to provide specialing. This accounted for 11% of all demand in that period. In the third quarter (October to December 2013), demand for the reason of specialing had risen by more than three quarters and accounted for 16% of all demand. In both May and June 2014 more than 5,000 hours were requested for specialing and overall in the first quarter of the current financial year the number of hours requested for this reason accounted for more than 21% of demand. This increase continued into July (most recent data available) with more than 6,000 hours requested – the equivalent of almost 37 FTE staff.

In the quarter April – June 2014, NHSP successfully filled 50% of shifts with bank staff with an additional 20% of requests being filled by agency. Whilst this is a lower percentage fill than the historic fill rates achieved by NHSP, the number of hours being filled is higher. However, the

supply of flexible workers is not sufficient to meet the full demand.

We recently approached NHSP to request they arrange some long term placements for high risk areas with significant vacancies. NHSP were unable to arrange this with their own bank staff and although they successfully co-ordinated a small number of long term placements with staff sourced through other agencies, this again was not sufficient to meet our full needs.

Bank provision (Scarborough)

Bank provision at the Scarborough Hospital site is managed by an in-house team. Detailed reporting on demand and usage started at the end of 2013.

In the first quarter of the current financial year more than 35,000 net hours were requested to meet temporary staffing demand (average 11,768 hours requested per month). This is the equivalent of a requirement for 72 FTE staff each week. This was a reduction in demand compared to the last quarter of the previous financial year when more than 46,000 hours were requested (average 15,441 hours requested per month). However, in July demand increased to 14,418 hours.

Overall fill rates for temporary staff demand at Scarborough for each month since November 2013 have been in excess of 80%. Recently however, the percentage of shifts filled with internal bank staff has reduced slightly, therefore increasing the reliance on more expensive agency staffing.

3. Conclusion

The primary concern identified through the information above is that there is not sufficient supply of registered nursing staff to meet current demand. From what is known about commissions for nursing education and the number of registered nurses entering the supply pool each year this situation is unlikely to improve in the short to medium term and recruitment into registered nursing posts is likely to continue to be challenging.

The current structure of the nursing workforce does not provide any real career framework or opportunities for progression for unregistered nursing support staff.

The age profile of senior nursing staff (band 6 upwards) gives some cause for concern and there is a need to develop plans to address the risks in relation to this.

4. Recommendation

The Board of Directors is asked to consider the following recommendations in relation to potential actions and solutions to address current nursing workforce challenges:

- Urgently consider the development of new roles & identify pilot areas where they should be implemented – specifically band 3 & 4 support roles
- Development of opportunities for gaining healthcare experience (short term, e.g. summer contracts) to attract a younger workforce
- Pro active succession planning to minimise potential risks relating to senior and experienced nursing posts becoming vacant through retirements. This may potentially involve the development of an internal talent pool
- Support more open discussions around alternatives when posts (in particular Specialist Nursing posts) become vacant rather than default being to replace like for like

- Support the continued exploration of innovative recruitment approaches, potentially including international recruitment

5. References and further reading

Health Education England. 'Workforce Plan for England. Proposed Education and Training Commissions for 2014/15

Picker Institute Europe. '2013 National NHS Staff Survey. Results from York Teaching Hospital NHS Foundation Trust.'

Author	**Sian Longhorne, Workforce Information Manager**
Owner	**Sue Holden, Director of Corporate Development & Interim Director of HR**
Date	**September 2014**

York Teaching Hospital NHS Foundation Trust
Human Resources Strategy Performance Report
Key Indicators Trust Summary
Covering Period April - June 2014

Key Indicator	This quarter (Apr - Jun 14)			Previous quarter (Jan - Mar 14)			Last year (Apr - Jun 13)			Regional Average	Up/down/no significant change	Status R/A/G
	Quarter average	Annual	LTS*	Quarter average	Annual	LTS*	Quarter average	Annual	LTS*			
Sickness	3.32%	3.54%	97	3.72%	3.56%	97	3.36%	3.67%	95	Most recently published data covers the quarter Jan-Mar 14. The average absence for acute trusts in the Yorkshire & Humber region for this period was 4.39% and this trust was ranked second of acute trusts.	**No significant change**	
Comments: Absence rates in both the acute and community settings have reduced slightly since the start of 2014 and the overall Trust absence rate continues to compare favourably to the rate in other similar organisations.												
Active Vacancies (FTE) Defined as vacancies approved by VC group	**Vacancies (average over quarter)**	**Vacancy rate (No. of vacancies/staff in post+number of vacancies)**		**Vacancies (average over quarter)**	**Vacancy rate (No. of vacancies/staff in post+number of vacancies)**		**Vacancies (average over quarter)**	**Vacancy rate (No. of vacancies/staff in post+number of vacancies)**		The NHS Information Centre no longer publishes these figures	**Down**	
	117.34	1.64%		156.9	2.16%		133.28	1.60%				
Vacancies within budgeted establishment (Finance data)	**Budgeted establishment**	**Actual paid**	**Variance**	**Budgeted establishment**	**Actual paid**	**Variance**	**Budgeted establishment**	**Actual paid**	**Variance**	A local acute trust has begun to co-ordinate a regional quarterly data collection of workforce metrics which incudes vacancies. However, there is not consistency in terms of how trusts calculate this metric and arguably is not valid as a benchmark.	**No significant change**	
	7583.57	7064.42	-6.85%	7623.28	7107.39	-6.77%	7447.56	6978.39	-6.30%			
Comments: Vacancy rates remains a difficult metric to calculate accurately due to the differences between the information held in financial systems (e.g. budgets & establishment) and in the ESR HR & payroll system (e.g. staff in post).												
Maternity Leave	**FTE on Maternity Leave at end of quarter**		**As % of staff in post**	**FTE on Maternity Leave at end of quarter**		**As % of staff in post**	**FTE on Maternity Leave at end of quarter**		**As % of staff in post**			
	192.31		2.73%	178.43		2.53%	142.93		2.07%	Benchmarking data is available for a small number of trusts participating in the regional quarterly data collection mentioend above. The average rate of maternity leave as at March 14 was 2.31%.	**Up**	
Comments: Although maternity leave rates have historically been consistent, there are areas which regularly have much higher than average rates. Overall, the rate of maternity leave Any operational challenges created by higher than average maternity leave in particular areas continue to be managed through the Workforce PIM & vacancy control processes.												
Turnover (FTE)	10.40%			10.20%			10.39%			12.5% (Yorkshire & the Humber regional average)	**No significant change**	
Comments: Turnover rates at the organisation have been consistent at just over 10% since integration.												
Appraisal activity	72.15%			72.41%			83.71%			National average for acute trusts in 2013 staff survey was 84%	**Down**	
Comments: The Trust has a target of 95% for appraisal activity rates. Whilst significant progress was made towards achieving this and the Trust's score for the key finding in the 2013 staff survey relating to appraisal was average for acute trusts, the reported rate of appraisals has been below 75% in each month since the start of 2014.												
Temporary workforce spend		**Spend**			**Spend**			**Spend**				
	NHSP Spend	£571,591.00			£562,747.00			£535,057.00				
	Bank	£444,891.00			£454,777.00			£349,350.00				
	Agency inc. external medical locums	£2,132,095.00			£1,826,265.00			£1,628,422.00				
	Overtime Spend	£305,377.00			£285,840.00			£329,954.00				
	Total temporary workforce spend	**Total spend**	**% of paybill**		**Total spend**	**% of paybill**		**Total spend**	**% of paybill**	No benchmarking figures currently available	**Up**	
		£3,453,954	4.69%		£3,129,629	4.27%		£2,842,783	3.98%			
	Comments: Temporary workforce spend has inceased since last quarter and is 0.71% higher as a % of the paybill than in the same quarter of last year. Agency spend accounted for almost 62% of all temporary workforce expenditure. Regular reports from NHSP relating to the provision of bank nursing staff at York indicate a significant increase in demand. This correlates with the challenges presented nationally with a shortfall in supply of registered nursing staff.											
Time taken to conclude disciplinary cases	**0-30 days**	8										
	31-90 days	10										
	91-180 days	5										
	181+days	2			Not available			Not available		No benchmarking figures available		
	Number of current cases:	16 (as at 31st Aug 14)										
	Comments: This is the first time that infomation relating to time taken to conclude disciplinary cases has been presented in this way. Of the two cases which took more than 181 days to resolve, one was delayed on the advice of Occupational Health due to the health of the individual. The other case was due to a parallel investigation taking place which needed to be resolved prior to the disciplinary. The number of cases this quarter remains consistent with previous periods.											
Compromise agreements	There were no COT3s or settlement agreements made in the quarter April - June 2014											

*LTS = staff on long term sickness absence classed as 29 days or more

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 24 September 2014

Education Strategy 2014-2017

Action requested/recommendation

It is essential we start to plan for a changed workforce. Increasing expectation by our patient's demand that we can demonstrate staff have the necessary skills and decision making ability to provide the best care possible.

The implementation plan will outline the timeframe to achieve this change, however the Board are asked to:

1. Approve the implementation of 'self declaration' with 'knowledge assessment' for statutory and mandatory elements of training.

2. Approve the development of extended faculty to enable the use of local education facilitators.

3. Acknowledge the changing funding structure.

4. Support and approve the development of inter-professional learning model, including implementation of integrated clinical faculty.

5. Approve the implementation plan.

Summary

In 2013 Health Education England was established to inform reform and review the way in which education to support health professionals was commissioned and quality assured. The setting up of regional Education and Training Boards brought into one structure under-graduate, post-graduate medical education, and registered non-medical training and non-registered training processes.

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	Initially presented at the Workforce Strategy Committee - 10 Mar 14 Chair of Executive Board approved out of committee on 18 Aug 14 and will have this action noted at the next meeting.
Risk	No risk
Resource implications	Resources implications will be detailed in the Implementation Plan
Owner	Sue Holden, Director Corporate Development
Author	Sue Holden, Director Corporate Development
Date of paper	June 2014
Version number	Version 2

Board of Directors – 24 September 2014

Education Strategy 2014-2017

1. Introduction and background

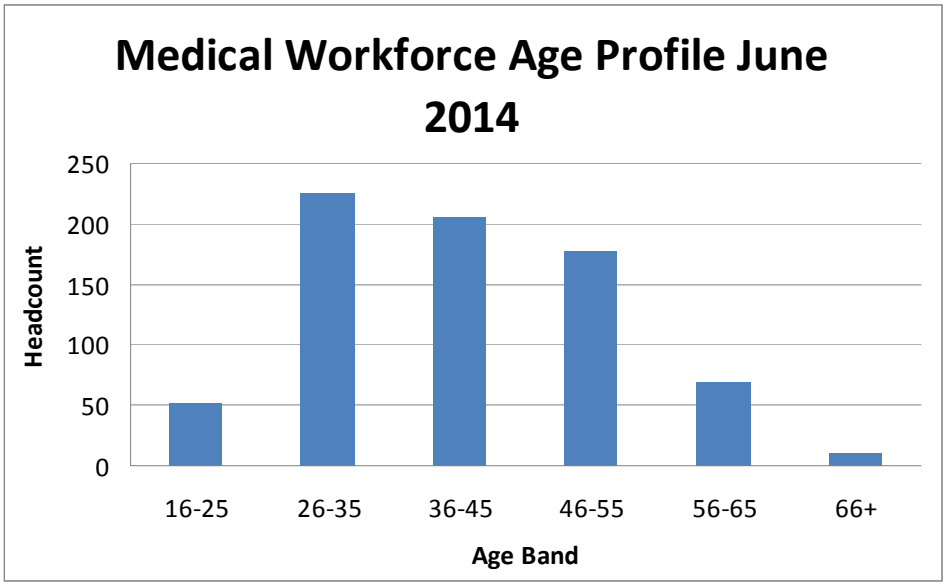
In 2013 Health Education England was established to inform reform and review the way in which education to support health professionals was commissioned and quality assured. The setting up of regional Education and Training Boards brought into one structure under-graduate, post-graduate medical education, and registered non-medical training and non-registered training processes.

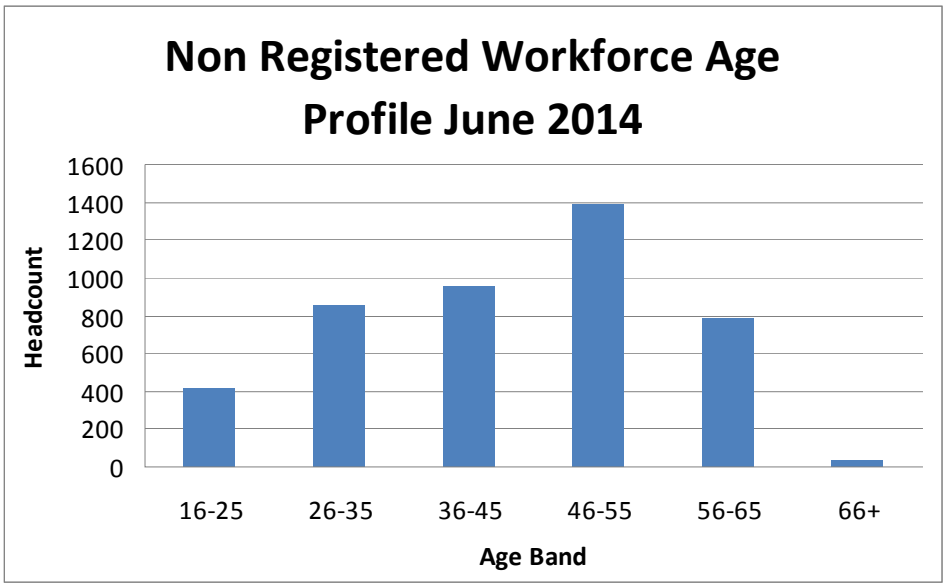
As an organisation we have made inroads into looking to deliver inter-professional learning experiences, especially related to leadership and development, however we now need to consider implementing a framework which will allow our staff to learn together the key clinical skills to ensure patient's receive the best possible care. The focus on team work has never been greater across the whole of the NHS enabling individuals to acquire clinical skills together, to the same assessed standard will improve our quality of provision. Creating scenario based interventions where multi professional learning underpinned by human factors experiences reinforces the need for clear leadership, excellent communication and team contribution will also support our patient safety strategy.

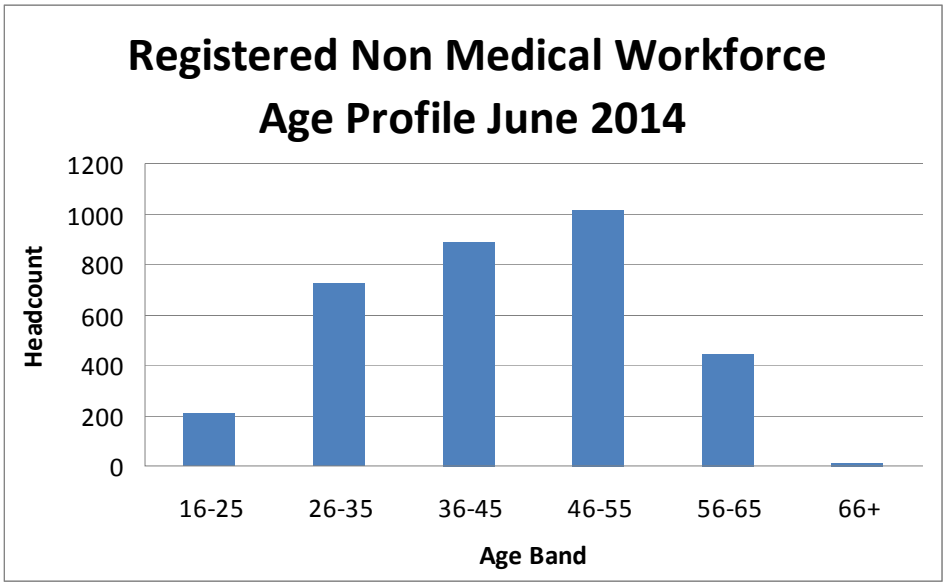
Underpinning all our education provision is a reliance on accurate information, evidence based interventions and up to date guidance. The Library Service continues to develop the role of clinical librarian to support practice based interventions. They also support individual personal development through the provision of learning resources.

In 2013 we commissioned a new learning management system to support the implementation of increased access to online learning along with self management of individual's learning records. We also developed the Trust values to highlight individual personal responsibility, this foundation has enabled the introduction, from April 2014, and the potential for staff to self declare competence. This is a significant shift in the maturity of the Trust in implementing and enacting its values in a tangible way so that staff can feel valued for their contribution and respected to declare and identify their own learning needs.

The following demographic data relates to staff employed by the Trust at the time of this report:


Medical Workforce Age Profile June 2014
250
200
150
100
50
0
Headcount
16-25
26-35
36-45
46-55
56-65
66+
Age Band


Non Registered Workforce Age Profile June 2014
1600
1400
1200
1000
800
600
400
200
0
Headcount
16-25
26-35
36-45
46-55
56-65
66+
Age Band


Registered Non Medical Workforce Age Profile June 2014
1200
1000
800
600
400
200
0
Headcount
16-25
26-35
36-45
46-55
56-65
66+
Age Band

Our workforce profile reinforces the need to look to develop a more flexible and responsive workforce, as well as a need to challenge traditional boundaries. An enabler to this is the provision of multi-disciplinary education, by learning together staff can recognise and value each others contribution to high quality, safe patient care.

2. Discussion

Staff are required to evidence appropriate learning on three levels:

1. Statutory required learning - that learning which is laid down in statute (law) i.e. fire training, equality and diversity etc.

2. Core learning described and mandated by the organisation which is deemed necessary to support delivery of the business i.e. information governance.

3. Speciality specific learning - learning that is required to maintain specific skills/competencies i.e. advance life support.

The funding streams to support this learning are managed and then devolved via Health Education Yorkshire and the Humber. Commencing in the financial year 2014/2015 Health Education England has implemented a re-distribution of funding. Historically, funding has been through:

- Medical and Professional Education and Training (Medical) (MPET)
- Service Increment for Training (SIFT) (backfill costs)
- Support Staff Learning and Development Fund (Band 1-4)

The funding streams have been allocated and managed separately with only medical staff having any element of budget to cover placement experience. In 2014 there will be money to support non-medical education and training placement costs, specifically targeted at ensuring a quality placement experience. This funding is <u>not</u> additional funding it has been created by reducing the funding and number of junior doctors' places. This will impact on the number of doctors able to support a service contribution and is intended to create a changed workforce configuration.

We recognise the need to develop new roles to support service and have introduced a programme of planned development of Advanced Clinical Practitioners. We are starting to review what roles should be developed with the non-registered workforce to compliment this shift. The purpose of these changes is to ensure that doctors undertake activities where they add greatest value to the patient experience.

Nationally, we know there is a planned reduction in doctors in training, a shift towards extended increased GP training and a consolidation and reduction in speciality training posts. The workforce needs to be trained and developed to meet the changed needs of patients, an increased elderly population with complex needs and specialist services centralised in a smaller number of acute providers. This will result in a changing requirement for non-medical staff to ensure their skills and knowledge are complementary and responsive to patient requirements.

Level 1 Training

A review of all statutory training has been undertaken. This has resulted in streamlining the programme, increased focus on non-face to face provision, and a requirement of annual review only for those areas which we are required by law to do. The new learning

management system - Learning Hub - will be the main vehicle through which staff will access this program. There will also be the opportunity to self declare competence following knowledge assessment, for elements of the program, ensuring staff take responsibility for their learning needs.

Level 2 Training

This training has been highlighted by the organisation as beneficial to patient experience and is responsive to the changing environment in which we all practice. The Learning Hub will enable some of this to be undertaken online, via webex webinar. The use of webinar and webex will also increase access for staff that are not site based. A significant element of this provision will be via face to face training by subject specialists.

Level 3 Training

These programmes will be developed within specialist areas and are specific to speciality i.e. midwifery. All learning of this nature will be provided within/by the speciality with a requirement to record learning for staff and update their personal record.

Consideration has been given to how we move towards inter-professional learning. To facilitate this we will start to develop skills training which will be open for all staff groups, assessed using the same framework and reviewed regularly to ensure maintenance of competence. We will develop clinical skills training in a modular format and create skills passports to ensure staff have the ability to move flexibly around the organisation with the confidence they are providing a consistent level of knowledge and skill. We will increasingly introduce ‘simulation’ to underpin learning and highlight the impact of decision making and team work. We will start to develop ‘simulated after incident reviews (SAIRs). These will enable teams involved in Serious Incidents to review their practice to highlight areas for improvement and development and implement change. This approach reinforces the Trust values of ‘listening in order to improve’ and will improve patient safety, through rapid cascade of learning. After Incident Reviews will be multi-disciplinary and will focus on the human factors that contribute to error.

We will develop a simulation strategy and identify faculty to support this provision. This is in keeping and aligned to an increased focus in under graduate education on simulated practice.

To facilitate these changes we will identify local education facilitators (LEF) who will form a Trust-wide resource to champion learning and support staff to maintain their practice evidence based. These LEFs will need to satisfy quality criteria and will be recognised across the organisation for their contribution to learning. By developing these roles we create increased capacity and capability thereby creating a sustainable learning environment. LEFs will link directly with the corporate education team, highlighting in a timely manner areas where further education and training is required.

The creation of dispersed faculty will improve:

- Access
- Consistency
- Quality
- Responsiveness

This approach also enables us to capitalise on core expertise whilst ensuring we develop capability more widely across the organisation.

A further element of the strategy will be to plan the development of new roles as previously mentioned. This work has already commenced with the recruitment of qualified Advanced Clinical Practitioners (ACPs) and training cohorts of ACPs. We intend to work with directorates to identify where alternative roles could be developed which support the registered workforce, these will include support worker roles which have a health and social care focus. It is intended to build on the 'Calderdale Framework' to assess and accredit such roles.

3. Conclusion

It is essential we start to plan for a changed workforce. Increasing expectation by our patient's demand that we can demonstrate staff have the necessary skills and decision making ability to provide the best care possible.

The implementation plan will outline the timeframe to achieve this change.

4. Recommendation

The Board are asked to:

1. Approve the implementation of 'self declaration' with 'knowledge assessment' for statutory and mandatory elements of training.

2. Approve the development of extended faculty to enable the use of local education facilitators.

3. Acknowledge the changing funding structure.

4. Support and approve the development of inter-professional learning model, including implementation of integrated clinical faculty.

5. Approve the implementation plan.

Author	**Sue Holden, Director Corporate Development**
Owner	**Sue Holden, Director Corporate Development**
Date	**June 2014**

Organisational Development & Improvement Learning (ODIL) - Leadership Training

Introduction

The ODIL team exists to support the organisation to achieve its purpose of providing quality and safe health care to its community. This is done by supporting staff to work in the most effective way they can, working with individuals, teams and whole departments to develop the way in which people work both independently and together. This is done through coaching, mentoring and mediation, leadership programmes, team development and bespoke OD interventions, as well as through the education of staff in tools and techniques that will help them to make positive changes using improvement methodology & manage conflict.

Key Team Objective

In working with the human dimension of organising and working, the ODIL team aim to improve organisational performance through developing human processes and creating an adaptive and continually learning organisation. This is in line with the educational strategy's objectives by planning for a changed workforce and demonstrating that staff have the necessary self, team & organisational awareness, knowledge, skills and decision making ability to provide the best care possible.

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributor	Target Date	Risks / Issues	Progress against Actions
Level 1 Statutory Training	N/a						
Level 2 Beneficial to Patient Experience	● Leadership programmes are designed to respond to the individual, complex and evolving environments that staff work, to maximise patient/client experience in all areas of the organisation. ● Ability for learning to be applied to individual and current environments of delegates to increase impact of training through use of 1:1 & team coaching ● All programmes reviewed annually/'in the moment' in response to key local/national initiatives. ● Open and Closed cohorts currently provided (eg CD, IMW, Matrons) depending on clinical need to maximise impact on Patient experience	●Further Development of Learning Technologies to support learning required (e.g. Webinars, Web Ex) including Team Coaching, in order to support cross site learning. 2 members of the team have been trained in the use of webex to facilitate Virtual Actions Learning Sets. ●Continue to evaluate and amend current programmes based on feedback from delegates and relevant stakeholders. ●Delegates to indicate in evaluation/ALS how patient experience has been/will be affected by the learning on programme	TE (HC FAH)	external programme Faculty CLAD	Ongoing	● Face to face is preferential for many of ODIL's offerings due to the nature of the work/number of delegates. ● Releasing staff to train in these technologies may present a challenge ● Access to internet based applications, ie webex,IT equipment, and room availability limited at times. This method may not appeal to some staff.	●The first cohort of a Consultant Development programme has recently started.
Level 3 Specialist Learning	See interprofessional learning						

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributor	Target Date	Risks / Issues	Progress against Actions
Interprofessional Learning	Both Senior Leaders and Emerging Leaders programmes to be designed in the main as inter-professional programmes, with associated Action Learning Sets incorporated to harness this experience. Closed cohorts are delivered where there is identified need/ benefit in doing this (e.g. Consultants new to the organisation or senior consultants considering role of Clinical Director/Deputy/Clinical Lead, Matrons, Ward Sisters). Focus links specialist area of practice.	Consultants Development Programme is to be evaluated on its completion. Support also provided to trainee advanced care practitioners by the use of action learning sets & individual coaching. Continue to encourage multidisciplinary learning	TE (HC FAH)	external programme Faculty CLAD	Ongoing re	Consultants having time to complete courses due to job plans.	
Skills Passport	●All leadership programmes have a programme portfolio that aims to be a pre-curser to the skills passport.	● Introduce the portfolio to all programmes with potential to go electronic. ● Potential use of Learning Hub to centralise recording of competencies achieved/courses & programmes attended. ● Explore academic providers for portfolio as accreditation process, including all leadership progs, and soft skills (inc introduction to coaching, effective conversations, making every patient and relative contact count and customer care) ● Maintain link for existing programmes eg Senior Leaders programme and link to negotiated study prog and seek a link for emerging leaders to a diploma level prog. ● Support the achievement of CME points for medical staff by using skills passport Link to talent management	TE (HC FAH)	external programme Faculty CLAD	Apr-15	● Current capability of Learning Hub as a central database to produce a skills passport. ● Cost implication of buying portfolios and access to IT and the portfolio if electronic, depending on where hosted. Development of Talent Management Strategy. Evidence of applying learning in practice. Link to Development Centres	●Many staff already have portfolios, a cultural shift is required for engage staff in their wider use.
Simulated Learning	Use of simulation exercises within pr	Further development of simulated int	TE				

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributor	Target Date	Risks / Issues	Progress against Actions
Learning Education Facilitators	Development of faculty of LEF's to support embedding of Leadership		TE				

Supporting Funding Streams): N/A

Organisational Development & Improvement Learning (ODIL) - Team Development & Bespoke OD Interventions.

Introduction The ODIL team exists to support the organisation to achieve its purpose of providing quality and safe health care to its community. This is done by supporting staff to work in the most effective way they can, working with individuals, teams and whole departments to develop the way in which people work both independently and together. This is done through coaching, mentoring and mediation, leadership programmes, team development and bespoke OD interventions, as well as through the education of staff in tools and techniques that will help them to make positive changes using improvement methodology & manage conflict.

Key Team Objective In working with the human dimension of organising and working, the ODIL team aim to improve organisational performance through developing human processes and creating an adaptive and continually learning organisation. This is in line with the educational strategy's objectives by planning for a changed workforce and demonstrating that staff have the necessary self, team & organisational awareness, knowledge, skills and decision making ability to provide the best care possible.

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Level 1 Statutory Training	N/a	Development of faculty of LEF's to support embedding of OD					
Level 2 Beneficial to Patient Experience	Learning & Development offered by ODIL in relation to this: • NHS Elect (Train the trainer) Customer Care training. Compulsory for all Ward Sisters/Matrons • Making your patient and relative contact count • Effective Conversations • Introduction to coaching skills for managers.	●Ongoing evaluation of the programmes. Link to WBL, Learning Hub	TE HC (ZN AR)	NHS Elect Leadership Academy CLAD	Aug-14	NHS withdrawal	●Programmes currently being delivered
	●Bespoke OD interventions to consider the impact of the intervention on patient experience in contracting (ie Its my ward)		FAH HC		ongoing	sustainability	OD Contracting forms ask the question 'what's the impact on the service to patients if no OD intervention occurs' to be used in prioritisation
		●Consideration of where Webex could be used as part of the ODIL offering as its key facility is to enhance the sharing of and access to information eg: Action Learning Sets.	TE AR		Apr-15	targeted' v 'rest of organisation'	
		●Evaluate IMW programme started with intent of making recommendations for development of future ward sisters	GD FAH	Clinical Audit Team Corporate Nursing	Dec-14	Sustainability Demonstration of impact/ROI	Clinical Audit team report published May 2014-action in progress

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Level 3 Specialist Learning		●Continue to contract on a request basis and engage with wider organisation for bespoke interventions which impact on team specific issues.	FAH GD HC		ongoing		
		●Marketing of Leadership Academy programmes with specialist groups	TE		ongoing		
		●Team Coaching to be offered as a service	HC		ongoing		
Interprofessional Learning	●Both Senior Leaders and Emerging Leaders programmes are designed in the main as inter-professional programmes, with associated Action Learning Sets incorporated to harness this experience. ●Closed cohorts are delivered where there is identified need/ benefit in doing this (e.g. Consultants Development or senior consultants considering role of Clinical Director/Deputy/Clinical Lead, Matrons, Ward Sisters). This focus links specialist area of practice.	● Consultants Development Programme is to be evaluated on its completion. ● Support also provided to trainee advanced care practitioners by the use of action learning sets & individual coaching. Continue to encourage multidisciplinary learning	TE	Army External programme 'Faculty'	Ongoing	●Consultants having time to complete courses due to job plans. Focus on 'self awareness' -v 'team development'	

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Skills Passport	● All leadership programmes have a programme portfolio that aims to be a pre-curser to the skills passport.	● Introduce the portfolio to all programmes with potential to go electronic. ● Potential use of Learning Hub to centralise recording of competencies achieved/courses & programmes attended. ● Explore academic providers for portfolio as accreditation process, including all leadership progs, and soft skills (inc introduction to coaching, effective conversations, making every patient and relative contact count and customer care) ● Maintain link for existing programmes eg Senior Leaders programme and link to negotiated study prog and seek a link for emerging leaders to a diploma level prog. ● Support the achievement of CME points for medical staff by using skills passport	TE GD		Apr-15	●Current capability of Learning Hub as a central database to produce a skills passport. ●Cost implication of buying portfolios and access to IT and the portfolio if electronic, depending on where hosted.	● Many staff already have portfolios, a cultural shift is required for engage staff in their wider use.
Simulated Learning		Deevelopment of 'team development' stand alone days			Apr-15	● Capacity and ability to be responsive to the timeframe required when SAIRS take place. Unsure what commitment this would be yet.	
Learning Education Facilitators	Development of faculty of LEF's to support embedding of OD						

Supporting Funding Streams): SSLDF External e.g Council

Organisational Development & Improvement Learning (ODIL) - Coaching Mentoring & Mediation

Introduction The ODIL team exists to support the organisation to achieve its purpose of providing quality and safe health care to its community. This is done by supporting staff to work in the most effective way they can, working with individuals, teams and whole departments to develop the way in which people work both independently and together. This is done through coaching, mentoring and mediation, leadership programmes, team development and bespoke OD interventions, as well as through the education of staff in tools and techniques that will help them to make positive changes using improvement methodology & manage conflict.

Key Team Objective In working with the human dimension of organising and working, the ODIL team aim to improve organisational performance through developing human processes and creating an adaptive and continually learning organisation. This is in line with the educational strategy's objectives by planning for a changed workforce and demonstrating that staff have the necessary self, team & organisational awareness, knowledge, skills and decision making ability to provide the best care possible.

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Level 1 Statutory Training	N/A						
Level 2 Beneficial to Patient Experience	● Currently offer Team Coaching and 1:1 coaching to support individuals/teams and their services to respond to changing patient need and changing environments. ● Coaching skills training offered to staff	● Consideration of where Webex could be used as part of/as a supplement to, the ODIL offering. E.g. Coaching or Mentoring, as a blended approach. ● Exploration of Health Coaching to benefit patient experience	HC		Apr-15	● Face to face is preferential for many of ODIL's offerings due to the nature of the work/number of delegates. ● Releasing staff to train in these technologies may present a challenge ● Access to internet based applications, ie webex,IT equipment , and room availability limited at times. This method may not appeal to some staff.	HC attended a Health Coaching conference March 2014
	● Mediation currently offered across the organisation to support difficult relationships that may impact on service and patient experience		HC			● Capacity of mediators - only 12 for entire organisation.	
		● Mentoring - develop this service & skills training, to establish best practice and allow staff to reach their potential and that of the service to patients	HC		Apr-15		● Introduction to Mentoring day taken place (March 2014).
Level 3 Specialist Learning		● Identify people to progress to develop the faculty of coaches in specific areas at a number of levels ● Coaching supervision to support quality of coaching.	HC		Apr-15	● Capacity of staff to coach/train at a higher level	CPD taken place and is planned for 2014-15

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Interprofessional Learning		● Inter professional coaching faculty to share learning. Exploit knowledge form partnership working.	HC		Apr-15		
Skills Passport		● Develop a portfolio for coaches based on coaching competencies that all coaches are expected to achieve - used as part of QA process. ● Log attendance at supervision on Learning Hub.	HC		Apr-15		
Simulated Learning	use of simulation in training scenarios	Develop/use of existig scenarios in training	HC		Apr-15		
Learning Education Facilitators	Development of faculty of LEF's to support embedding coaching, mentoring, mediation		HC		Apr-15		

Supporting Funding Streams): SSLDF External e.g. Council

Organisational Development & Improvement Learning (ODIL) - Service Improvement

Introduction

The ODIL team exists to support the organisation to achieve its purpose of providing quality and safe health care to its community. This is done by supporting staff to work in the most effective way they can, working with individuals, teams and whole departments to develop the way in which people work both independently and together. This is done through coaching, mentoring and mediation, leadership programmes, team development and bespoke OD interventions, as well as through the education of staff in tools and techniques that will help them to make positive changes using improvement methodology & manage conflict.

Key Team Objective

In working with the human dimension of organising and working, the ODIL team aim to improve organisational performance through developing human processes and creating an adaptive and continually learning organisation. This is in line with the educational strategy's objectives by planning for a changed workforce and demonstrating that staff have the necessary self, team & organisational awareness, knowledge, skills and decision making ability to provide the best care possible.

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Level 1 Statutory Training	N/A						
Level 2 Beneficial to Patient Experience	● Level 1, an introduction to Service improvement Learning is only offered as a free standing module. ● Levels 2 and 3 Service Improvement learning programmes are offered as both freestanding modules and also attached to all leadership programmes ● All programmes are continuously evaluated.		GD/AR		ongoing	Proposal to support Apprenticeship training & assessemnt of learning/achievement ? From Aug 2014 with all levels of SI training- unknown demand to date	● Levels 1 & 3 are new offerings, ● Level 2 has recently been revised following evaluation.

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Level 3 Specialist Learning	● Level 3 is a 3 day programme designed to support those undertaking larger improvement projects. Closed modules are offered within the organisation for some staff on internal leadership programmes ie Clinical Director & New Consultants so that the content can be tailored to their specific needs. ● Service Improvement learning is also delivered for external partner organisations, University of York, HYMS and the Deanery providing this learning to students in training & those on post registration programmes.		GD/AR	Deanery. Link to PG. HYMS: Link to LARC. York University: CIT	ongoing	Capacity v demand management	● Level 3 - recently designed.
Interprofessional Learning	all levels of training programmes open to all staff						
Skills Passport	●Project plans and assessment are documentation that are contained within the leadership & bespoke programme portfolios.	assessment of competence of applic	GD/AR		ongoing		
Simulated Learning	simulation used on all programmes						
Learning Education Facilitators	Development of faculty of LEF's to support embedding of Service Improvement-Improvement Champions					Readiness of Learning Hub	Discussions with CLAD & with DMs re identifying Champions

Supporting Funding Streams): SSLDF

Work Based Learning - Clinical

Introduction The Work Based Learning - Clinical team are focussed on the development of learning opportunities for bands 1-4 clinical staff & currently sit within Corporate Learning. The HR Workforce team lead on the training, education & role development of the unregistered workforce bands 1-4

Key Team Objective To integrate a partnership working to enable the development of bands 1-4 clinical staff in response to service need, with an initial work focus on the further development of HCAs & other support workers (AHPs)

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Level 1 Statutory Training	N/A						
Level 2 Beneficial to Patient Experience	Mandatory training for unregistered clinical staff, who are required by the Organisation to acquire & maintain their clinical skills, appropriate to band/role to enable them to deliver care based on the best available evidence & best practice	Establish the current position relating to the agreed approach by the Organisation to the development of HCAs by the WBL & HR Workforce teams. To support the design & implementation of a framework to facilitate a blended learning approach-content, delivery & methods	TBC	HR Workforce, Learning & technologies team, CDT, Corporate Nursing, AHP Leads,HEIs, Other external bodies	TBC	May be duplication & silo working currently	Review of Directorate/team structure
Level 3 Specialist Learning	The breadth & depth of non registered role development may vary depending on the clinical speciality area & requirements of the role within that area. Initial scoping work is underway to further support the development of HCAs in enhancing their skills in partnership with WBL, HR Workforce & Corporate Nursing	Determine the specific service requirements	TBC	as above	TBC	Insufficient capacity within clinical areas for staff to attend training & achieve assessment of competence	
Interprofessional Learning	Link to Post Grad, HYMS, Clinical education & CDT tabs		TBC		TBC		
Skills Passport	Core clinical skills training obtained in the organisation will need to be transferable, OSCE format (OCN accreditation)	Link to Learning Hub tab			TBC		
Simulated Learning	Link to Post Grad, HYMS, Clinical education & CDT tabs		TBC		TBC		

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Learning Education Facilitators	Potential for LEFs to be actively involved in supporting unregistered staff assessment & development. Potential to appoint additional Peripatetic LEFs.	Identify role and structure of LEFs and Peripatetic LEFs within clinical areas across organisation.	TBC	Corporate Nursing, CDT, AHP Leads	TBC	insufficient capacity for LEFs working within clinical areas to train & assess staff to achieve competence	

Supporting Funding Stream's): ACP funding, SSLDF

Clinical Development Team

Introduction The Clinical Development Team is part of the wider Applied Learning & Research Directorate. Our role is to facilitate learning and development in clinical practice ensuring best practice through a sound evidence base.

Key Team Objective To support the organisation in providing appropriate clinical skills training, maintaining training in line with current guidance and best practice, promoting best outcomes and harm reduction where required. Providing targetted training where required, as identified by evaluations or highlighted areas for improvement and development.

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Level 1 Statutory Training	N/A						
Level 2 Beneficial to Patient Experience	Mandatory training for allied healthcare professionals, who are duty bound by their professional bodies & the Organisation to acquire & maintain their clinical skills to enable them to deliver care based on the best available evidence & best practice	Continue to support the design & implementation of a more blended learning approach-content & delivery & methods e.g. Elearning, Webinar, Train the trainer. To support the existing supervision and competency pathway to ensure follow up actions are undertaken in the local area e.g. recording of attained competence on Learning Hub.	MK (TL)	Learning Technologies Team	Mar-15	Currently there is an increased demand for development & delivery of skills competence based training because of raised awareness relating to Q&S, changing workforce/roles & larger organisation. It is envisaged this will continue to increase going forward. There is limited resource within the team (WTE 1.8). There is no capacity to develop training relating to learn from incidents e.g. near misses, SIs AIs	
Level 3 Specialist Learning	As above. Currentlly input into specialist areas as & when requested e.g.Core clinical skills training is not currently provided for paediatrics.	e.g. work with specialsit team to develop appropriate training packages for Paediatric Skills.	MK (TL)		01/09/2014 -ongoing as & when	as above. The changes to highlighted in Clinical Education tab is likely to identify additional workstream relating to specialist areas e.g Imms & Vaccs	Links have been made with the educators for the Yorkshire and Humber Paediatric Critical Care Operational Delivery Network (PCC ODN) and training has been planned which will focus on Paediatric Critical Care with Resuscitation and Stabilisation.
Interprofessional Learning	Link to Post Grad, HYMS, Clinical education tabs		MK (TL)	Learning Technologies Team, Post Grad, HYMS, Clinical Education Team		Roles sitting outside of the Directorate including Clinical Educators & Specialist Nurses do not link into this strategy/framework	
Skills Passport	Current core clinical skills training obtained in the organisation is transferable, OSCE format	Link to Learning Hub tab	MK (TL)		Dec 15		

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Simulated Learning	Link to Post Grad, HYMS, Clinical education tabs		MK (TL)	Learning Technologies Team, Post Grad, HYMS, Clinical Education Team, Skills Technicians			
Learning Education Facilitators	Link to Clinical Education tab						

Supporting Funding Stream(s): N/A

Clinical Education

Introduction This newly formed team is responsible for supporting the development & embedding of clinical education within the organisation for all non-medical staff. There is a key focus on identifying & supporting non-med students in high quality placement & learning environments in order to give assurance to the HEYH & the organisation & receive tariff

Key Team Objective The introduction of the non-med Tariff for non medical students has brought the opportunity to re-focus on the quality & provision of education & improving the learning environment for all non-medical students. This will enable a high quality learning environment to be created for all clinical staff including medical students

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Level 1 Statutory Training	Requirement from HEE -Let B to provide evidence of a quality student placements/experience for non-medical students. Best Practice Guidance doc (2014)	Ensure the quality assurance indicators for students working in the organisation are achieved	MK	HEE,HEIs, LetB steering group, Education Strategy Group	Mar-15	non-med tariff funding is dependant on evidencing quality student placements & learning experience	All outcomes in Quality Placement in Healthcare-Best Practice guidance-HEYH 2014-3 key themes -6 outcomes- must be achieved for 2014/15
Level 2 Beneficial to Patient Experience	The achievement of All outcomes in Quality Placement in Healthcare - Best Practice guidance - HEYH 2014 will help to underpin the skills & knowledge of students & staff to be complimentary & responsive to patient requirements	Link to WBL - Clinical tab	MK	WBL - Clinical Team, Learning Technologies Team, HR, Corporate Nursing, AHP Leads, HYMS, Post Grad, CDT	Mar-15		
Level 3 Specialist Learning	Non-medical student allocation covers the full range of specialist clinical areas/learning environments-scoping work (in addition to PPQA) is required to determine specific requirements & current provision/outcomes for students in these areas		MK	PLFS (PEFs)	Mar-15		
Interprofessional Learning	Interprofessional Learning opportunities need to be identified for all non-medical students	Link into Post Grad/HYMS/CDT/Resus implementation plan	MK	WBL - Clinical Team, Learning Technologies Team, HR, Corporate Nursing, AHP Leads, HYMS, Post Grad, CDT	Mar-15		
Skills Passport	n/a						

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Simulated Learning	Interprofessional Learning opportunities using simulation will need to be identified for all non-medical students	Link to Post Grad, HYMS, Clinical education, CDT tabs	MK	WBL - Clinical Team, Learning Technologies Team, HR, Corporate Nursing, AHP Leads, HYMS, Post Grad, CDT	Mar-15		
Learning Education Facilitators	Appointment of Clinical Skills (education) Facilitator posts (CEFs) x 2 to address LetB Sch 4 QA requirements of non-medical practice placement provision. It is envisaged that the CEFs will work closest with the LEFs working closely in clinical practice (when identified)	Assessment of learning environments against Sch 4 Best Practice requirements. Support the creation of the LEFs. Link to WBL-Clinical tab. Pilot, evaluation and future roll-out of "Living the Values" document for non-medical students, supported by Mentors in practice. Creation of LEF posts & structure & framework.	MK	HEYH, Corporate Nursing, AHP Leads, HR, HEIs	Mar-15	PLF roles will cease to be supported by Let B March 2015. No clarity re LEF role as yet	

Supporting Funding Stream(s): Let B sched 4 non med tariff

Resuscitation Team

Introduction The Clinical Development Team is part of the wider Applied Learning & Research Directorate. Our role is to facilitate learning and development in clinical practice ensuring best practice through a sound evidence base.

Key Team Objective To support the organisation in providing appropriate clinical skills training, maintaining training in line with current guidance and best practice, promoting best outcomes and harm reduction where required. Providing targetted training where required, as identified by evaluations or highlighted areas for improvement and development.

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Level 1 Statutory Training	Basic Life support is currently delivered on an annual basis, as per the Resuscitation Council recommendations.	Elearning packages to be sourced to provide and appropriate level of knowledge for differing clinical staff according to their level of proficiency appropriate to their role. This would be followed by practical skills training, possibly be a role of a registered LEF.	TL	Internal Faculty	review impact June 2014	Proposal following submission of business case for BLS to be 3 yearly with exceptions i.e. target for non-attendance (?perf man) & provision more frequently for those who identify need with line managers support. This does create issues around forward planning (actual numbers) & may pose further risk, although curently attendance at BLS is less than 50% & for some people it is not known if they have attended annually, so there is already 'identified risk	
Level 2 Beneficial to Patient Experience	ILS training is currently to staff who require it for their role, delivered as per the Resuscitation Councils recommendations.	Link with the Lead Nurse for Deteriorating Patients and determine a way that AIRA and ILS could be used collectively to support the Patient Safety Strategy. Link to PG strategy	TL	Internal Faculty	review impact June 2014	Capacity released from BLS delivery may enable more capacity for ILS delivery to high risk areas/clinical staff, althogh this has yet to be determined	
Level 3 Specialist Learning	PBLS & PILS are provided locally, any staff member with responsibility for caring for children should undertake PBLS as a minimum and this has required annual updating. ALS is run locally and provide training for critical care clinicians. The resuscitation team delivers an interactive session on DNACPR, GD/TL are members of DNACPR group & contribute to Stratgey/actions	Introduce a similar system to BLS (As per Level 1 action) Introduce a 2 day face to face ALS course for F1 Doctors Further work is required to develop a blended learning approach for DNACPR.	TL	internal Faculty External Faculty	Ongoing	Factors outside of control re staffon shopfloor adopting DNACPR guidance CQC previous visit/recommendations	

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Interprofessional Learning	All the above courses outlined are multidisciplinary Course which incorporate simulation as a teaching tool.	Link to PG Clinical simulation & CDT, Clinical Education tab	TL	internal Faculty External Faculty	Ongoing		
Skills Passport	Staff may holde & require a progression through levels of Resus training -BLS-ILS-ALS	Identifying need of individual staff groups v clinical need	TL	ongoing	Ongoing		
Simulated Learning	Simulation training is used within all resus programmes including additional specialist interventions e.g. midwifery	Other courses to be developed for simulation are: AIRA (Acute Illness Recognition & Assessment) and RAMSI (Recognition and Management of the Seriously Ill). Link to PG CDT Clinical Education tabs	TL	internal Faculty External Faculty	Ongoing		Dr Claire Wensley, Consultant Paediatrician is liasing with the Hull based Sim Fellow to secure further training for both York & Scarborough Sites.
Learning Education Facilitators	Development of LEFs to support existing Resus faculty	See Action from Level 1	TL		Ongoing		

Supporting Funding Stream(s): ALS/ILS

Medical Devices

Introduction The Medical Device Training team offer 2 types of training. Training based on individual Medical Devices, and training based on the general principles in the use of Medical Devices.

Key Team Objective To ensure quality training is available to all appropriate staff requiring it, so making a safer patient environment in relation to the safe use of Medical Devices.

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Level 1 Statutory Training	Medical Device Awareness training is currently delivered on the Statutory training programme. An e-learning package has been developed for Dr's to complete as part of either their induction to the Trust and or their revalidation.	A Knowledge assessment tool is in development. E-learning to be developed for all staff (other than Dr's) as an alternative to face to face training, should staff not pass their knowledge assessment.	KU			There is a potential that completion of an e-learning package for staff that have not passed the knowledge assessment would not be sufficient. To this end face to face training should not be ruled out completely.	
Level 2 Beneficial to Patient Experience	Medical Device Open Days have been developed to allow staff to drop in to training sessions on a set day to receive the training on specific Medical Devices. Ward Walks (where the trainers visit the ward areas) are also being arranged.	Medical Devices Open Days have been set for 2014 to cover 8 main geographical areas.	WM			Only a selected number of devices can be covered through these training days, and in no way could all devices be cover for all specialities using this training format	
Level 3 Specialist Learning	Bespoke training sessions are developed and delivered as and when required for specialist areas.	N/A	KU				
Interprofessional Learning		Interprofessional learning can be achieved for medical devices, but suitability would depend on the specific device and clinical area.	KU				
Skills Passport	The Medical Device Matrix gives managers an overview of their staffs' Medical Device training, allowing the manager to see what their local areas training needs are.	Linking the Medical Device Matrix to the new Learning Hub, so that staff can view their own training requirements for Medical Devices.	KU & WM			There are approximately 1600 different medical devices in the Trust, so to add these devices individually to the learning hub would probably be an impossible task. There needs to be some form of link from the Learning Hub to the Matrix to ensure staff have a wider understanding of device training they require.	

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Simulated Learning	Training is provided to areas as and when required after an incident, and posters are developed to share best practice, to enable staff to learn from issues that have been raised.	Develop training sessions in line with Resus and Clinical Development Team that covers simulation of training skills, learning from events that have previously occurred within our organisation and if possible learn from other organisations. Link to PG tab	KU				
Learning Education Facilitators	There is an online training resource available for Link Trainers. This will help trainers find user manuals, competency documents, e-learning & training packages relevant to specific devices.	Work with the LEF's to be a local guide & trainer for Medical Device training and resources.	KU & WM			The Trust Intranet system need some development to assist easy access to user manuals, training packages etc… Staff Room needs a specific training area that then need to be sub-divided for specialist areas to own. These areas can then be developed so appropriate information can be developed and made available	

Supporting Funding Stream(s):

Learning Hub

Introduction

The work of the new technologies team in 2014 is concentrating on the development and roll out of the new online learning system, Learning Hub. A new team structure will be finalised by July 2014 utilising CLAD staff with appropriate skills. Once the usage of LH has become embedded within the organisation and any issues arising from the roll out have been resolved, then the team will move on to content development for different specialities within the Trust. They will provide gatekeeper activities for the system which will need regularly updating to ensure learning is current, produced in an interactive format and linked to the latest copies of policies etc. There will be liaison with policy holders to ensure currency of data. LH can generate reports on training activity so the team will be able to provide training activity and compliance data to add in to the metrics already reported by HR to the Board.

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Level 1 Statutory Training	Pilot and roll out of LH in June 2014	Troubleshooting usage of system by new users. Develop a hotline for user enquiries.	SW	LT / Other Staff	Jun-14	There is no understanding of the level of support required by staff initially when LH is rolled out.	
		Finish off Learner and Manager data verification.	SW	LT / other staff	Dec-14		
		Timetable user awareness sessions for rest of the year and advertise the new stat / mand process.	SW	LT / other staff	Start June 2014		
		Develop / upload information sheet for the first page of LH containing 'how to' information for users	SW	LT / other staff	May-14		
		Train departmental link advisers in the system to enable them to access it and act as a point of assistance for local staff e.g. helping them to login / book course.	SW	CLAD / other staff	Dec-14		
		Development of SOPs for system use by LT staff e.g. entering data, process for developing new packages	SW	LT / other staff	Oct-14		
		Move / convert current Training Tracker packages to LH format e.g. those currently used in HYMS / junior doctor / IT inductions.	SW	LT / other staff	Jan-14		
		Develop process and templates for reporting on training activity in conjunction with HR metrics already provided to Board.	SW	CLAD / WBL/ ODIL/ HR	Sep-14		
		Identify quiet spaces within the organisation with PCs to signpost users to, to complete their online training. Book areas at set, regular periods for access by learners and advertise. Needs to tie in with learning environment work done by ODIL.	SW	LT staff	Current PC access provision - Nov. 2014.		

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
		Regular updates on system and usage to all staff	SW	LT / other staff	Ongoing		
Level 2 Beneficial to Patient Experience	Other training	Identifying and inputting external users who have an SLA with York e.g. Leeds partnership group	SW	LT staff	Feb-15		
		Identify other systems used within the organisation to record training e.g. Q Pulse and discuss how this training should be placed on LH instead so there is only one system to access for all training information.	SW	LT staff	Apr-15		
Level 3 Specialist Learning		Inputting other training that is non stat / mand and is currently hosted on NLMS e.g. Mamma Mia induction, HEE Ed sups programme	SW	LT staff	Feb-15		
		Work with specialties / groups within the Trust to develop core e-learning targetted at certain staff e.g. insulin awareness programme.	SW	LT staff	Ongoing - start Feb 2015		
Interprofessional Learning		Work with SNS to explore Webinar functionality and usage and review (with SMEs) training that can utilise this tool. Explore links from LH to webinar.	SW	LT staff / HYMS/ PGME / CLAD	Aug-15		
		Identify groups of staff / individuals who are having difficulty (or not) accessing LH	SW	All ALAR teams	May-15		
		LH system hosting moved to external servers so that all staff (esp. Community) can access from Internet / mobile devices.	SW	LT / SNS	Jun-15		
Skills Passport		Develop a clinical passport type process that all staff can access when leaving the organisation which records their training and dates whilst employed or on placement at York. For non training staff - possibly links into HR leaving processes?	SW	HR	Dec-15		
Future projects	Future projects	Identify areas that need regular review and establish 'gatekeeper' processes for LT team.	SW	LT staff	Jun-15		

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
		Consolidate link advisers role (maybe link with local clinical educators?) to push information into the organisation	SW	Other ALAR teams	Mar-16		
		Explore other LH functionality e.g. Mahara for online appraisal documentation and the e portfolio section. The latter could be developed for HCAs and ACPs in the first instance.	SW	NM / AD / BG	Jul-16		
		Share basic expertise / e learning packages regionally with other hospitals but also social work, local authorities etc	SW		Jul-16		
		Explore income generation potential through development of bespoke e learning modules	SW		2017		
Simulated Learning		Work with specialties / groups within the Trust to develop core e-learning as a response to critical incidents which could support debrief simulations.			2017		
Learning Education Facilitators		See above					

Work Based Learning - Non Clinical - Bands 1- 4

Introduction The work based learning team (non clinical) will concentrate on two areas of work a) development of learning opportunities for bands 1-4 non clinical staff working with others e.g. ODIL and b) organisational learning with direct reference to AIRS and SI's. The requirements for NHSLA are changing from passive (standard driven) to proactive (learning from incidents).

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Level 1 Statutory Training	Bands 1-4 staff are historically a group that do not engage well with SM requirements	Develop a robust feedback process for departments and organisationally, through data capture, to ensure that these staff access S/M training.	**JC**	LEFs	Dec-14		
	To support development of 'a learning organisation' and meet new NHSLA criteria of learning from incidents.	1. Set up a process for obtaining information / looking for patterns within adverse incidents from the Datix system (AIRS). Also to obtain timely information from SIs	JC	Risk and legal / patient safety / simulation / other training teams.	Jan-15		
		2. Set up a process to link in with the different training teams so that training issues identified in 1 can be addressed.	JC	Risk and legal / patient safety / simulation / other training teams.	Jan-15		
		3. Provide background information and support in developing bespoke training.	JC	WBL team	Ongoing once team formed		
Level 2 Beneficial to Patient Experience	Customer services	Develop a new framework / content for the qualification to encompass more staff, working with accrediting organisation.	JC	MW / ODIL	Jun-15		
Level 3 Specialist Learning	New learning	Identify what experience / learning the organisation may need to provide differently for a more flexible workforce including quality assuring what is provided.	JC	Trust	Ongoing		
Interprofessional Learning	Apprenticeships	Open these up to all non clinical bands 1- 4 to reflect their learning requirements with respect to personal development and changing job requirements.	JC	MW / ODIL	Jan-16		
Skills passport		All learners will need to keep supporting documentation e.g. assessments in the form of a portfolio or designated area on LH.	JC	MW / SW / ODIL/ LEFs	Mar-15		

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Simulated Learning		Staff will be involved in debriefs from CI/ SI		Deteriorating patient group/ CI/ SI response team	Ongoing		
Learning Education Facilitators	Links with WBL- clinical / ODIL						

Clinical Skills

Introduction

The teaching of clinical skills and the use of simulation in teaching / learning has become a national issue, not just for meeting training curricula but also as a learning tool in the response to patient safety incidents within the organisation. (Francis report). Immersive learning is recognised as the most effective in that the experience and knowledge gained is retained in a different way by all individuals involved. In order to prevent situations arising in the first place it is important that clinical staff have refresher training in how to recognise a deteriorating patient and deal effectively with the situation if it arises. It is and should be a whole team approach and so the training should cover the multidisciplinary team. See clinical skills strategy.

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Interprofessional learning	Multidisciplinary teaching - Open up PG/UG skills teaching to non medics. Constraints would be numbers of attendees especially if the teaching is hands on, appropriateness of what is being taught to a mixed skill audience, availability of facilitators (would need extra brought in from clinical skills team) and syllabus timeframes in which to get the core group through practical assessments.	Review HYMS teaching and timeframes initially to see if involvement of other staff groups is possible / realistic.	JG / JW	PGS, EJ, GM, Clin skills team, medical educator.	Sep-16		
		Up skill / refresh current clinical skills facilitators to create 'breadth' so that more staff are available to support planned teaching and can assist others at peak times.	?MW	Clin skills teams	Ongoing		
	Human Factors training.	Discuss the feasibility / need for taking all non trainee doctors through Human factors training.	AD/ AC	AW / MW PG teams	Sep-14		
	Resource development	Work with the clinical skills teams to establish a central repository of created scenarios which have been tested and quality assured. These to be accessible to all training staff to reduce the need to constantly develop new resource.	AD/ AW/ MW	PG, Clinical skills, Resus	Jul-15		
		Review current training, staff leads and equipment resource. Create a centralised database for that information to be kept in a dedicated area of Staff Room.	AW/ MW	Clinical skills technicians	Aug-14		

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Simulation	Clinical Skills technicians	Continue to support clinical skills apprentices through practical training until they reach a point where they can start supporting simulated sessions in the larger organisation as well as ALAR.	AW / MW	PG teams, HYMS, clin skills staff, CS regional network	Dec-15		
	Develop more simulated scenarios to support changing School curricula	Work with the regional simulation Fellows from Medicine and Surgery.	AW/MW	PG teams	Jul-16		
		Review possibility for a Trust simulation Fellow at the next round of HEE recruitment.	AD/ AC	AW / MW PG teams	Jul-14		
	Medical educator. Currently due to pressure of job plans any consultant with an interest in using the High Fidelity trainers for income generating courses is too busy with clinical work to develop this teaching.	Appoint a clinical skills facilitator with a specific medical remit for developing advanced simulation training for higher trainees as part of our regional responsibility but also to develop and facilitate training on the High Fidelity simulators. There are additional requirements for clinical skills teaching in the Foundation curriculum and at induction and this individual would be integral to all this as well as working closely with clinicians, Schools of medicine and Surgery and the Clinical skills and Resus teams to support more generic teaching.	MW/ AW	Consultants	Oct-14		
Organisational	Strategy	Write an organisational clinical skills strategy.	AD/ GD	MK, clinical skills working group.	Jul-14		
	Link to CDT	Develop a process for including other staff roles in training which is agreed with their managers.	MK	PLFs			

		ORGANISATIONAL EDUCATION STRATEGY					
	Applied Learning and Research Directorate York and Scarborough - Health Library and Information service						
Overall Workforce / Education strategy	**Current status**	**Task description**	**Actions**	**Lead**	**Contributors**	**Target Date**	**Progress**
	Background - Main aims are: to provide a library service which continues to underpin professional development and learning through access to peer reviewed literature and information to deliver high quality information to inform management and clinical decision making at point of need.; to raise the profile of the service; to increase electronic access to a greater breadth of information resources; **to train individuals and departments in effective information seeking strategies;** to support organisational development and KM activities; to deliver a full range of information services to support research, education and practice.; to empower our staff to develop their own information management skills. For more detail see Clinical Librarian action plan 2014/15.						
Level 1 Statutory Training	Current access to corporate induction is limited to that for junior doctors.	Increased involvement in organisational face to face induction	Get involved in HCAs induction making the session more interactive with a structured framework to work through and leading to the development of a study skills module	HB	Library team/ C Skilbeck	Jun-16	
Level 2 Beneficial to Patient Experience	Immediate access for staff to up to date information and evidence based practice supports patient safety and experience	Investigate use of social media/ mobile technologies	Investigate available technologies, barriers to use and how they could enhance the library service. Ensuring appropriate links with Learning Hub purpose and functionality.	JM	CLs and library team.	Dec-15	Would need permission organisationally to start utilising these given information governance challenges and lack of consistent mobile IT equipment in the Trust.
		Development and introduction of electronic LibGuides	Investigate and assess LibGuide provision	JM /HB	CLs and library team.	Sep-15	

Overall Workforce / Education strategy	Current status	Task description	Actions	Lead	Contributors	Target Date	Progress
		Investigate remote access to stock and services	Undertake user surveys, arrange promotional roadshows and introduce appropriate services	HB	HB and library team	Sep-15	
		Develop an online enquiry service.	Investigate appropriate platform. The new Heritage management system is a potential option as it has a webpage which can be set up to do this which can be linked to from the OPAC.	HB/JM	CLs and library team.	Jul-16	Depends on purchase of Heritage
		Support for Knowledge Management work within the organisation	Offer support / get involved in Knowledge management projects where appropriate to build organisational expertise	JM	CLs and library team.	Ongoing	

Overall Workforce / Education strategy	Current status	Task description	Actions	Lead	Contributors	Target Date	Progress
		Service - Investigate demand for / develop embedded CL support to more departments, teams and projects	Maintain presence at community sites and Clinical Governance meetings. Explore other opportunities - Bridlington, Grand Rounds, ACP training. Investigate other CL services re provision of evidence overviews and tiered standards of service.	JG/ MS	Library team	Ongoing	
Level 3 Specialist Learning	Access to specialist information supports learning	**Electronic** - Further development of YorLIG	Expand YorLIG to include more departments	JM	CLs and library team.	Ongoing	
		Review of current journal provision.	Investigate the reduction of local e journal provision by taking advantage of regional procurement process and increased YorLIG provision. This frees up funding for more targeted use e.g. to increase numbers of free ILLs available to departments and update the print reference resources. The library will continue to subscribe to key titles.	JM/ HB	CLs and library team.	Oct-14	

Overall Workforce / Education strategy	Current status	Task description	Actions	Lead	Contributors	Target Date	Progress
		E book provision	Investigate appropriate ebook platforms and readers.	JM /HB	CLs and library team.	Jul-16	Depends on purchase of Heritage
		Development and introduction of electronic LibGuides	Investigate and assess LibGuide provision	JM /HB	CLs and library team.	Sep-15	
		Training - Equalise access to training and literature searching services across the organisation.	Provide a remote literature searching request and training service. Visits and delivery of training to community sites and workplaces. Investigate screen casting and webex.	JG/ MS	Library team	Jun-15	

Overall Workforce / Education strategy	Current status	Task description	Actions	Lead	Contributors	Target Date	Progress
		Ensure the training offer reflects and meets needs of user community and Trust as well as ALAR strategies	Undertake training needs analysis and review training frameworks. Create lesson plans and materials. Develop a study skills session. Target other groups e.g. GPs in training. Develop bitesize sessions open to all staff. Map sessions against KSF and / or professional competencies. Build on previous work in supporting ACPs.	JG/ MS	Library team	Dec-14	
		Development of cross site KM tools to assist CL efficiency and team working.	Examples Webex, Delicious, Diggo sites.	JG/ MS	Library team	Jan-16	
Interprofessional Learning	Library services support all users and can make links between different information sources to support multidisciplinary learning.	Development of 'Knowledge Centres'	Investigate local needs and similar provision in other Trusts. Implement on a requested basis.	JM	CLs and library team.	Aug-16	

Overall Workforce / Education strategy	Current status	Task description	Actions	Lead	Contributors	Target Date	Progress
		Link with course providers within the organisation	Review with course providers what the information needs of current and new (ACPs) learners are and match to / purchase resources	HB	JM/ library team, CLs	Mar-15	
	Partnership working with other library professionals enhance the knowledge base which benefits staff	**External** - Review and renegotiate SLAs as required	Continue to develop external links within the region and build information partnerships through SLAs e.g. Leeds and York Partnership Trust, CCGs, HEE Y&H, YSJ, HYMS	HB		Ongoing	
Quality Assurance		**Organisation** - Libraries Quality Assurance Framework (LQAF).	Continue to engage with regional process	HB/ JM	CLs	Ongoing	
		Finance	Liaise with finance to secure ongoing resource funding.	HB		Ongoing	
		Review strategies and mechanisms to record and promote quality of CL activities.	Peer review of training. Establish performance indicators for literature searches. Follow up interviews about quality of literature search service and training.	JG/ MS	Library team	Dec-14	

Overall Workforce / Education strategy	Current status	Task description	Actions	Lead	Contributors	Target Date	Progress
		Strategies	Review strategies and mechanisms to record and promote impact of CL activities	JG/ MS	Library team	Ongoing	
Operational		**Marketing** - Review marketing strategy and marketing materials	Use PESTLE, SWOT. Market segmentation exercises to be carried out with senior library team	Senior Library Team	Library team	Dec-14	
		Knowledge - Increase the skills and knowledge within the team through CPD activity	Collection and sharing of papers / info etc on X drive for other staff to review.	Senior Library Team	Library team	Ongoing	
		Management - Implemention of RFID technology	Install RFID (Radio-frequency identification) to enhance the circulation of library materials. Purchase equipment, train staff, tag stock and train library users. Implement and review.	JM /HB	Library team	Dec-14	

Overall Workforce / Education strategy	Current status	Task description	Actions	Lead	Contributors	Target Date	Progress
		Purchase new Library management system (LMS) to regional NHS preferred system - Heritage.	Survey the market and purchase appropriate system with enhanced functionality. Liaise with York St John and IT dept about implementation. Develop project plan. Investigate external hosting.	JM /HB	Library team	Dec-15	Funding has been obtained to purchase Heritage and a project plan is now being put together taking in to account YSJ plans.

Hull York Medical School (HYMS)							
Introduction	Undergraduate and Postgraduate medical education are changing, with increasing synergy between standards for training e.g. induction, educational supervisor / trainer training. Curricula and expectations re clinical skills and simulation training are also under review as there is a shift towards full registration with the GMC at the end of medical school. There is still a need to take into account training that is specifically targeted for medical students / staff through their curricula which may not be appropriate for other staff e.g. wet lab dissection. There is also a national move towards multi-professional training and the involvement of other clinical team members in that e.g. AHPs, especially when associated with Critical / Serious Incidents. Clinical teams are being reconfigured and that impacts on availability and quality of departmental training for students, so addressing this will be a challenge as well as getting 'buy in' from Trust teams and local managers. There is currently a review underway of the HYMS curriculum (2014). The changes are being supported but are presenting a high level of challenge in terms of new elements, increased expectations on clinical teaching and SSIPs and significant changes to timetable.						
Overall Workforce / Education Strategy	**Current Status**	**Action**	**Management Lead**	**External Contributors**	**Target Date**	**Risks / Issues**	**Progress against Actions**
Level 1 statutory training	**N/a**						
Teaching	Currently F1 doctors and other grades are involved directly in student teaching. Changes to the curriculum and those following the merger with Scarborough have resulted in some inequality in teaching provision.	Work with SNS and learning technologies team to understand webinars and then utilise this to deliver the same teaching content, simultaneously across both hospital sites for some topics.	GM / AF	PGS / EJ	Jun-15		
Level 3 Specialist learning	Deteriorating patient	Continue to support and build on current 5th year simulation training around team working, communication and recognising the critically ill/ deteriorating patient.	PGS / EJ	JG/ JW/ CL	Ongoing		
	Higher level teaching.	Encourage HYMS students to attend Grand Rounds and the non clinical elements of Foundation teaching.	PGS / EJ	GM / AF/ Assoc docs			
		To support quality assurance of this teaching, develop clinical teaching assessments.	GM / AF	PGS / EJ / HYMS Assoc Docs	Jun-15		
	QI Projects - Currently the status of these is unknown due to the curriculum review	Develop QI training for the students linking in with the ODIL team. Also for educational and clinical supervisors	PGS / EJ	MW/AW	Aug-15		
Interprofessional learning	Multidisciplinary teaching	Review areas of teaching / placement which might benefit from the inclusion of other clinical staff e.g nurses.	PGS / EJ	SLO teams	Jun-15		
	Induction	Move current induction materials from the current static software (TT) to LH which is a more interactive online system.	PGS / EJ	SW	Jan-14		

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
		Review HYMS induction against that provided for Postgraduate doctors to ensure that both are consistent in message and content. Possibility of combining both?	PGS / EJ	AW/ MW	Mar-14		
	Assistantship - Changes in the curriculum mean that during this period 5th year students will be on hospital sites for an 8 week block. This will increase pressures in the clinical areas.	Develop a more robust system for buddying students with F1 doctors	PGS / EJ	MW/AW	Jun-16		
		Identify more clinical supervisors. To minimise impact on consultants, look at training ST3s / SAS doctors / ? Senior nurses for this role.	PGS / EJ	MW/AW / AC	Jun-16		
Skills passport	Students already have portfolios of work and assessment booklets.	Work with HYMS to have this converted to electronic	PGS / EJ	HYMS central	Ongoing		
Simulated learning	Clinical skills and simulation	Maintain communication with organisational clinical skills facilitators re developments in teaching which might support the new HYMS curriculum.	PGS / EJ	JG/JW / MKs team	Ongoing		
Careers	Currently undergraduate and Postgraduate doctors have separate Careers events.	Work with HEE Y&H to develop a mixed careers event.	PGS / EJ / MW /AW		Sep-16		
LEFs	N/a						

Post Graduate Medical Education

Introduction Undergraduate and Postgraduate medical education are changing, with increasing synergy between standards for training e.g. induction, educational supervisor / trainer training. Curricula and expectations re clinical skills and simulation training are also under review as there is a shift towards full registration with the GMC at the end of medical school. There is still a need to take into account training that is specifically targeted for medical students / staff through their curricula which may not be appropriate for other staff e.g. wet lab dissection. There is also a national move towards multi-professional training and the involvement of other clinical team members in that e.g. AHPs, especially when associated with Critical / Serious Incidents. The aim is to get to a stage where the training is proactive rather than reactive. Clinical teams are being reconfigured and that impacts on availability and quality of departmental training, so addressing this will be a challenge as well as getting 'buy in' from Trust teams and local managers.

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Level 1 Statutory training		Review current induction programme and policy to ensure that it meets NHSLA expectations and is consistent across sites.	AD	AW/ MW	Sep-14		
Level 2 Beneficial to patient experience	All Postgraduate Education supports safe practice and patient safety	Build an extra day into the Foundation doctors programme on generic topics i.e. Teach the teacher and Ethics so that other clinical staff can be invited to take part and train with the doctors. Identify which staff groups may benefit from this type of training.	AW/MW	Foundation faculty	Aug-14		
Interprofessional learning	At every training opportunity to consider if a multi-professional approach is appropriate.	Develop networks with other training providers internally to agree a system / process for sharing / identifying / developing training opportunities	AW/ MW	CLAD / ODIL/ Simulation teams / AHPs	Ongoing		
		Work with the appropriate teams to consolidate current courses provided to support the deteriorating patient strategy i.e. RAMSI, AIRE. This includes review of content to ensure it is identical and delivered in the same way across all hospital sites. That suitable faculty are trained e.g. ACPs and the training is targetted at all staff. Eventually a hybrid of both courses needs to be developed for delivery to all staff.	AW/ MW	PG staff/ Simulation teams	Feb-15		
		Review other local teaching programmes for suitability to include non medical staff.	AW/MW	Nursing/ AHPs/ College tutors	Ongoing		
		Introduce York Pharmacy course for F1 doctors in Scarborough	MW/AW	Pharmacy- Lynn Ridley, Helen Holdsworth	Aug-14		
		Review junior doctor induction in line with LH implementation and to ensure that the programme is delivered consistently at both main hospital sites.	AD / AW/ MW	PG staff	Aug-14		
		Review junior doctor induction in line with HYMS student induction to provide a comparative experience.	AW/ MW	PGS/ EJ	Feb-15		

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
		Review processes in GP VTS scheme to see if there are any areas of good practice which could be adopted for other trainees.	AW/MW	BJ/ KU/ GP tutors.	Jun-15		
		Identify possible routes to give junior doctors and ACPs more experience in Community settings.	AW/MW	PG and GP teams	Sep-15		
		Work with WBL team who will be setting up a process for informing ALAR teams about Critical and Serious Incidents that may have a training recommendation /requirement. Action / develop suitable learning when appropriate. Develop portfolio of scenarios that have been used. Would some learning from incidents be in the form of action learning sets?	AW/ MW	WBL / other training teams.	Ongoing		
		Continue to develop external partnerships with other hospitals and community / GP / Mental health to share good practice and developments. Continue to build on provision of training regionally e.g. surgical courses for CTs and develop new links e.g. CcRISP course,	AW/MW	PG teams/ regional MEMs	Ongoing		
Skills passport	All doctors in training are expected to maintain a current e portfolio of experience and assessments.						
Future		Explore whether Bridlington could be used as a venue for generic teaching between Scarborough, Hull, York.	AW/MW	PGS/ EJ	Apr-15		
Other medical grades		Encourage and utilise the SAS doctors more e.g. those who have completed the 'Leading from the front' training to 'market' this to other staff; also develop as staff educators.	AC plus DDME	AW/MW/AD	Ongoing		
		Work with HEE Y&H towards the changes that will be coming through medical education, where roles may become more generic and training / career routes alter accordingly e.g. more doctors in to GP/ psychiatry.	AD/ SH				

Corporate Learning & Development (CLAD)

Introduction With the implementation of the online Learning Hub (LH) some of the work of the CLAD team will change. The first step towards this is a restructure of this team together with the staff from work based learning (for non clinical staff) and the Learning technologies team. Out of this will fall three different teams across the two hospital sites (stat/ mand, Work based learning and Learning Technologies) with greater cross boundary working. The trusts personal responsibility framework underpins all levels of professionalism and training and needs to be identified as such in all new employment contracts and marketed to the organisation. There is still a general unawareness that it exists.

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Level 1 Statutory training	Ongoing maintenance of the stat / mand programme	Team restructure. Identification of new / changed workstreams. Dedicated members of the team to support specific activities. Annual review of activity to feed in to ALAR training data for reporting to Board.	JC, MW, SW	AD / ODIL / PG/ HYMS/ Library	Oct-14		
	QA of stat/ mand content	Work with SMEs to establish quality indicators for their subjects. Random audit as a quality check.	JC/ MW	SMEs / ERG	Jun-16		
	Develop feedback / evaluation processes for courses	Work with training providers to design these elements and agree how the information will be collated and shared	MW	JC, SW, ODIL, Resus, Med ED	Mar-15		
	Ensure more robust mechanisms behind face to face learning	Development of centrally held lesson plans, objectives for the sessions as well as a current collection of all presentations / videos used for backfill purposes. Link to LH for the Knowledge assessments .	AD / GD	JC, MW, SW, ODIL, Resus, Med ED	Sep-15		
	Access issues 1.	Work with trust to address access to e learning provision using the recommendations from the In house skills audit 2014. These include the learning environment (quiet study space), availability of PCs, offsite staff and alternative provision where applicable. There needs to be equality of access for all levels of staff	AD /GD	Trust staff	Jun-16		
	Access issues 2. Lack of IT skills is preventing access by some staff to online learning.	Set up drop in sessions for staff to become more familiar with the concept of e learning and to provide some baseline guidance. This will work in conjunction with a new IT assessment for basic IT skills.	SW / JC	MW/ IT	Aug-15		
Workforce	Annual organisational TNA	Review / refresh. Set up a process for capture of internal and external learning available. Link to learning leave process?	MW	JC, BC, Trust managers	Jul-15		

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
	DNAs to training	Develop a process with HR and other training providers for notifying staff who do not attend for training. Automated emails?	MW	SW/ JC?	Mar-15		
	Collation of training data for those courses which do not necessarily sit within LH e.g. ODIL developed courses	Agree process with ODIL and other outliers and link this in with the Learning Technologies Team so data is in a consistent format. Agree what that format might be.		JC / MW / HR / ODIL/ other training areas			
	Develop a process to centrally record qualifications that staff enter the organisation with	Links to payroll, HR, develop a personal profile page for new staff which needs to be completed the first time they use LH and which is interrogatable? Simple process needs agreeing	MW	JC/ SW	Jul-15		
	Talent management	Develop a secondment register of departments willing to host staff looking at different working practices / roles and a process for doing so.	AD/ GD	JC/ MW	Jan-16		
	New learning leave policy implementation	To advertise the policy organisationally so that learning leave is applied for responsibly and in a timely fashion and managers are aware of potential overlaps. This will form part of ALAR reporting metrics eventually.	MW	WBL team	Mar-15		
	Supporting other departments	Review admin support currently agreed with other areas e.g. OD, CDT, Resus, manual handling etc in light of team reconfigurations especially in Scarborough to bring all arrangements in line.	JC/ MW		Oct-14		
	Supporting Trust partners	Discuss shared access to stat / mand and induction training to social work, local authority and other areas e.g. Hospice staff.	AD/ SH	JC/ MW	Sep-15		

	ORGANISATIONAL EDUCATION STRATEGY						
Applied Learning and Research Directorate York and Scarborough - Advanced Clinical Practitioners (ACPs)							
Workstream	**Task description**	**Actions**	**Lead**	**Contributors**	**Target Date**	**Progress**	
Introduction -staff are being recruited into these posts to support a number of organisational challenges: WTD which is having an impact on clinical areas in terms of staff being released for training; national reduction in junior doctor training places which will reduce the numbers of medical staff able do more generic clinical tasks; an ageing very specialised workforce; the need to support community as well as acute staff; the need to 'grow our own' specialists who become the bridge between traditional medical and nursing tasks and provide a more flexible workforce. They are being managed centrally initially and rotated through different clinical areas until their final speciality is 'fixed' towards the end of a two year MSc programme. There is a need to ensure that training mechanisms are robust, targeted, transparent and appropriate. 'Growing' these staff on an identified needs basis will support patient care through the availability of upskilled ward teams.							
Level 1 Statutory training	Induction	Co-ordinate / refine placement, corporate and clinical skills induction to meet national standards.	CS/ NM	AD	?		
Level 2 Beneficial to patient experience	Identify current skill level for each applicant and record that information centrally.	HR share recruitment forms. PGME to create spreadsheet of data for possible input into Learning Hub (LH) at a future date	Nat McMillan (NM)	AW	Jul-14		
	Support - Ensure that clinical skills teaching is monitored in terms of suitability for role.	Implement process for governance of practice / development of new skills.	BG		Jul-14		
	Ensure robust and appropriate supervision of practice	Discuss supervision of ACPs at Steering group and impact on current clinical supervisors. Develop a framework / process	BG/ NM	AD	Sep-04		
	Ensure appropriate line management in place	Discuss at Steering Group	BG / NM	AD	Sep-14		

Workstream	Task description	Actions	Lead	Contributors	Target Date	Progress	
	Ensure access to support mechanisms	At induction? Introduction to counselling, Occ H, slot ACPs into supporting doctors framework? Also access to team coaching and personal coaching for change.	NM / AD	AW/ HC/ FA-H	Jun-14		
	Raise awareness of ACPs work within the organisation	Team brief / Staff Matters/Senior clinicians and directorate meetings	NM		Aug-14		
Level 3 specialist training	Ensure that core clinical competencies are included in the two year MSc curriculum	Review core competencies	Bev Geary (BG)	Cathy Skilbeck (CS)	Jul-14	New cohort starts June 2014	
	Ensure that new curriculum meets organisations' expectations	Meet with University to finalise bespoke package	BG	CS	Jul-14		
	Increase capacity around non medical prescribing supervisors (DMPs)	Recruit additional consultants into this support role	BH/JB		Dec-15		
	Ensure ACPs are fit for final speciality role	At interview for speciality, identify what specific additional skills an individual may need. Identify how/ where this may be achieved. Also build this into the training for the next cohort	BG	AD/ AW / Maria Wilkinson (MW)	Sep-15		
	Evaluate local training programme	Identify quality indicators / benchmarks for training with the university and evaluate the programme on completion.	? University ? Trust feedback		Jun-16		
	Ensure educational supervision in clinical placements	Recruit additional consultants into this support role	AD/NM		Dec-15		

Workstream	Task description	Actions	Lead	Contributors	Target Date	Progress	
	Develop peer support for trainees	ALS and quality circles established within each cohort. Explicit within job description that qualified ACPs provide peer support and mentoring to new trainees.	NM/ODIL		Ongoing		
Interprofessional learning	Link core competencies with Foundation doctors training where possible so ACPs can access their sessions	AW to share competency lists with BG for review. BG to identify where ACPs may link in with Foundation programmes.	BG	CS / Anne Waddington (AW)	Jul-14		
	Support clinical skills teaching for all ACPs but particularly non nurses.	Meet with Sheffield Hallam re APACS course for clinical skills teaching on site	BG / AD	Skills technicians	Jul-14		
Skills passport	Create e portfolios for learning evidence and CPD recording	Explore and populate Mahara, an attachment to the LH	SW / NM	HR - other ALAR teams	Jul-15		
	Share ACP experience / good practice and raise profile regionally	At conferences / posters / published articles. Links with regional group and stakeholders.	BG/ NM		Ongoing		
Simulated learning	Develop ACPs to act as educators e.g. ALS instructors	Ensure ALS course is covered in core competencies and encourage ACPs to take on instructor status where appropriate.	BG	Resus team	Ongoing following initial course		
LEFs	N/A						

Blank page

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 24 September 2014

Chairman's Items

Action requested/recommendation

The Board of Directors is asked to note the report.

Summary

This paper provides an overview from the Chairman.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There is no reference to CQC outcomes.

Progress of report	This paper is only written for the Board of Directors
Risk	No risks
Resource implications	No resource implications
Owner	Alan Rose, Chairman

Author	Alan Rose, Chairman
Date of paper	September 2014
Version number	Version 1

Board of Directors – 24 September 2014

Chairman's Items

1. Strategy and Context

The Trust is undergoing additional scrutiny by Monitor over the coming months, focusing on our ED performance and selected referral to diagnosis and treatment times. Naturally, the Review will be broader, in the sense that our tracking, management, assurance and action on these matters will be taken by others as indicators of our overall competencies in running the Trust. I have full confidence that we will learn from the Review and benefit from it.

My instinct is that the timing of this is reflective of the crucial current year we are in. A year of incredibly tight tolerances for our financial performance, extreme pressure on a number of care metrics and significant reconfigurations and continued integration of some of our processes and services; add to this the evolution of our Director team (by January we are likely to have 5 Directors operating differently to a year or so ago) and the management groupings that support the organisation and the Board. The aggregate and interdependence of these issues is very significant for us as a transition. Navigating 2014/15 successfully is crucial to our continued success and momentum. We have ridden such waves before and I am confident we can continue to do so.

We should be aware of significant change and downsizing at NHS England; we are beginning to see the impact of their new Chief Executive. The commissioning structures (specialised vs. local) are changing to load more into the latter, and the CSUs are radically aggregating to only 9 across the country. We will see more changes and more strategic guidelines in the coming months.

2. Governance & Governors

By the time of the meeting this month, we will have enjoyed our Annual Open Day and Annual General Meeting – both held in Scarborough this year – we can reflect on these.

The Governor elections are closing this week and we will announce the new Council of Governors before the end of the month; their first meeting is on October 9th in Malton and we will have a full complement of 27 for the first time in a couple of years, with every constituency being fully represented.

The campaign to appoint a new Chair of the Trust opens on October 1st and will be open until early November.

3. Recommendation

The Board of Directors is asked to note the report.

Author	**Alan Rose, Chairman**
Owner	**Alan Rose, Chairman**
Date	**September 2014**

Blank page

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 24 September 2014

Chief Executive Report

Action requested/recommendation

The Board is asked to note the content of the report.

Summary

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

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes

Progress of report	Report developed for the Board of Directors
Risk	No specific risks have been identified in this document.

Resource implications	The paper does not identify resources implication
Owner	Patrick Crowley, Chief Executive
Author	Patrick Crowley, Chief Executive
Date of paper	September 2014
Version number	Version 1

Board of Directors – 24 September 2014

Chief Executive Report

I am sure you are as conscious as I am that Monitors investigation into the Foundation Trust is of profound importance to us in terms of our reputation as a Foundation Trust within the NHS and, crucially, the potential damage this might have on the confidence we enjoy amongst our patients and community. It is vital we treat this process with the utmost respect. It is vital we account for ourselves honestly and transparently. I have written to all senior clinicians setting out the background to the investigation, what this might mean for us and my expectations as we go forward. I thought it useful you see this as my report.

I am sure by now you have seen the press coverage outlining Monitor's announcement to formally investigate the Trust for breaching waiting times , in the main, in ED (across the Trust) and Fast Track referrals to our symptomatic breast service in Scarborough.

I have attached Monitor's formal notification which is worth a read as it perfectly illustrates the regulatory overview and scrutiny we are subject to and the potential gravity for any organisation who is considered in breach of its licence. Monitor has a vital role to play and it is one we must respect. Monitor is not, in itself, concerned with our absolute performance but more about how the Trust governs itself. The investigation will consider whether we are clear about the risks we face, that our performance fairly reflects our capacity and capability and that we are taking reasonable steps to address the risks and issues that confront us (daily). I am satisfied this is the case and both the issues in question are well documented and receiving constant attention but of course my assertion will be fully tested! For your information I have also attached a copy of our press release that has been widely reported on and a recent letter to Scarborough CCG that spells out our commitment to the breast service in Scarborough.

Whilst I am disappointed in Monitor's intervention I have to say it has been inevitable when reflecting on our reported performance and, to date, our inability to resolve the underlying problems. From our own point of view we have faced repeated difficulty in recruiting key staff into ED on both major sites, and in breast radiology and we know this is likely to continue for some time as recruitment is a national and well documented problem in both services. For breast services we do have the advantage (and opportunity) as an integrated organisation to offer an interim solution in York within our own resources that simply would not have been available previously to Scarborough. This is allowing us to reshape the delivery of the service over the coming months to equip and sustain the service for the community of Scarborough and district in the long term. With regard to ED we are close to agreeing additional resources for investment across the whole system in both our localities that should help improve things based on our experience of this in the period January to March of this year, when similar investment was made and the target was achieved. I am clear that both our ED teams are working flat out to maintain a service that is being squeezed at both ends i.e. facing increasing pressure at the front door and difficulties with moving patients ready for admission to the wards promptly. As such the failure of this target is, as I am sure you appreciate, a shared responsibility within our hospitals as well as in part the responsibility of our commissioners to ensure alternatives to hospital care exists where appropriate.

However, whilst I am confident that we can manage this process with Monitor we do have to see this as a example of how easily it is to fall foul of the system we work in and I would ask you that we all take time to reflect on this and consider how we might, individually and collectively, help ensure this experience isn't repeated.

Being part of the NHS is important to me as I am sure it is for you. It is a privilege we all share and one that comes with huge responsibility for you and I and our senior colleagues to ensure that we really do make the most of what we have to offer and the opportunity we currently enjoy as a larger organisation. Good things are happening. A significant redevelopment of the Scarborough site and the expansion of services in of Bridlington is now underway which has been long overdue, our combined resources place us in a stronger position than either organisation previously enjoyed, and we continue to plan the development of all our services with ambition. Despite the economic environment there is a rarely a week goes by when I am asked to approve a further growth in our consultant body. Last year we invested £4m in nursing and we continue to grow our staffing overall. This doesn't happen by accident and is down to everyone's hard work, managing our resources well and this is contributing to a steady improvement in the underlying quality of our provision as evidenced in part by the significant improvement in our SHMI over the last year or so. Clearly, there is a lot to do and we can never progress fast enough for my liking but that is the world we have chosen to be part of.

Our patient feedback is good and improving but it is really hard work...but is hard anywhere you care to look across the health service and there is a fragility of provision in particular in the hospital sector that is unprecedented. Financially it would be harder without the funding we are receiving for the next 3 years to support the merger and this offers us an opportunity few other organisations have, so let's not waste it. In that context many of us will have to adjust to new circumstances and the way we work. That is already happening and is a pre-requisite to riding the changing demands on health services, not just in the UK, but also internationally. Setting ever higher standards of compliance with good clinical practice is unarguable and a responsibility of each and every one of us. The fact that we continue to haemorrhage funds due to our failure to collectively comply with some of these basic standards is unacceptable to me as I trust it is to you. Every penny wasted is a lost opportunity for reinvestment and it is never "someone else's" job to manage the consequences of this…it is the biggest shot in the foot I can think of and one that, with the right engagement, we can resolve.

In summary I do believe that Monitor have every right to seek our reassurance and the investigation is their means to this end. I am confident we can provide this but I am asking you, as one of my most senior colleagues, to consider the environment we are working in and recognise that by design this is difficult. We do have an opportunity presented by the merger of our main hospitals to manage much of this that others do not enjoy and we can't afford to waste it.

I am of course happy to discuss any aspect of this with you individually or collectively at any time.

Author	**Patrick Crowley, Chief Executive**
Owner	**Patrick Crowley Chief Executive**
Date	**July 2014**