York Teaching Hospital NHS
NHS Foundation Trust

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

on: **Wednesday 25 January 2017**

in: **Boardroom, Foundation Trust Headquarters, 2nd Floor Admin Block, York Hospital, Wigginton Road, York, YO31 8HE**

Time	Meeting	Location	Attendees
9.00 - 11.00	Group & Optional Individual Photographs	Boardroom, York Teaching Hospital	Board of Directors
11.00 – 12.30	Board of Directors meeting held in private	Boardroom, York Teaching Hospital	Board of Directors
12.30 – 13.00	Lunch		Board of Directors
13.00 – 16.00	**Board of Directors meeting held in public**	**Boardroom, York Teaching Hospital**	**Board of Directors and members of the public**

The values of the Trust are:

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

…with patients at the centre of everything we do

These will be reflected during all discussions in the meeting

York Teaching Hospital NHS
NHS Foundation Trust

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

On: **Wednesday 25 January 2017**

At: **13.00 – 16.00**

In: **Boardroom, Foundation Trust Headquarters, 2nd Floor Admin Block, York Hospital, Wigginton Road, York, YO31 8HE**

A G E N D A					
No	***Time***	***Item***	***Lead***	***Paper***	***Page***
General					
1.	13.00 - 13.10	**Welcome from the Chairman** The Chair will welcome observers to the Board meeting.	Chair		
2.		**Apologies for Absence and Quorum** • No apologies received.	Chair		
3.		**Declaration of Interests** To receive any changes to the register of Directors' declarations of interest, pursuant to section 6 of Standing Orders.	Chair	A	5
4.		**Minutes of the Board of Directors meeting held on 30 November 2016** To review and approve the minutes of the meeting held on 30 November 2016.	Chair	B	9
5.		**Matters arising from the minutes** To discuss any matters arising from the minutes.	Chair		
6.	13.10 – 13.20	**Patient Story** To receive the details of a patient story.		Verbal	
7.	13.20 – 13.35	**Chief Executive Report** To receive an update on matters relating to general management in the Trust including an STP update and Winter Pressures.	Chief Executive	C	21

No	Time	Item	Lead	Paper	Page
Our Quality and Safety Ambition: Out patients must trust us to deliver safe and effective healthcare					
8.	13.35 – 13.55	**Quality and Safety Performance issues** To receive the minutes from the meeting and associated key papers: • Patient and Quality Safety Report • Medical Director Report • Safer Staffing	Chair of the Committee	D D1 D2 D3	27 55 87 99
9.	13.55 – 14.05	**Director of Infection Prevention and Control (DIPC) Quarterly Report** To receive for approval the quarterly report.	Director of Infection Prevention and Control	E	107
10.	14.05 – 14.15	**Maternity Services Annual Report** To receive for approval the Maternity Services Annual Report.	Chief Nurse	F	115
14.30 – 14.40		**Tea break**			
Our People and Capability Ambition: The quality of our services is wholly dependent on our teams of staff					
11.	14.40 – 14.50	**Workforce and Organisational Development Committee Issues** To receive the minutes from the meeting and associated key papers: • Minutes of the meeting held on the 15th November 2016 • Draft minutes of the meeting held on 18th January 2017	Chair of the Committee	G	143
12.	14.50 - 15.00	**Workforce Metrics and Update Report**	Chief Executive	H	167
13.	15.00 – 15.15	**Freedom to Speak Up/Safer Working Guardian Report**	Chief Executive Freedom to Speak Up/Safer Working Guardian	I	181

No	Time	Item	Lead	Paper	Page
Our Finance and Performance ambitions: Our Sustainable future depends on providing the highest standards of care within our resources					
14.	15.15 – 15.40	**Finance and Performance issues** To receive the minutes from the meeting and associated key papers: • Finance Report • Efficiency Report • Performance Report • Capital Report	Chair of the Committee	J J1 J2 J3 J4	197 223 241 247 255
15.	15.40 – 15.45	**2016/17-37 – Development of the Plastic Surgery Service** To receive and approve the business case.	Chief Executive	K	269
16.	15.45 – 15.50	**Governance Documents** The Board is asked to approve the Reservation of Powers and Scheme of Delegation, Standing Orders, Standing Financial Instructions.	Foundation Trust Secretary	L	289
Our Facilities and Environment ambitions: We must continually strive to ensure that our environment is fit for our future					
17.	15.45 - 16.00	**Environment & Estates Committee** To receive the minutes from the meeting.	Chair of the Committee	M	387
Any Other Business					
18.	16.00	**Next meeting of the Board of Directors** The next Board of Directors meeting held in public will be on 22 February 2017 in the Boardroom at York Hospital.			
19.		**Any Other Business** To consider any other matters of business.			

Register of directors' interests
January 2017

York Teaching Hospital NHS
NHS Foundation Trust

Additions: No changes

Changes: No changes

Deletions: No changes

A

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

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)	**Member—**Great Exhibition of the North (2018) Board	Nil	Nil	**Chair—Charitable Trustee** **Act as Trustee** –on behalf of the York Teaching Hospital Charity **Trustee and Vice Chair—**of the Joseph Rowntree Foundation and Joseph Rowntree Housing Trust **Chair—**Advisory Board, Centre for Lifelong Learning University of York **Member—**Executive Committee YOPA **Patron—**OCAY **Chairman** - City of York Fairness and Equalities Board **Member –**Without Walls Board	**Director—**London Metropolitan University **Vice Chairman—**Rose Bruford College of HE	Nil
Mr Patrick Crowley (Chief Executive)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil

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

B

York Teaching Hospital NHS
NHS Foundation Trust

Minutes of the meeting of the Board of Directors of York Teaching Hospital Foundation Trust, held on 30 November 2016 in public at Selby War Memorial Hospital, Doncaster Road, Selby.

Present:

Non-executive Directors:

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

Executive Directors:

Mr A Bertram	Director of Finance
Mrs B Geary	Chief Nurse
Mr M Proctor	Deputy Chief Executive
Mr J Taylor	Medical Director
Mrs J Walters	Chief Operating Officer

Corporate Directors:

Mr B Golding	Directors Estates & Facilities
Mrs S Rushbrook	Director of Systems and Networks
Mrs W Scott	Director of Out of Hospital Care

In Attendance:

Mrs L Provins	Foundation Trust Secretary
David Thomas	Director Manager, Emergency Department
Donna Exton	Deputy Sister, Emergency Department

Observers:

Mrs S Miller	Public Governor – Ryedale
Mrs M Jackson	Public Governor – York
Mr M Reakes	Public Governor – York
Mr M Lee	Staff Governor – York
Mrs A Bolland	Public Governor – Selby
Mr R Chilvers	Public Governor - Selby

The Chair welcomed everyone to the meeting which had been moved into the Council Chambers at Selby.

16/150 Apologies for absence

Apologies were received from Patrick Crowley, Chief Executive.

16/151 Declarations of interest

Ms Symington asked whether there were any further declarations of interest at the meeting. No further declarations of interest were raised.

Ms Symington asked whether there were any interests to be declared in respect of the papers due for discussion at the meeting. No declarations were made.

16/152 Minutes of the meeting held on the 26 October 2016

The minutes of the meeting held on the 26 October 2016 were approved as a true record of the meeting.

16/153 Matters arising from the minutes

No matters arising were raised.

16/154 Patient Story – Role of the Clinical Navigator

Donna Exton provided the Board with a briefing on the Clinical Navigator Role established within the Emergency Department (ED) at York. Donna explained the dynamics of the role and provided some examples of patient experience.

Ms Raper welcomed the description of the role and asked whether it was part of the established protocol of the role. The role had been initiated at St Thomas Hospital in London and is now a recognised role which looks to triage patients entering the department and ensure that they are seen in the most appropriate place, whether this is in ED or back at their GP Surgery.

Donna noted the governance behind the system was provided by the Manchester triage system and this provided the senior nurses with the confidence to make the necessary decisions. Donna stated that the nurses were able to implement the frailty scoring and work with the rapid assessment team to direct patients to the frailty pathway. She also noted that in relation to data all redirected patients were audited and that any patients not waiting to be seen would be highlighted to their GP. Donna stated that a senior nurse is located in the waiting room which enhances safety.

Mrs Adams noted that the CQC had been unhappy with the pathway, but this had shown that something positive had been created from it. Mrs Adams congratulated the staff.

Ms Symington thanked Donna Exton for her informative presentation.

16/155 Report from the Chief Executive

Mr Proctor, Deputy Chief Executive, presented this report on behalf of the Chief Executive. Mr Proctor stated that the Sustainability and Transformation Plan for the patch had been published on the 21 November. The plan provided a high level narration about the intended direction of travel and focuses on the health and social care needs of 6 localities.

Mr Proctor stated that at the recent City of York Health & Wellbeing Board there had been requests for more detail; he explained that this would be determined by locality boards which would be developing project teams to develop and determine the detail of the plans for each locality. There would be a small central project team to gather information and intelligence and as things begin to be proposed, wider consultation would be carried out. Mr Proctor noted that one of the things that needed to be understood was the differential between *consultation* and *engagement with public*, which would be carried out as the plans are developed.

Ms Raper asked when a communications strategy would be received. Mr Proctor stated that this was in development, but that the footprint was looking to engage an STP level communications lead. He also highlighted that the Communications Lead for the Trust would be involved in the local arrangements and that the Communication Leads would hopefully meet before Christmas.

Mr Proctor stated that there was still a lot of debate to be had on a number of areas including whether to have an estates strategy for the whole area or do it by locality.

Prof. Willcocks stated that the Non-executive Directors would welcome some sense of the governance arrangements and how they could be involved. Mr Proctor stated that this was one of the difficulties: he had had to explain to the Health & Wellbeing Board that individual boards were still sovereign and that this would, in effect be “change by consensus” and as yet, the governance arrangements of that were still unclear. He stressed that any decisions involving the Trust would have to come back to the Board. Prof. Willcocks stated that it would be useful if that were captured somewhere.

Prof. Willcocks stated that in discussion with one specialty within the Trust, an individual had raised that their area was not specifically mentioned in the STP- but that they wanted to be part of it and make a contribution. Mr Proctor stated that this would be reflected in any detailed planning, which would involve directorates, but that a lot of the work would be more about outreach into the community.

Mr Sweet stated that there was a lot of suspicion in the national press surrounding STPs. Mr Proctor noted that the Health & Wellbeing Board were also concerned about this and that issues surrounding the communications around the closure of Archways had exacerbated things, but that this was a learning point for the Trust. Mr Proctor stated that he is taking every opportunity to communicate directly with Councillors, but stressed that the element of the plan involving this area would focus on primary and community care. Mr Sweet also noted that it was the CCGs responsibility to do consultation work around the plans.

Ms Symington stated North Yorkshire County Council were not in support of the designated STP footprint. Mr Proctor stated that the Council are still lobbying, but that this would be unlikely to change anything. Mr Golding stated that it was probably more to do with Public Health who have limited staff resource to cover the number of areas. Mr Proctor stated that it was also difficult getting one Local Authority Representative to represent all 6 areas.

The Board discussed the recent (successful) Clinical Summit which had been founded on re-engaging clinicians across the patch and had looked at how to integrate and work together for the benefit of patients in the area.

16/156 Quality Safety & Performance Issues

Mrs Adams stated that the Committee continues to monitor some long standing challenges through the action log so that key issues remain at the forefront of the agenda. She noted the concerns around the out of hours service and the acute medical service on the Scarborough site, but noted that this will be picked up later in the meeting. She noted the Committee were pleased to hear about the good recruitment in specialist nurse staffing for the renal unit. She also noted the extensive pressures in the Trust and stated it was about how the Trust safeguards patients in this situation especially regarding long waits.

Mr Taylor highlighted the formality to the process of looking at each 12 hour trolley wait in some depth, and assured the Board that during these investigations it had been established that no harm has come to the patients, despite the delays. Patients who are looked after in the ED departments are supported and receive the appropriate medical care for their needs at the time. He stressed patients are continually monitored, but that this does stretch and stress the system. Work is being progressed around "flow" and safer bundles to minimise impact, but it remains work in progress.

Mrs Rushbrook stated the arrivals boards have been implemented and these can be seen further down the pathway enabling more active decisions about patient care to be made.

Mr Taylor highlighted that a Clinical Summit, which had included ambulance staff had taken place on the 29 November and there had been a discussion about ways of improving patient flow. Mrs Geary stated that comfy rounds risk assessments had also been adapted for use in ED. Mr Taylor also stated that staff had been asked to document apologies for any extended stay in ED.

Mrs Walters stated patient safety was paramount and that an extended stay in ED does not mean that patients are not being well attended and looked after, although it is obviously not ideal. Mrs Walters stated that the increased volume of patients is significant, but that patients were being managed in a calm and systematic manner.

Mr Taylor stated that the Trust had a legal responsibility in relation to Duty of Candour (following the Francis Report) in relation to patients receiving an apology and the Trust investigating and learning from an incident. An internal audit report had been received, which showed that in the main clinicians are complying with the duty and are apologising when an untoward incident occurs. However, formal written apology compliance is poor. An action plan is being implemented and staff are being re-educated and supported. He noted that standard template letters had been put on Datix and CPD to ensure they are part of the response process. This will also be included in statutory and mandatory training.

Prof. Willcocks noted that the charity had recently provided money to support staff development in letter writing for complaints and good feedback had been received.

Mrs Adams stated that the organisation is taking the actions forward from Never Events. She asked Mr Taylor to brief the Board on the 2 recent never events. Mr Taylor gave an overview of the 2 never events, one was in theatre where there are clear guidelines for staff: the Never Event was therefore down to human error, requiring reinforcement of due

process and was a low level of harm. However, the second Never Event was more complex and involved Outpatients (OPD) nurse practitioners. The WHO checklist does not apply in OPD so elements are being adapted and will introduce checking and marking in some areas where appropriate.
Mr Keaney asked where the Trust stood in relation to Never Events with other organisations. Mr Taylor did not have the information, but was clear that the Trust is very open and honest in relation to these events.

Mr Taylor stated that the Trust had vaccinated 61% of front line staff as part of the flu campaign and needed to get to 75% by the end of the year to achieve the CQUIN.

Mrs Geary provided an update on nurse staffing stating that a large cohort of around 90 newly qualified staff had started in the Trust and once they were in patient areas there would be approximately 70 vacancies left, which is the best place the Trust has been in for a long time. She noted the successful recruitment marketplaces that took place in both York and Scarborough and stated that there are plans to hold this annually. The Trust is also working with Coventry University to develop staffing levels.
Mrs Geary also stated that Health Education England exchange programme for the Indian nurses was progressing and she was still waiting to hear whether the Trust would be a fast follower in relation to the national nurse associate role. Although she did stress that there is still some national debate about regulation of the nursing associate role.

Mrs Adams noted that the Committee had received considerable assurance from the ward by ward data which had been made available and that this evidenced that issues are being acted upon.

Mrs Geary raised that she would like to amend the Quality and Safety Committee's latest minutes to ensure a more accurate reflection of the meeting. She stated that the Trust had seen a growing trend locally in the number of adolescents self-harming and this had also resulted in couple of serious incidents for the Trust. Mrs Geary stated that unfortunately the Trust was seen as a place of safety, but often it was not the most appropriate environment and that further work was required with external bodies to ensure a more appropriate response. Mrs Geary highlighted that these concerns were reflected in the nursing and corporate risk registers. Mrs Geary briefed the Board on the current Child and Adolescent Mental Health Services (CAMHs) which is being discussed with Tees, Esk and Wear Valley (TEWV) and the CCG.

Mrs Geary stated that all the incidents are being recorded and work is being done with TEWV on a local action plan which includes specific risk assessment and one to one training for staff. She noted that some of these patients are particularly challenging and the nursing staff were not particularly experienced with mental health patients. Mrs Adams stated that there were prevalent national inequalities with children and mental health and that the Trust needed to keep pushing to ensure the right services were provided.

Mr Sweet asked what plans there were for getting better value out of nurse rostering as he noted that there were staff who owed the Trust hours whilst working on the bank. Mrs Geary stated that a deep dive has been done in ED and AMU in the first instance and other wards were planned in. She noted it was more about modifying behaviours then issues with the system.

16/157 Workforce and Organisational Development Committee Issues

Prof. Willcocks stated that there had been marginal changes in the monthly sickness metrics, but this tied in with the use of agency nursing staff so did need to be kept under scrutiny. She noted that back problems and stress were the 2 biggest reasons for sickness and that despite the figures being lower than the regional level, the Trust should not be complacent. Prof. Willcocks stated that the Junior Doctors contracts were due to come into force and the Trust has put in place the Safer Working Guardian and the Junior Doctors Forum. She also noted that the appraisal figure was at 73%, which while disappointing was improving.

Prof. Willcocks stressed that temporary staffing was every ones issue and that vacancies and sickness were the main reasons driving it. She noted the incentives being offered during the winter period and that they had made a huge difference last year. Prof. Willcocks also highlighted the reporting complexities which were becoming a huge industry for Trusts. Prof. Willcocks highlighted that the agency cap is set for the Trust at £17.2m and that the Trust spent £9.9m from April to September and is now going into the period of greatest demand. She noted it was this area that gave her most concern despite being aware of what is being done.

Mr Proctor stated that the first point he wished to make was that the Trust needed a temporary staff workforce to cover absences in the workforce, which is a constant management balance. He also pointed out that the market has changed and there is significantly more flexibility in the workforce. It was also recognised that there is likely to be a 20% reduction on the temporary staffing spend from 2015/16.

Mrs Geary stated that there was a significant reduction in nursing agency use since July last year and that was due to the senior team challenging every single agency shift - an onerous commitment.

Prof. Willcocks also mentioned that it was hoped that the work on e-rostering would produce a benefit. Mrs Geary stated that bank and agency usage and e rostering are being looked at in the Emergency Department and Acute Medical Units on both sites in the first instance, but that there had been significant vacancies in ED in York. Prof. Willcocks stated that the investment in bank staff in order to regularise their employment was improving the situation.

Mr Taylor stated that critical parts of the medical staff including ED and general medicine at Scarborough continued to be an issue. General Medicine shortages in Scarborough are partly due to long standing problems with middle grades and trainees. The Trust was also in the position of having to employ some locums in the long term due to the need to provide capacity in some specialties. Mr Bertram stated that being a locum had become a way of life for some doctors especially due to the personal service tax benefits available. He also noted that the Chancellor would be looking to clamp down on this in April next year which would significantly change the dynamics of the market place.

16/158 Finance and Performance Issues

Mr Keaney stated that the agenda was expanding, but that a number of items including a paper on tenders were reassuring. However, he stressed that there are still a number of

concerns. Mr Keaney stated that the emergency care standard was still very challenging and that the standard had been failed, but despite this he stated that the Trust was still offering a safe service to patients, which was very reassuring. The failure of the standard would also inevitably affect the STP funding trajectory. Mr Keaney stated that David Thomas, the Emergency Department Directorate Manager had been invited to provide a 6 month update on acute and emergency care.

Mrs Walters stated that David would provide some of the context in which the Trust is working and where the Trust is with plans to improve performance. She highlighted that the Trust was at REAP 5 (Resource Escalation Action Plan) and provided a brief overview of the REAP levels. Mrs Walters stated that the Trust had achieved a score of 85% for the emergency care standard against the sustainability and transformational funding trajectory of 90% for October and the current position was only 82%.

David provided the Board with a presentation on the performance of the Emergency Departments in York and Scarborough together with some of the progress on the actions being taken to improve performance. A key point was the non-elective admissions had risen by 10% and GP admissions by 16% giving a picture of the rising pressure the Trust faces.

Ms Raper raised an issue regarding action RAG rating and Mrs Walters stated that actions need to embed in order to demonstrate progress and some of the developments will take a year to 2 years to fully embed. Ms Raper asked what was within the control of the Trust and what opportunities there were. As an example she asked if there were enough ACPs. Mrs Walters stated that in relation to ACPs, another 6 would be starting in January. She also noted that the majority of the increases had been in ambulatory care, but that 2.6% of attendances still required admission. It was the ACPs that were providing that initial assessment point in ED to identify which pathway the patient should be put on.

Ms Raper welcomed the update and noted how complex things were, but wondered how this triangulated with the availability of medics.

Mr Taylor stated that the work being done by ACPs speeded up the process especially the request for investigations and tests. The next step would be to bring together all the teams to work together at the front door. This work was leading the way at Scarborough and was part of a national programme.

Mrs Adams said it sounded excellent, but that she still had some concern about the limited space in ED .She also observed that there was still a challenge to fill empty slots in the medical rota and the out of hospital arrangements needed to be put in place. She asked how patients would be safeguarded in the assessment area in the future when there were currently not enough doctors in the hospital and that recruitment of medical staff was an on-going challenge. David explained that the assessment area of the plan was not in place yet, but patients were being kept safe and looked after whilst waiting for beds, but this was causing delays.

Mrs Adams asked whether this delivery in ED by down-stream specialists negated the need for ED consultants. David stated that the model is not fully mature yet, but a facility is needed where all the specialities including ED can come together. Elements are starting to be put into place in relation to the Frailty Geriatrician working every afternoon and an Acute Physician working occasionally in the ED.

Mrs Rushbrook stated that creating the model allowed mapping to inform workforce and flows so that then patients could be identified and streamed appropriately. She noted the model and processes would be continually refined.

Mr Proctor stated that the process had involved all the different specialties in the planning and was being adapted continually. He also noted that the introduction of the ACP role in ED had surpassed all expectations especially those of the ED consultants and this was genuinely about the hearts and minds of staff being changed as this work moved forward. Mr Proctor stated that the primary concern of the development was patient safety, but it was a very iterative and gradual process. The full model will require a capital scheme and there is currently only an element of this capital available.

Prof. Willcocks stated that she was excited by the visual hospital boards, but had received feedback that some may be in the wrong place. Mrs Rushbrook stated that she and her team had been around every single ward in both York and Scarborough and presented to the teams. Again she noted that this was an iterative process with the wards using the boards more than they had expected. Mrs Walters stated that the Trust would continue to grow the model, work with primary care and maximise the use of the A & E delivery board system wide approach.

Ms Symington thanked David Thomas for the presentation and the reassuring discussion on a subject which was of primary concern to the Board. She noted that the Trust was on REAP score 5, the highest level and stressed the importance of supporting our staff in pressured times. Ms Symington stated that the Board would like to hear about further progress in 6 months and how the work in the community fits into this.

Action: ED and community developments update in 6 months

Mrs Walters stated that the 18 week recovery plan had been taken to the Finance and Performance Committee and detailed the increased use of day case and the private sector to bring the Trust back on track by February.

Mr Keaney stated that he absolutely recognised the commitment and the initiatives being put into place and it would be good to see performance going back up to reward all the hard work being put in.

Mr Bertram provided an overview of the finance position stating that income and expenditure in month 7 showed a surplus of £3.5m against a planned surplus of £3m. He noted the £1m buffer from last month had reduced due to the performance issues, including a loss of £142k a month each in relation to the emergency care standard and 18 weeks and then 2 months of not meeting the 62 day cancer target. Collectively these had produced penalties of £400k. Mr Bertram stressed that the Trust could not sustain this over many more months and if it continued it would impact the control total payments of £3.4m a quarter. However, he did note that some of the funding could be recovered if the Trust were to achieve targets at a later point of the year although this will be challenging.

Mr Bertram stated that he shared the concern raised by Mr Keaney around the risk to achieving the year end position, but that currently he was still forecasting that the Trust would hit the control total. He stated that the risk was significant, but delivery was being monitored through meetings and at the end of quarter 3 there would be an opportunity to consider whether the control total was still deliverable.

Mr Bertram stated that in relation to cash, the Trust had not yet received the quarter 2 payment from NHSI which had been delayed due to a failure of the assurance process; however, NHSI stated that this money would be with the Trust by the end of today.

Mr Keaney stated that in a private business falling income would stimulate action to increase sales. He asked whether the Trust could do anymore elective activity? Mr Bertram did not think that this was an option. He noted that both of the main commissioners were in significant financial distress and do not have the means to pay for the activity. He also noted the Vale of York CCG briefing regarding the delay of surgery for patients with an increased BMI and those who smoked. Mr Keaney stated that all the relevant risks had been included and updated on the risk registers which were discussed by the Committee.

Mrs Scott acknowledged the potential financial risks, but asked if it was worthwhile encouraging the Board to think differently and to fund investment in out of hospital provision, as the Trust did not have the bed capacity for acute patients, leading to cancelled elective activity. Mr Bertram stated that the current tariff model would make this difficult as avoiding admissions would mean the Trust not being remunerated for the activity and would increase the level of savings required.

Mrs Walters stated it was a good point regarding working together and that if the Trust did not have to open winter escalation areas this would save money. She thought it would be worthwhile looking differently at next winter. Mrs Rushbrook stated that the closure of Archways was an opportunity to show how this could work.

Prof. Willcocks thought this would be a useful topic for an away day discussion together with the increased use of volunteers.

Mrs Rushbrook raised that there was no primary care cover in York or Scarborough over the Christmas and New Year period and Ms Raper stated that this clearly brought into question the idea of joint working as this was totally the wrong direction of travel. Mr Bertram stated that full representation had been made regarding this concern.

16/159 Business Case Laboratory Medicine Capital Scheme 2016/17-21

Mr Bertram stated that he was genuinely pleased to be able to present this case which was a vision conceived following the acquisition of Scarborough Trust. He noted that there had been artists impressions included on the pathology stand at the Strategy Poster Day held in York and there was real enthusiasm in the team around this development. Mr Bertram stated that this was a material capital investment and that capital funding depreciation had been built in.

The development would see the York laboratory extended and significantly refurbished as it had not been touched since the 1970s together with the demolition of the Scarborough Pathology Unit which he described as ‘horrific’. Histopathology and microbiology would be consolidated on the York site avoiding capital duplication of equipment and saving £400k non-recurrently, which fit with the Lord Carter principles.

Mr Bertram noted a minor setback to the case in respect of the detail regarding an extension of the cytology programme which had been based on being the preferred bidder for a £2m pathology contract. Unfortunately, the Trust was not selected as the

preferred bidder, which is an enormous blow. Mr Bertram stated that the Trust is currently making representations about this decision. He noted that this development will reduce the finance by £200k, but that the case was already based on £400k savings.

Mr Bertram was really keen to stress that the cytology element was only a small part of the case and that the case would allow the future proofing of the York laboratory for growth. He also stated that the redevelopment of Haldane Ward at Scarborough into a new modern blood science hot laboratory was part of the case.

The Board approved the business case.

16/160 Acute Medical Model

This item was discussed as part of the Finance & Performance Committee feedback.

16/161 Emergency Planning Report and Annual Self-Assessment against Core Standards

Mrs Walters stated that an annual report would be brought to the Board detailing the governance arrangements and how the Trust was progressing against the core standards.

Ms Raper welcomed the additional assurance, but asked why an accountable emergency officer was not appointed. Mrs Walters highlighted page 203 of the pack which showed the governance arrangements around the team through to Mrs Walters and ultimately to the Chief Executive. She noted that every Trust has different arrangements in place and these days having a separate accountable officer was a luxury.

Mrs Adams found it very encouraging that it received so much attention, but thought that the best way to prepare was usually to practice. Mrs Walters stated that practice events are costly, but a table top exercise will be carried out in the future.

16/162 Next meeting of the Board of Directors

The next meeting, in public, of the Board of Directors will be held on Wednesday 14 December 2016 in Room S33, Postgraduate Centre, Scarborough Hospital.

16/163 Any Other Business

Cyber Attacks – Ms Symington stated that she had asked Mrs Rushbrook to give an update on the current issue of cyber-attacks on NHS organisations. Mrs Rushbrook agreed to give a brief overview with a bigger update in January.

Mrs Rushbrook stated that the reasons behind the Leeds pathology system break down for 5 days was in respect of equipment, the lack of backup systems and third party contracts. In light of this, her team has reviewed the Trust's systems and also asked a path supplier to come in and check things through. She also noted that Donald Richardson had been asked to sit on the Leeds Board which is reviewing the patient safety aspects of the Leeds breakdown in service.

Mrs Rushbrook stated that North Lincolnshire and Goole Trust had been targeted by a cyber-attack involving ransom ware which had got through a hole in their fire wall over a weekend.

Mrs Rushbrook stressed that all organisations were in danger of being attacked and that the Trust was looking at prevention. She stated that this is difficult with the number of services we provide to other Trusts, (circa 8600), provision over 22 sites, 18,000 ports of entry, 6000 PCs and approximately 500,000 emails being sent and received. She noted that approximately 4,000 of those emails would be infected and 10,000 spam emails blocked. Additionally medical devices are now being added to the network which adds another level of vulnerability. Mrs Rushbrook stated that she is working with our infrastructure suppliers to protect the network, but she stressed that if an attack occurs the system will be shut down without discussion to protect the overall integrity of the system.

Action: Mrs Rushbrook to provide a presentation on cyber-attacks in January 2017

Delays in Treatment - Ms Raper raised whether the delays in treating patients, which includes patients with a high BMI and those that smoke, that Vale of York CCG are putting in place will have an impact on the Trust. Mr Taylor stated that the same guidance has been issued as had been previously issued and support has been received from 10 Downing Street. It is clear that the delay is designed to meet financial objectives, but there is also a clear public health message being sent out. He also noted that there is an ever increasing list of exceptions coming through. Mr Proctor thought the main impact would be on orthopaedics.

Board Assurance Framework – Ms Symington took the Board through the BAF risks to ensure they had been adequately covered especially the red risks.

December Scarborough Strategy Poster Day – Ms Symington noted that this was the same day as the Board meeting which was due to be held in York. It was agreed that the meeting would be moved to Scarborough to enable the Board to attend some of the strategy event.

Action list from the minutes of the 30 November 2016

Minute number	Action	Responsible office	Due date
16/163	Presentation to the Board on cyber attacks	Mrs Rushbrook	January 2017
16/158	ED and community developments update in 6 months.	Mrs Walters Mrs Scott	June 2017

Outstanding actions from previous minutes

Minute number and month	Action	Responsible officer	Due date

16/137	Action dates need to be specific	Mrs Provins	immediate
16/140	Mr Taylor to include the antibiotic usage monitoring in his next Report.	Mr Taylor	November 2016
16/112	The Board to receive the refreshed Equality and Diversity objectives	Mr Golding	April 2017
15/087 Diverse Workforce	A proposal around investment in training for specialist and middle grade doctors in the future to be presented to the Board when developed	Mr Crowley	When available
16/057 Communications Strategy Update	Present a further update on the Communications strategy at the November Board meeting.	Mrs Brown	November 2016
16/048 Environment and Estates Committee	Programme in a session on health and safety into the Board day	Mrs Provins	January 2017

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 January 2017

Chief Executive's Report

Action requested/recommendation

The Board is asked to note the report.

Summary

This report provides an overview from the Chief Executive.

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

Implications for equality and diversity

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

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

Reference to CQC regulations

There are no references to CQC outcomes.

Progress of report	Board of Directors
Risk	No risk.

Resource implications	No resource implications.
Owner	Patrick Crowley, Chief Executive
Author	Patrick Crowley, Chief Executive
Date of paper	January 2017
Version number	Version 1

Board of Directors – 25 January 2017

Chief Executive's Report

1. Chief Executive's Overview

As is the case up and down the country, our services are increasingly in demand as we enter the winter period with an increase in attendances in our emergency departments and the need to admit an increased number of patients who are acutely unwell. The pressure has been recently compounded by the holiday weekends and the five day closure of many GP practices and other services.

Our winter plans are designed to help us to be resilient during what is always a time of increased pressure. The plans are in place to help us maintain wherever possible the safe and effective delivery of services throughout the winter period. However, with activity at times peaking at unprecedented levels, particularly with regard to the volume and acuity of patients admitted, this has inevitably had an effect on some aspects of our performance. Our delivery of the 18 week standard has been affected as urgent cases are prioritised, although there has been improvement on several cancer access targets, which demonstrates the huge effort going in to continue to deliver for all patients through the winter months.

The busy Christmas period has inevitably had an impact on the emergency care standard and it is important that we continue to make every effort to sustain performance as best we can, to support patient flow and ensure that patients are not delayed unnecessarily.

Reducing demand on our acute bed base has been a priority and our community teams have continued to do a sterling job in managing more patients in the community and especially at home. While we admitted a lot of very ill and often elderly patients to hospital there was also a high attendance of people with non-emergency conditions, and we are working with the Clinical Commissioning Group's(CCG) to reiterate the message that people should think carefully about which services they access.

Linked to this, and following support from Scarborough and Ryedale CCG, the Ryedale Community Response Team (CRT) is in the process of further expanding its service to support the residents of Scarborough and Filey. This is being done in a phased approach. The first phase started in December when Ryedale CRT "stretched" capacity to be able to accept step down referrals from Scarborough Hospital. Phase 2, starting this month, will see the team starting to accept 'step up' referrals from Scarborough and Filey GP practices. Closely linked to this is the work being done to get patients out of hospital in a timelier manner, using the discharge to assess model. There are regular working group meetings with partner agencies to support the processes needed to be able to discharge patients once they are medically optimised.

Whilst our CRT's in York are also exceeding their planned capacity, plans are being worked through to try and expand this further. It is important to note that there has been a bit of 'noise' in relation to the closure of Archways and the impact this may have had on our current pressures in York. However, this is not the case, and our community response team is successfully managing those patients (and more) who would have been admitted to Archways more appropriately in their own home.

I know that everyone has worked extremely hard to keep patients safe and to support each other under pressure, and I want to thank everyone for their continuing efforts.
It is worth noting that in many respects we have been 'spared' some of the worst aspects of winter so far this year, both in terms of the weather and the lower numbers of norovirus cases affecting our bed base and these remain a risk. However, taking this into account, the underlying strain on the system as a whole is a cause for concern and I will be ensuring that the A&E Delivery Board, accountable for managing the Vale of York and Scarborough urgent care system, reviews and refreshes its approach to whole system working and to winter planning in particular in the coming weeks.

International Development

In January we hosted a visit from senior colleagues working at Sunnybrook Health Centre in Toronto. If you recall both the Deputy Chief Executive and myself spent a short time in Toronto with the Sunnybrook management team and senior clinicians in support of the work they have embarked on to develop a Quality and Effectiveness strategy. The party included their Chief Nurse and Director of Finance. We organised a programme around their needs including sessions describing our approaches to: Efficiency, Nurse Staffing, Out of hospital Care, Performance Management, Improvement and utilising data to inform decision making.

Their feedback was incredibly positive particularly about the quality of our staff, they were also envious of our culture and the way clinicians were involved at all levels of decision making. They are keen to maintain links with our organisation and explore further the possibilities of future cooperation including exchange visits. It was gratifying to hear how highly colleagues from another system rated our organisation, our systems and processes and the staff we have working for us.

We continue to explore other international opportunities, some of which are beginning to take shape in China. Our "offer" continues to centre on clinical advisory services, governance support and training and development, reflecting core business that we are comfortable with. Our current approach is to explore these opportunities in collaboration with Northumbria and Gateshead Foundation Trusts, having agreed a memorandum of understanding to support this work, and separately EY who are partners in a consortium currently exploring a significant development opportunity in mainland China. In both arrangements I see our role initially as managing and supporting low risk sub-contracts in order to build experience and expertise in what is essentially a new and unproven venture for this Trust.

The Director of Estates and Facilities is leading, on my behalf, the development of a strategy document to help shape our intent and I will schedule this for a Board of Directors strategy session in due course.

Cervical Screening

The Trust has been responsible for providing the cervical screening service for North Yorkshire and a number of other neighbouring communities for some 16 years. Following a recent procurement exercise the service was lost to another Foundation Trust. We were advised that despite the significant leading quality of York's bid, the Trust has lost the contract on the grounds of cost. The Trust's bid team became concerned about the procurement process and the new provider's ability to deliver the service for the tendered price. The Trust sought to challenge the contract award. I am delighted to report that following this process the other Trust has withdrawn their bid and the contracting authority has awarded the contract to us. This award will see the North Lincolnshire and Goole community added to the current catchment served by the Trust. The Cytology Team are delighted with this outcome and have immediately set about mobilisation of the new

communities in time for delivery from April 2017.

In the news

It will not have escaped anyone's notice that the NHS continues to make the headlines. Local and national coverage of winter pressures has been widespread, and the debate continues as to the ability of health and social care services to cope with increasing demand. NHS Chief Executive Simon Stevens appeared in front of the Commons Public Accounts Committee earlier this month and was vocal in his defence of the NHS, challenging the Government's comments that the NHS has had more funding than it asked for, and that the worst of the pressures are isolated to a small number of places. This further fuelled the debate at a time when the NHS is under intense scrutiny over winter pressures.
Locally we have continued to be asked to provide a commentary on winter pressures, ranging from A&E, to norovirus, to escalation (OPEL) levels, to delayed transfers of care. We are using these opportunities to reinforce our infection prevention messages, and those around thinking twice before going to A&E.

BAF at a glance

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

2. Recommendation

The Board is asked to note the report.

Author	**Patrick Crowley, Chief Executive**
Owner	**Patrick Crowley, Chief Executive**
Date	**January 2017**

York Teaching Hospital NHS
NHS Foundation Trust

Board Assurance Framework – At a glance.

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

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

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 January 2017

Quality & Safety Committee Minutes – 22nd November 2016

Action requested/recommendation

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

Executive Summary

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

Review of Chief Nurse and Medical Directors Risk Registers.

Patient Safety items for this month

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

Clinical Effectiveness items for this month

- Nursing Dashboard
- Internal Audit overview

. Patient Experience items for this month

- Friends and Family
- Patient Advice and Liaison

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

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

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

Implications for equality and diversity

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

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

Reference to CQC regulations

References to CQC outcomes.

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

Progress of report	These minutes have only been submitted for the Board.
Risk	
Resource implications	Resources implication detailed in the report.
Owner	Jennie Adams, Non-Executive Director
Author	Liz Jackson, Patient Safety Project Support Officer
Date of paper	November 2016
Version number	Version 1

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

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

	Agenda Item	Comments	Assurance	Attention to Board
	Last meeting notes dated 18 October August 2016	The minutes of the meeting held on the 18 October 2016 were agreed as a true and accurate record.		
	Matters arising and action log CRR Ref: MD2 & MD8	The Committee reviewed the action log and the matters arising. Item 1 – The Committee discussed the issues in Radiology. JT advised that this is a very complicated work in progress. Recruitment campaigns with possible incentives are being looked in to with HR and advice is being sought around the agenda for change framework. Additional support staff and Consultants are being considered to improve both the out of hours and seven day services with the aim to improve the quality of service across both acute sites. JA advised the Committee that she had observed the area for the new CT scanner during a walk round at Scarborough Hospital and was pleased to note that the funding was available for these necessary changes and preparatory work is due to begin in the new year. Item 2 - The Committee queried if the Internal Audit report around compliance with the Duty of Candour has been published. JT advised that there has been a delay; however, the report has now been signed off and is ready for publication. PA added that this report will go the next Audit Committee before being submitted to the Board in January. JT explained that Internal Audit had found that the Trust is complying with the Duty of Candour in terms of verbal notification and apologies; however there is an issue with demonstration of compliance with written communication to patients. Written letters that can be filed in patient notes are being looked in to. It is clear that further education around the requirements of this legislation is needed. One factor is the subjective nature of what constitutes		JT to update Board on Audit findings around Duty of Candour

	Agenda Item	Comments	Assurance	Attention to Board
		moderate or serious harm. Staff are being advised that if in doubt the duty of candour should be fulfilled, this should always be followed for Never Events and SIs irrespective of the actual level of harm incurred. Items 3 & 5 – The Committee queried if CHKS were able to visit in January to discuss Clinical Effectiveness bench marking in more detail. The Committee also asked if the National Cardiac Arrest Audit which was published in October could be presented in January along with some analysis of any particular learning for our own Trust. **Action: LP agreed to liaise with DP re CHKS** **Action: JT to liaise with DP re National Cardiac Arrest Audit** Item 8 – The Committee queried if a formal set of actions have been agreed following discussions regarding the Acute Medicine senior review at SGH. JT advised that he attended the Senior Physicians meeting at Scarborough Hospital to collaboratively discuss new sustainable ways of delivering out of hours care and, rather disappointingly, no agreement was reached. Other approaches to aiding implementation of these changes to working patterns are now being considered and a job plan review may be invoked. Feedback is yet to be received from the wider senior clinical body regarding the changes required by the Acute Medical Model, the implementation of which is being led by Ed Smith. The Committee noted the inclusion of 2 Emergency Department complaints at SGH involving inappropriate discharge from the department. The committee were assured that decisions to discharge ED patients were still the responsibility of medical staff rather than ACPs. The committee agreed to monitor the impact of the AMM from a safety perspective via patient feedback and other sources. **Action: JT to update at the January Meeting.**		
	CRR Ref: MD2 & MD6			
	CRR Ref: MD3	Item 17 – The Committee queried the date of the Information Governance awareness week. **Action: DP to advise the Committee.** Item 19 - The recruitment of renal dialysis staff was discussed in detail at		

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

	Agenda Item	Comments	Assurance	Attention to Board
		an action plan.		
	Risk Register for the Medical Director and Chief Nurse	The Committee noted that there had been no amendments to the Risk Registers for the Chief Nurse and the Medical Director and queried if the risks on the Medical Directors register could be reworded to be more explicit, with special attention to MD4. JT felt that many of the risk descriptions pre-dated his appointment as MD and that he would be happy to revisit them in order to better capture the specific issues involved. JT will review the register and update the Risk Committee of any alterations. **Action: JT to review Risk Register.**		
	CRR Ref: CN9 & CN10	CN9&10 –BG confirmed that recently there has been an increase in the incidences of self-harm amongst adolescents and seasonal trends have also been identified. Two serious incidents have occurred within the Child Health Directorate involving children who have tried to harm themselves whilst in-patients on our wards. Nursing and Medical Staff express concerns that they do not have the skills to care for these patients and their psychological needs; and the patients need to be deemed 'medically fit' prior to receiving a psychological review from the CAMHS. In addition the CAMHS is limited to in-hours Monday to Friday and have some staffing issues which can impact upon us as patient assessments can be delayed. Whilst we have met with TEWV they believe that further work needs to be undertaken around the commissioning of the Tees Esk and Wear Valley Service, meanwhile further staff training is required in both risk assessment and MH first aid in this area in this area. In the interim we have put in place a plan that all patients who self-harm receive 1:1 care until TEWV have a full service. The committee felt this situation was putting young patients and the Trust at considerable risk and thought that it warranted a wider Board discussion to explore options.		BG to raise at Board.
	CRR Ref: MD1	MD1 – The Committee discussed the number of medicines administration, dispensing and prescription errors that featured in the integrated dashboard, these ranged between insulin errors, missed medication and	The committee were assured by the detailed level of ward by ward data available	

	Agenda Item	Comments	Assurance	Attention to Board
		outpatient dispensing. JT agreed to look in to this further. MS added that no themes or trends have been identified through investigation of these incidents. BG explained that a Nursing Medicines Management Group has been developed alongside the MDT Medicines Committee. Incidents are brought for discussion so that issues can be understood. Individual interventions or ward action plans are put in place.	and the attention given to medication errors by the senior nurse for medicines management.	
	Patient Safety			
	Nurse Staffing CRR Ref: CN2	BG advised the Committee that the newly qualified registered nurses have now commenced in post along with some return to practice individuals. More than 70 have attended induction and the preceptorship programme is in place. The recruitment fairs have had a positive impact and the possibility of exchange nurses from India is being discussed with NHS England and Health Education England next week. The Trust has been identified as a 'fast follower' in regard to the Associate Nursing Role. The committee noted the reduction in actual vacancy levels for RNs on both acute sites following the latest round of recruitment. A response around the use of the care hours per patient day data and the regulation of the nurse associate role is awaited from the England Chief Nursing Officer. Senior nurse leaders have admitted that there is more work to be done before real value can be had from collection of this data. The Committee queried if the relaxing of visiting hours has had any impact on patients being nursed by their visitors. BG explained that Johns Campaign has come in to place as the family had wanted to nurse this patient. This needs to be reviewed on a case by case basis. The AMUs on each site have the same acuity but there are very different CHPPD levels on each. BG advised that an Acuity and Dependency audit is imminent and will be led by Becky Hoskins who has identified ED and AMU as priority areas for a deep dive review.	The Committee were assured by the continued focus in this area and the positive steps that have been taken.	BG to update Board

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

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

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

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

Quality & Safety Committee – Action Plan – November 2016

No.	Month	Action	Responsible Officer	Due date	Completed
1	Sept 2016	To provide an update on the options being looked at with	Medical Director	Nov 16 – moved to	

		regard to the new radiology risk – Discussion at Sept Board. Board walkround of Radiology being organised by LP.		Jan 17	
2	Sept 2016	The Committee Requested feedback from the internal audit of Duty of Candour. Nov 16 – The final report will be reviewed by the Dec Audit Committee and to Q & S in Jan 17.	Medical Director (Health Care Governance)	Nov 16 – moved to Jan 17	
3	Sept 2016	To invite Glenn Miller, Clinical Effectiveness Chair.	Foundation Trust Secretary	Nov 16 – moved to Jan 17	
4	Sept 2016	Committee to receive additional assurance from mortality review group.	Deputy Director of Patient Safety	Jan 17	
5	Aug 2016	To invite a representative from CHKS to talk the Committee through the system.	Deputy Director for Patient Safety	Nov 16– moved to Jan 17	
6	Aug 2016	To discuss with the Deputy Director of Healthcare Governance a simple system to flag concerns with National Audits - DP noted that the Clinical Effectiveness Committee is being reviewed which should incorporate this action.	Deputy Director for Patient Safety	Nov 16– moved to Jan 17	
8	Jun 2016	Outcome of discussions with CD for Medicine and action plan (time out 27.09.16) – The Committee to request sight of the action plan.	Foundation Trust Secretary	Nov 16– moved to Jan 17	
14	Jul 2016	Review the Critical Care Action Plan at the end of the year	Medical Director	Dec 2016 – moved to Jan 17	
16	Jul 2016	Annual National Cardiac Arrest Audit with trends and benchmarks to be presented when published.	Deputy Director for Patient Safety	Nov 16– moved to Jan 17	
17	Oct 2016	MD2 – Risk Register DP to check on whether the date was correct for the Information Governance awareness week.	Deputy Director for Patient Safety	Nov 16	
21	Oct 2016	Night Owl Initiative update following receipt of the National Inpatient Survey.	Deputy Chief Nurse	Following receipt of National Inpatient Survey – May 2017	
23	Oct 2016	Patient Experience Volunteer findings to be reported	Deputy Chief Nurse	March 2017	

		back to the Committee.			
24	Oct 2016	SI backlog to be brought to the next meeting.	Deputy Director for Patient Safety	Nov 16– moved to Jan 17	
25	Oct 2016	DP to provide further information on the trial of paper incident forms in the next Medical Director's Report.	Deputy Director for Patient Safety	Nov 16– moved to Jan 17	
26	Nov 2016	JT to review the wording of the risks included on the MD Risk Register.	Medical Director	Jan 17	
27	Nov 2016	Review the number of medicines administration errors to identify themes.	Medical Director	Jan 17	
29	Nov 2016	High level governance overview of SI numbers.	Medical Director	To be provided on a 6 monthly basis	

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 January 2017

Quality and Safety Minutes – 17 January 2017

Action requested/recommendation

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

Executive Summary

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

Review of Chief Nurse and Medical Directors Risk Registers.

Patient Safety items for this month

- Nurse Staffing
- Infection Prevention
- Maternity Services
- Serious incidents

Clinical Effectiveness items for this month

- Electronic Prescribing Medicines Administration (EPMA)
- National / Local Safety Standards for Invasive Procedures (Nat/LocSSIPs)
- National Cardiac Arrest Audit
- 7 Day services in hospitals: clinical standards

Patient Experience items for this month

- Patient Experience Quarterly Report

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

1. Assurance on measures to protect patients from harm at times of high operational pressures
2. An update on the Maternity Service
3. The work of the Patient Experience team
4. Actions from the audit of Duty of Candour compliance
5. An update on Mortality review process and quarterly mortality report.

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

Implications for equality and diversity

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

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

Reference to CQC regulations

References to CQC outcomes.

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

Progress of report	These minutes have only been submitted for the Board.
Risk	
Resource implications	Resources implication detailed in the report.
Owner	Jennie Adams, Non-Executive Director
Author	Liz Jackson, Patient Safety Project Support Officer
Date of paper	January 2017
Version number	Version 1

Quality & Safety Committee – 17th January 2017 Boardroom, York Hospital

Attendance: Jennie Adams, Philip Ashton, Libby Raper, James Taylor, Beverley Geary, Diane Palmer, Lynda Provins, Liz Jackson

CHKS presentation attendees: Janet Heaton, Donald Richardson, Sue Rushbrook

	Agenda Item	Comments	Assurance	Attention to Board
	Last meeting notes dated 22 November 2016	The minutes of the meeting held on the 22 November 2016 were agreed as a true and accurate record, following the update of the Mental Health information made prior to the meeting.		
	CHKS Discussion	The Committee felt that the agenda can be very safety dominated and wish to have a more robust process for gaining assurance around clinical effectiveness, to ensure that the treatments provided are appropriate and effective. Janet Heaton from CHKS attended the Committee to explain what they can provide. CHKS work closely with the Trust Performance Information Team who all have access to an online tool. JH led the Committee through the high level patient safety and quality indicators that can be accessed and compared to peer organisations. The Trust have a low incidence of misadventure (a range of harm events) compared to the peers. SR explained to the Committee that some CHKS data is included in the Board reports and is also used for data quality and benchmarking, as well as informing the accuracy of coding. DR advised that he found funnel plots more revealing than the traffic light system and can inform if the trust is a performance outlier or within normal variation. In his view the traffic light system can provide false assurance in some cases and raise unnecessary concern when sample sizes were very small.. The Committee agreed that it would like to be able to benchmark clinical outcomes and compliance with best practise more effectively and suggested that this information may not be the focus of CHKS but rather		

	Agenda Item	Comments	Assurance	Attention to Board
		need to come from national audits and databases held by the royal colleges etc. The Committee would like to review Clinical effectiveness more regularly and requested that the MD liaise with Glenn Miller, lead for the Clinical Effectiveness Group to explore a few possible sources of assurance on clinical effectiveness to present to the committee in due course.		
	Matters arising and action log CRR Ref: MD2 & MD8	The Committee reviewed the action log and the matters arising. Item 1 – JT advised the Committee that there are a series of planned changes with regard to the current risk in Radiology on the Scarborough site and the inability to recruit. From February the out of hours radiology on call will go to an outsourced service, which will leave more resource to run an improved seven day service. Unfortunately the Trust has been unable to recruit further CT Radiographers, with support from Human Resources the possibility of incentivising these positions is being looked in to alongside the policy and procedures for Agenda for Change staff. Item 2 – The Committee queried if there was an action plan in place following the final report from the internal audit of Duty of Candour (DoC). DP confirmed that the report had been presented to the Audit Committee; JT added that there is an action plan in place, some of which is already in progress. DoC will be added to the Consultant statutory and mandatory training and DP and Glenn Miller are looking for a suitable programme. The issue has been discussed at Exec Board to raise awareness and Patrick Crowley will send an information letter to the Trust staff from the Board of Directors. **Action: JT to feedback progress of the action plan at the February meeting.** **Action: LP to pick up other limited assurance audits with the Executive Directors.** Item 3 – Glenn Miller was unable to attend this meeting due to other commitments. **Action: JT to invite GM to February meeting to discuss Clinical**		JT to update Board on DoC audit actions - to date and planned

	Agenda Item	Comments	Assurance	Attention to Board
		Effectiveness.		
	CRR Ref: MD4	Item 4 – The Committee queried if the themed Mortality Report that is presented at Patient Safety Group could be shared with the Committee members. JT advised the Committee that there has been progress with the Mortality Review process and proformas and training has taken place with further sessions scheduled. **Action: DP to circulate Mortality Review report to Committee members.** **Action: DP to include Mortality progress in the quarterly report from the Patient Safety Group.**	The Committee took assurance from the focussed work in this area.	JT to highlight ongoing work in this area and any key findings from the latest report
	CRR Ref: MD2	Item 8 – JT advised the Committee that there has been further progress made in General Medicine on the Scarborough site. Agreement has been made to move to a shift system rota; however the detail is still to be discussed.		
	CRR Ref: MD2, MD4 &MD7	Item 14 – Steady progress is being made with the Critical Care Action plan following the CQC inspection. The additional bed on each site is 80% open. The Trust has been unsuccessful in recruiting additional Intensivists and General Anaesthetists to the Scarborough site. The ICU rota will be changed to a 1:8 with support from the Intensivists from the York site. The plan was to change the general anaesthetic rota to a 1:8 however this would have a significant impact in York if they were to support this. The recruitment of a clinical educator is part of a large business case which is currently going through the approval process.		
	CRR Ref: MD3	Item 17 – DP advised the Committee that the Information Governance Awareness day is scheduled to take place on the 16th February 2017.		
	CRR Ref: MD1	Item 27 – The Committee queried the pharmacy medicines errors, JT confirmed the Ed Smith is reviewing the detail of these errors; however the errors in question were from the externally sourced pharmacy in the main reception at York and not the Hospital Pharmacy. David Pitkin, Chief Pharmacist, has investigated these issues and advised that this pharmacy		

	Agenda Item	Comments	Assurance	Attention to Board
		will soon be replaced by Lloyds Pharmacy. BG confirmed that it is the Hospital Pharmacy that organise TTOs not the outsourced pharmacy. The remainder of the actions on the log are part of the agenda items. Operational Pressures The Committee queried the quality and safety impact of the current operational pressures. BG explained that there is a bespoke COMFE tool for use in the Emergency Departments on both sites, apologies are given to all patients experiencing long waits in the department, these patients are followed up when on the admitting wards and all discussions are documented in the patient notes. Patient feedback has been positive due to their recognition of the current pressures. A number of escalation areas have been opened leading to high usage of agency staff. Johnson Ward at Bridlington has been opened to full capacity. Surgical Assessment Units on both sites have been staffed by additional medical staff on weekends to enable swift discharge of patients. A full capacity protocol has been initiated by the senior clinician in the Scarborough Emergency Department in exceptional circumstances (twice to date); patients were moved from the Emergency Department to Ward areas whilst remaining on trolleys. Full assessments are put in place. JT and BG are working together to develop strict criteria for this protocol which can only be led by the senior clinician. Two potential safety incidents are currently under investigation, one patient who arrested in the Emergency Medicine cubical and the delayed treatment of a stroke patient. The Emergency Department are mindful that the ambulance flow is not being managed, which is due to the patient flow throughout the hospitals. The Safer bundles initiative has seen a reduction in length of stay. Data from the winter plan is still being analysed, acuity has increased, as has demand. The winter pressures commenced earlier than previous years and there was no access to primary care for a week over Christmas. The Stranded Patient Initiative has been introduced which records patients with a length of stay of 7 days or more. ~~Unfortunately~~ This includes Ward		BG/JT to provide nursing and medical perspectiv e of winter pressures at Board.

	Agenda Item	Comments	Assurance	Attention to Board
		37 and White Cross Court which highlights the social care issues. The Committee queried if there had been any impact from the cancellation of life saving surgeries. JT explained that the Royal College of Surgeons are collating figures. The Trust figures have not been collected as yet; however surgeries may have been cancelled when no high dependency/ICU beds were available.		
	Risk Register for the Medical Director and Chief Nurse	The Committee noted that there were no changes to the Corporate Risk Registers. JT explained that he is meeting with the Deputy Director of Healthcare Governance next week to review the Medical Director Risk Register in order to present the MD risks in his own format.		
	Patient Safety			
	Nurse Staffing CRR Ref: CN2	The Committee noted the improved percentage RN fill rates reported in the Chief Nurse report. BG advised that October and November saw a significant number of new registrants commencing in post. There are still some gaps in hard to recruit to areas and an increase in agency spend will be seen over the winter period. There is no further update on the recruitment initiative for nurses from India. Health Education England are aware that the Trust wish to be a part of this initiative and figures are awaited. The Associate Nurse role will be piloted in March and there has been a lot of interest. Becky Hoskins has visited the pilot site and the Trust is ahead in terms of arrangement of assessment centres and interview dates. Regular one to ones are held with Health Education England. The Ward reconfiguration has taken place and the acute assessment unit has opened. The staffing model has improved the time in which patients can be treated and discharged. The staffing model on AMU has been reviewed. A Senior Nurse role has been advertised who will lead the staff on AMU, AMU and the AAU.	The Committee took assurance from the attention given to this issue and the progress made.	
	Infection Prevention	The Committee felt that the DIPC quarterly report was very positive considering the current operational pressures.	The committee were assured by the work of the IPC	

	Agenda Item	Comments	Assurance	Attention to Board
	CRR Ref: CN7 & CN8	BG advised that, following investigation, 11 of the 13 cases of Clostridium Difficile reported in quarter 3 showed no lapses in care. 7 cases of MRSA have been reported; however the Trust has seen a significant increase in screening and the positive patients have been acutely ill with multiple lines in situ, this has also led to an increase in MSSA. The investigations into the Gastro CPE and SCBU MRSA incidents have now been closed and action plans are in place. There has been an outbreak of influenza A in the Trust and there have been some very sick patients. 6 areas have been cohorted. The Committee queried if action plans from previous outbreaks had led to noro-virus being less prominent this year. BG advised that there has been an overall change in behaviour. Social Care workers have been educated and are now able to visit closed wards. Work has been undertaken with the Commissioners to ensure that infected patients do not come into hospital if at all possible. There had also previously been issues in areas of over occupancy. The Infection Prevention and Control Team have been working closely with ward areas and the additional bed is no longer in place on Oak ward – a previous hot spot. BG explained that the external auditor had found that there was an absence of data to evidence good governance around water safety e.g. the running of taps. Water safety is part of the Estates and Facilities portfolio and will be discussed in detail at the Environment and Estates Committee. BG advised that there had been no further incidents of surgical site infections reporting in Bridlington and explained that an external review is scheduled to take place in February.	team and the current low rates of infection in some of the key hospital acquired infections.	
	Maternity Services	The Committee focussed its attention on the Maternity Services Annual Report which was an excellent report and contained many positive aspects and identified actions from investigations. The Committee recognised that there is still some work to do but congratulated the Directorate on the fantastic work undertaken.	The Committee were assured by the positive improvements in this area.	BG to highlight progress made at Board.

	Agenda Item	Comments	Assurance	Attention to Board
		BG explained that there has been an increase in the acuity of women and the mental health needs of those using the Maternity Services. Practical steps are being taken and problems are being addressed. Reporting has improved and learning is being fed back. The directorate are supported by CNST and have risk midwives in place. Liz Ross, Head of Midwifery, has challenged culture and supported staff in making necessary changes.		
	Serious incidents	The Committee were encouraged by the inclusion of more recent SIs in the Medical Directors report. DP advised that the backlog will now be included in a separate overview report so that more up to date learning can be included in the Committee papers. Training is now taking place around the new Serious Incident investigation procedure, with additional training being offered to Nursing staff in the community. The Committee reviewed the NLRS data and noted that the Trust is still a relatively low reporter in relation to its peers. DP advised that the Trust is aiming to increase its overall number of incident reports by 10%, which is currently being achieved. There has been an increase in the number of Medical Staff reporting incidents and the Compliance Team have visited high reporting Trusts in an effort to learn from best practice.. A user group has been established who are reviewing the DATIX form and how incidents are reported and another group is reviewing the feedback and learning process. Incident reports will continue to be monitored and learning shared. JT advised that there is still some work to be undertaken around a no blame culture.	The Committee were assured by the impending roll out of the new SI procedure and look forward to seeing the benefits of this work.	
	Clinical Effectiveness			
	Electronic Prescribing Medicines Administration (EPMA) CRR Ref: MD1	The Committee welcomed the very detailed plan for the EPMA roll out and queried if the Trust was on track for implementation. JT advised that work is on-going and the pilot is going well. The roll out of EPMA should have a positive impact on many patient safety and quality issues.	The committee were assured by the progress to date and the detailed implementation plan.	
	National / Local Safety	JT advised the Committee that this initiative would bring something similar		JT to

	Agenda Item	Comments	Assurance	Attention to Board
	Standards for Invasive Procedures (Nat/LocSSIPs)	to the WHO Surgical Safety Checklist into force across all areas where invasive procedures are undertaken, with the aim of achieving consistency and standardisation across the organisation – and thereby reduce the chances of repetition of recent Never Events in outpatient environments.		highlight at Board
	National Cardiac Arrest Audit	The Committee reviewed the high level cardiac arrest audit data for York Hospital and noted that, as part of the benchmarking data, the hospital was slightly under average in the number of reported in-hospital cardiac arrests. JT explained that the Trust are dealing with quite small numbers and detail is also needed as to whether the arrest was avoidable or not. DP advised that the audit and action plan are monitored in detail by the Deteriorating Patient Group and some of the actions form part of the DNACPR Group agenda. **Action: DP to provide overview of Scarborough report to February meeting.** **Action: Executive Summary and Action plans from annual report to come to June meeting.**		
	7 Day services in hospitals: clinical standards	The Committee queried if 100% of patients were receiving twice daily consultant visits on a weekend as shown in the data. DP advised that there are certain parameters for the audit which leads to the inclusion of only a small cohort of patients. The standards are currently being changed and the system will be reviewed once the new standard comes in to place. It was previously advised that the information would be published on the NHS choices website; however, this is not yet available. **Action: DP to provide a review at the march meeting.**		
	Patient Experience			
	Patient Experience Quarterly Report	The Committee noted the encouraging information included in the Patient Experience Quarterly Report and congratulated the team on the work undertaken. The Committee queried if the Trust were compliant with the accessible information standard of the Partially Sighted Society. BG agreed to check the standard and feedback to the Committee. **Action: BG to look in to further.**	The committee were assured by the increasingly robust approach to collecting, and learning from, patient feedback and progress within	BG to update Board

	Agenda Item	Comments	Assurance	Attention to Board
		The 1.79% FFT response rate for community services is correct, however we had 5198 contacts last month, some of these will be multiple visits to patients (insulin administration for example can be 2 or 3 times per day) due to this NHSE don't use 'response rates' as an indicator for Community services. Hester will contact the writer of the Patient Experience part of the board pack to work together to make sure the information is valid. The Committee drew its attention to the 1.79% Community Friends and Family response rate included on page 11 of the Performance Report. BG agreed to look in to this further. **Action: BG to look in to further.** *This was a proactive approach by the team to work with this group who have historically had accessibility issues. There is an 'Accessible Information Standard' which is being managed via the fairness forum and looks at all aspects of accessibility.* The Committee noted the inclusion of the themes identified from complaints and were please that these topics were already the focus of the Committees discussions. BG advised that the Complaints Policy has been amended which will reduce the time it takes to respond. Complaints around experience will be dealt with by the Matron and those around treatments and procedures will go to the Directorate Managers. Complaints will be completed by the investigating officer and then checked by the Matron, Directorate Manager and the Chief Nurse Team. The Committee welcomed the structured approach to recording compliments and shared BGs concerns that the Trust do not capture these well. The Committee queried if the national 'Helpforce' initiative would impact on the volunteer initiatives already in place. BG explained that the Trust will need to understand what they will gain from this initiative and will be mindful not to destabilise the successes that are already in place. BG advised the Committee that the new visiting times have been received	the volunteering team.	

	Agenda Item	Comments	Assurance	Attention to Board
		well across the organisation with the exception of the Elderly Medicine Directorate in York. This area was included in the pilot 18 months ago and further work will be undertaken with them.		
	Additional Items			
	Patient Safety Walk Rounds	The Committee showed some concern that there were not always Executive Directors on the Patient Safety Walk Rounds. DP advised that the team will try to ensure that there is always an Executive-Director present; however due to the volume of walk rounds arranged it is not possible to always have one.		
	Mortality in Emergency Medicine	The Committee discussed the increase in mortality in Emergency Medicine. BG advised that every death in this area is reviewed and a lot of patients have been brought in no longer alive. This has raised concern around end of life care in the community.		
	Out of Hours ward transfers	The Committee noted that the number ward transfers out of hours, 10pm to 6am, are now within the contractual threshold.		
	Risk Register Round up	CN6 - Safeguarding was discussed in detail at the November meeting. CN9 & CN10 – Mental Health provision was discussed in detail at the November meeting.		
	Next meeting of the Quality and Safety Committee: 14th February 2017 Boardroom, York Hospital at 1.30pm.			

Quality & Safety Committee – Action Plan – January 2016

No.	Month	Action	Responsible Officer	Due date	Completed
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3	Sept 2016	To invite Glenn Miller, Clinical Effectiveness Chair. Nov 16 – moved to Jan 17 Jan 17 – GM unable to attend	Foundation Trust Secretary	Feb 17	
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21	Oct 2016	Night Owl Initiative update following receipt of the National Inpatient Survey.	Deputy Chief Nurse	Following receipt of National Inpatient Survey – May 2017	
23	Oct 2016	Patient Experience Volunteer findings to be reported back to the Committee	Deputy Chief Nurse	March 2017	
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26	Nov 2016	JT to review the wording of the risks included on the MD Risk Register.	Medical Director	Feb 17	
29	Nov 2016	High level governance overview of SI numbers	Medical Director	To be provided on a 6 monthly basis	

30	Jan 2017	7 Day services in hospitals: clinical standards DP to provide review paper	Deputy Director for Patient Safety	Mar 17	

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Patient Safety and Quality Performance Report

January 2017

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

Patient Safety & Quality Performance Report

Chapter Index

Chapter	Sub-Section
Quality & Safety	Quality & Safety Chapter Index
	Quality & Safety Index
	Quality & Safety Summary
	Litigation
	Patient Experience
	Care of the deteriorating patient
	Measures of harm
	Never Events
	Drug Administration
	Safety Thermometer
	Mortality
	Patient Safety Walkrounds
	Maternity Dashboards
	Community Hospitals Summary
	Quality and Safety Miscellaneous

Quality and Safety Summary: Trust

Patient Experience	Target/ Threshold 2016/17	Monthly Target/ Threshold	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Litigation - Clinical Claims Settled	-	-	5	1	2	3	6	2	5	9	5	1	8	2
Complaints	-	-	25	40	46	36	30	33	33	50	44	36	37	33

Care of the Deteriorating Patient	Target/ Threshold 2016/17	Monthly Target/ Threshold	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
12 hour Post Take - York	85%	85%	85%	85%	87%	90%	84%	87%	84%	84%	82%	82%	85%	87%
12 hour Post Take - Scarborough	80%	80%	55%	53%	64%	63%	60%	58%	58%	52%	52%	53%	61%	60%
14 hour Post Take - Trust	100%	100%	81%	80%	86%	86%	83%	84%	82%	80%	79%	80%	84%	83%
Acute Admissions seen within 4 hours	80%	80%	84%	85%	84%	87%	83%	81%	87%	80%	74%	77%	81%	88%
NEWS within 1 hour of prescribed time	90%	90%	87.2%	85.6%	85.2%	86.8%	87.6%	87.1%	87.7%	87.8%	88.1%	87.8%	87.9%	87.1%
All Elective patients to have an Expected Discharge Date (EDD) recorded within 24 hours of admission	Q1 91% Q2 91% Q3 93% Q4 93%	93%	88%	93%	94%	89%	87%	86%	88%	88%	88%	88%	88%	85%

Measures of Harm	Target/ Threshold 2016/17	Monthly Target/ Threshold	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Serious Incidents	-	-	11	27	21	17	12	31	15	17	12	9	18	14
Incidents Reported	-	-	1313	1370	1313	1281	1196	1229	1253	1252	1058	1169	1196	1182
Incidents Awaiting Sign Off	-	-	1344	1389	1348	987	780	724	686	763	813	752	670	768
Patient Falls	-	-	314	315	274	273	236	255	225	218	194	226	213	258
Pressure Ulcers - Newly Developed	-	-	61	69	86	69	73	62	56	65	96	123	126	122
Pressure Ulcers - Transferred into our care	-	-	145	132	126	125	116	123	150	109	62	64	65	70
Degree of harm: serious or death	-	-	8	7	7	7	4	11	10	12	11	5	5	4
Degree of harm: medication related	-	-	105	97	132	129	118	107	143	144	112	138	147	148
VTE risk assessments	95%	95%	98.2%	98.4%	98.5%	98.6%	98.9%	98.7%	98.6%	98.3%	98.5%	98.7%	98.3%	98.3%
Never Events	0	0	0	1	0	1	0	1	1	1	0	0	0	0

Drug Administration	Target/ Threshold 2016/17	Monthly Target/ Threshold	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Insulin Errors	-	-	6	6	16	7	9	10	9	10	9	13	9	8
Omitted Critical Medicines	-	-	16	17	11	19	13	12	8	15	17	15	17	18
Prescribing Errors	-	-	21	24	27	26	28	25	35	42	32	30	26	22
Preparation and Dispensing Errors	-	-	17	10	10	15	13	13	12	14	10	23	37	24
Administrating and Supply Errors	-	-	45	39	68	60	57	46	64	56	41	59	48	54

Safety Thermometer	Target/ Threshold 2016/17	Monthly Target/ Threshold	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
% Harm Free Care - York	-	-	96.7%	96.3%	96.4%	95.3%	97.5%	95.6%	95.1%	97.1%	96.7%	96.5%	96.8%	96.9%
% Harm Free Care - Scarborough	-	-	93.3%	95.5%	91.7%	93.3%	95.6%	94.5%	94.1%	91.2%	90.9%	93.2%	92.6%	94.2%
% Harm Free Care - Community	-	-	83.3%	88.1%	92.1%	93.1%	90.5%	91.2%	83.6%	93.5%	92.3%	91.0%	88.1%	87.9%
% Harm Free Care - District Nurses	-	-	94.2%	97.8%	95.0%	97.7%	93.8%	96.5%	96.3%	95.4%	95.6%	95.4%	96.1%	95.4%

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

Infection Prevention	Target/ Threshold 2016/17	Monthly Target/ Threshold	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Clostridium Difficile - meeting the C.Diff objective	48 (year)	48 (year)	7	5	3	3	1	3	3	2	1	3	2	8
Clostridium Difficile -meeting the C.Diff objective - cumulative	48 (year)	48 (year)	57	62	65	3	4	7	10	12	13	16	18	26
MRSA - meeting the MRSA objective	0	0	1	1	0	1	0	1	0	2	0	2	0	1
MSSA	30 (year)	30 (year)	2	2	3	9	2	2	2	5	0	8	4	5
MSSA - cumulative	30 (year)	30 (year)	32	34	37	9	11	13	15	20	20	28	32	37
ECOLI			11	15	7	5	5	7	8	14	10	4	5	5
ECOLI - cumulative			74	89	96	5	10	17	25	39	49	53	58	63
MRSA Screening - Elective	95%	95%	78.2%	69.2%	74.1%	82.9%	84.5%	85.8%	89.9%	83.7%	85.0%	89.9%	86.4%	84.0%
MRSA Screening - Non Elective	95%	95%	75.6%	73.9%	75.6%	82.2%	83.6%	86.3%	86.6%	86.7%	86.4%	86.0%	85.8%	83.9%

Stroke (one month behind due to coding)	Target/ Threshold 2016/17	Monthly Target/ Threshold	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Proportion of patients spending >90% on their time on stroke unit	80%	80%	88.2%	86.9%	82.4%	84.9%	92.1%	85.2%	82.9%	88.3%	93.6%	90.6%	87.1%	1 month behind
Proportion of patients who experience a TIA who are assessed & treated within 24 hrs	75%	75%	87.5%	85.7%	100.0%	88.9%	100.0%	68.8%	79.0%	73.7%	n/a	n/a	n/a	1 month behind
Scanned within 1 hour of arrival	50%	50%	82.4%	70.0%	72.2%	73.3%	76.2%	50.0%	60.0%	54.2%	63.6%	75.0%	68.0%	1 month behind
Scanned within 24 hours of hospital arrival	90%	90%	92.6%	95.4%	90.8%	93.4%	94.1%	93.2%	92.9%	93.5%	92.5%	96.5%	96.3%	1 month behind
Proportion of stroke patients with new or previously diagnosed AF who are anti-coagulated on discharge or have a plan in the notes or discharge letter after anti-coagulation	n/a	n/a	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	1 month behind

AMTS	Target/ Threshold 2016/17	Monthly Target/ Threshold	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
AMTS Screening	90.0%	90.0%	94.2%	90.1%	89.7%	92.1%	91.3%	90.4%	92.5%	85.4%	86.5%	91.2%	87.8%	87.8%

Patient Experience

210 PALs contacts were recorded across the Trust in December. As seen in previous months, the majority were related to Communication (24.8%).There were 22 complaints at York, 10 at Scarborough and 1 in Community in December; a total of 332 have been reported year to date.

The Friends & Family Test (FFT) is no longer a CQUIN but forms part of the Trust's Commissioner contracts.
The Trust achieved a 30.56% response rate to the Inpatient FFT in December 2016. A total of 3,014 responses were received from Inpatients across the Trust. The 90% target for the % of respondents recommending the Trust was achieved across all sites.
The Trust achieved a 13.91% response rate to the ED FFT in December (York: 14.62%, Scarborough 11.06%). This is an improvement on the response rate achieved in December 2015 (9.86%). The Trust is yet to achieve the 90% target for the % of respondents recommending the ED departments, the Trust has consistently achieved 70-80% between April and December 2016.
The Trust achieved a 1.79% response rate to the Community FFT in December. This includes a 34.5% response rate achieved by the Community Hospitals alone. The Trust continues to consistently achieve the 90% target for the % of respondents recommending the Trust.
A 40.03% response rate was achieved across the Maternity FFT in December. Maternity postnatal achieved the highest response rate of 49.41% in December. The 90% target for the % of respondents recommending the Trust was achieved across all stages.

Measures of Harm

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

14 Serious Incidents were declared in December (6 x York, 3 x Scarborough & 5 x Community). 7 of the SIs were attributed to 'clinical incident', 2 were attributed to 'slips, trips and falls' and 5 to pressure ulcers. A total of 145 SI's have been declared YTD.

Infection Prevention

1 case of healthcare associated MRSA bacteraemia was identified during December. 7 cases have been identified YTD, 4 at York, 2 at Scarborough and 1 Community.

8 cases of Cdiff were identified in December, this takes the YTD total to 26. The yearly threshold for 2016/17 remains at 48 cases however monthly allocation allows for more cases during the winter months. The Trust is currently within threshold.

5 MSSA cases were identified during December. A total of 37 cases have been identified YTD, the Trust has now breached the yearly threshold of 30.

5 cases of E-Coli were identified during December. A total of 63 cases have been identified YTD.

Quality and Safety - Miscellaneous

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

Cancelled Operations
71 operations were cancelled within 48 hours of the TCI due to lack of beds in December. A total of 220 have been cancelled in Q3, in comparison there were 182 in Q3 of 2015/16.

Cancelled Clinics/Outpatient Appointments
145 clinics were cancelled with less than 14 days notice across the Trust in December; the lowest number reported YTD. 682 outpatient appointments were cancelled for non clinical reasons; 400 at York and 282 at Scarborough.

Ward Transfers between 10pm and 6am
97 ward transfers after 10pm for non clinical reasons were declared in December, this is within the contractual threshold of 100 per month.

AMTS
The Trust failed to achieve the 90% target for AMTS screening in December, performance was 87.8%. The Trust has failed to achieve the target in 4 months of 9 this financial year.

Care of the Deteriorating Patient

The Trust achieved 75.6% in the proportion of Medicine and Elderly patients receiving a senior review within 12 hours of admission in December. This is comparable with November's performance of 75.7%. Scarborough achieved 60% in December, York 87%.

The Trust achieved 87.8% in the proportion of Medicine and Elderly patients seen by a doctor within 4 hours of admission against the 80% target. This is the Trust's best performance in the last 12 months.

The Trust has an internal target of 90% of routine observations being undertaken within 1 hour of the prescribed time. The Trust has continually failed to achieve target throughout 2016/17 and achieved 87.1% in December. Scarborough has consistently achieved the target for the last 8 months; December 91.8%.

Drug Administration

There has been a notable increase in Dispensing errors in October and November at York. Healthcare at Home have recently experienced a high turnover of staff which has contributed to the increase in errors as the service has mostly been delivered by locums. The vacancies are currently being recruited to and a new manager has been appointed. Trust Senior Pharmacy staff are also meeting with the Chief Pharmacist from Healthcare at Home on a weekly basis and they have provided an action plan that includes the review of all policies and processes. Trust Pharmacy staff are in the process of delivering training to their old and new staff to help to improve the situation. December has seen an improvement with the number of dispensing errors reducing to 16, compared to 20 in October and 31 in November.

Mortality

The latest SHMI report indicates the Trust to be in the 'as expected' range. The July 2015 - June 2016 SHMI saw a 1 point decrease for the Trust and Scarborough, and a 1 point increase for York. Trust - 99, York 96 and Scarborough 106.

There were 214 Inpatient deaths across the Trust in December, including 132 at York and 64 at Scarborough.

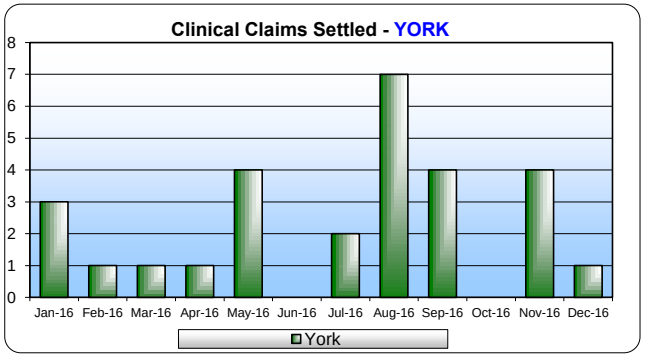
18 ED deaths were reported in December at York and 12 at Scarborough.

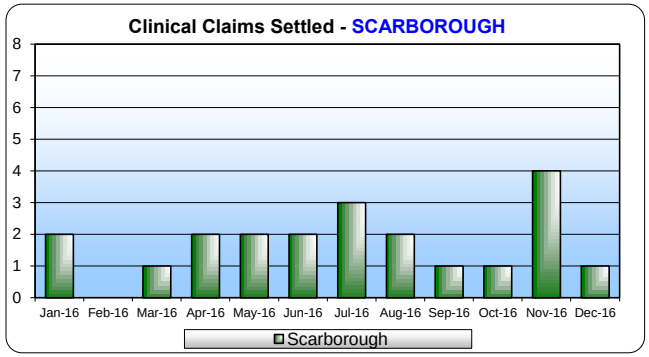
CQUINS update (Operations Team)

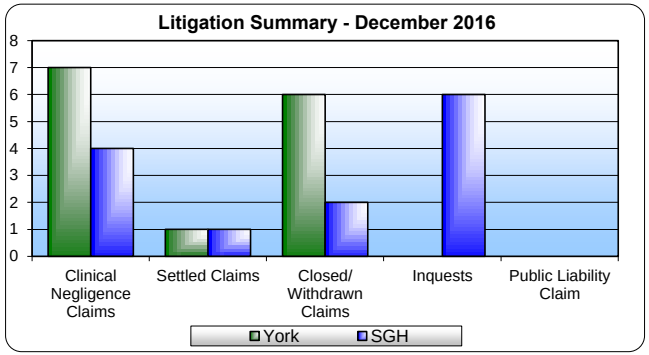
The Trust will receive payment for CQUINS in Q2 in line with predictions: full payment with the exception of Sepsis Screening in ED and Inpatient Treatments, where part payment is currently being negotiated with the CCGs. Partial payment will also be received for Adult Critical Care Timely Discharge,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

Litigation

Indicator	Site	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Clinical Negligence Claims Received	York	9	3	6	8	9	9	4	7	6	7	3	7
	Scarborough	3	9	6	10	7	8	8	3	4	6	11	4
Clinical Claims Settled	York	3	1	1	1	4	0	2	7	4	0	4	1
	Scarborough	2	0	1	2	2	2	3	2	1	1	4	1
Closed/ Withdrawn Claims	York	2	10	5	2	2	5	13	7	6	3	7	6
	Scarborough	1	12	14	0	3	5	4	17	7	7	6	2
Coroners Inquests Heard	York	2	3	1	1	2	2	1	5	5	1	4	0
	Scarborough	4	3	2	6	3	6	3	2	2	2	5	6







Patient Experience

PALS Contacts
There were 210 PALS contacts in December.

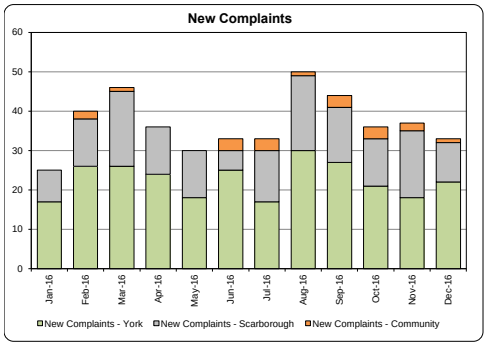
Complaints
There were 33 complaints in December; 22 were attributed to York, 10 to Scarborough and 1 to Community.

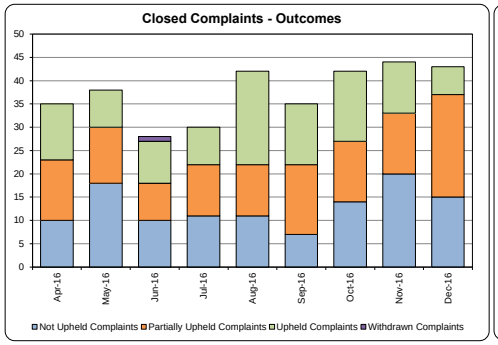
New Ombudsman Cases
There were no New Ombudsman Cases in December.

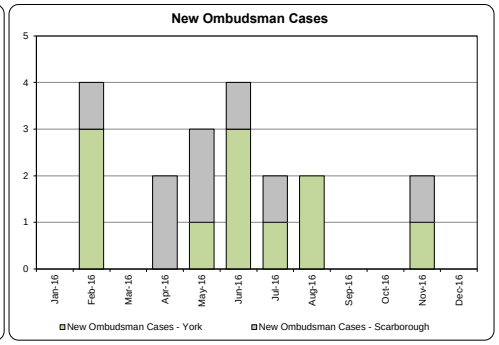
Compliments
41 compliments were received by the Chief Executive in December 2016. This is in addition to the many cards and letters received directly by wards and departments.

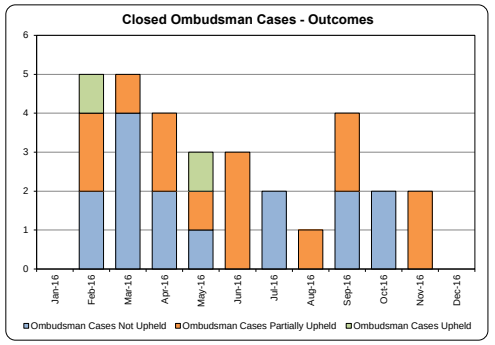
Patient Experience

January 2017



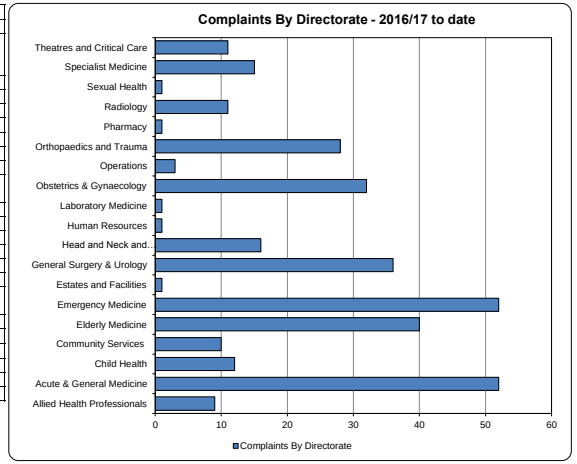






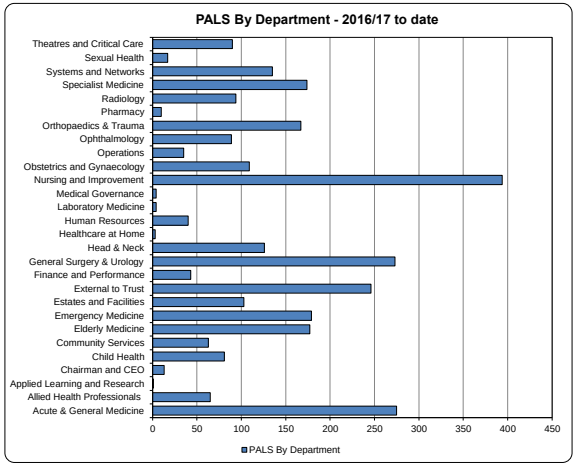
Complaints By Subject	Dec-16	YTD
Access to treatment or drugs	0	20
Admissions, Discharge and Transfer Arrangements	5	87
All aspects of Clinical Treatment	18	273
Appointments, Delay/Cancellation	3	94
Commissioning	0	2
Comms/info to patients (written and oral)	12	188
Complaints Handling	0	0
Consent	1	7
End of Life Care	2	10
Facilities	2	19
Mortuary	0	0
Others	0	0
Patient Care	10	145
Patient Concerns	0	15
Prescribing	3	32
Privacy and Dignity	4	31
Restraint	0	0
Staff Numbers	0	6
Transport	0	7
Trust Admin/Policies/Procedures	9	72
Values and Behaviours (Staff)	13	146
Waiting times	2	21
TOTAL	**84**	**1174**

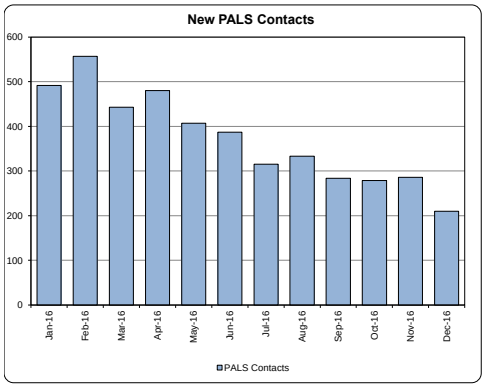
Due to new reporting the number of complaints/PALs contacts by subject is greater than the total number of complaints because each subject within the complaint can be identified as opposed to just the one deemed to be the 'primary'.

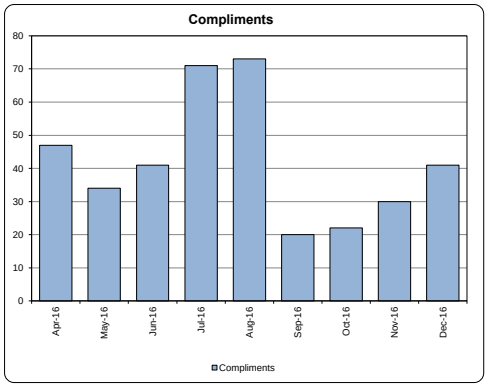


PALS By Subject	Dec-16	YTD
Access to Treatment or Drugs	9	93
Admissions and Discharges (Excluding Delayed Discharge due to absence of care package)	14	101
Appointments	43	289
Clinical Treatment	22	151
Commissioning	0	6
Communication	52	350
Consent	0	1
End of Life Care	1	11
Facilities	0	35
Integrated Care (including Delayed Discharge Due to Absence of a Care Package	0	3
Patient Care	10	92
Patient Concerns	7	60
Prescribing	3	22
Privacy, Dignity & Respect	0	7
Staff Numbers	0	3
Transport	0	21
Trust Admin/Policies/Procedures Inc. pt. record management	19	229
Values and Behaviours (Staff)	17	155
Waiting Times	13	**73**
Total	**210**	**1702**

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

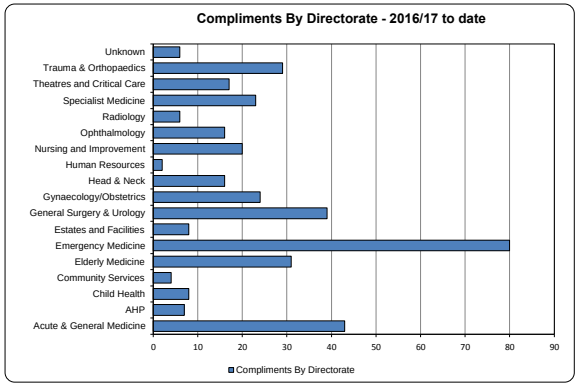






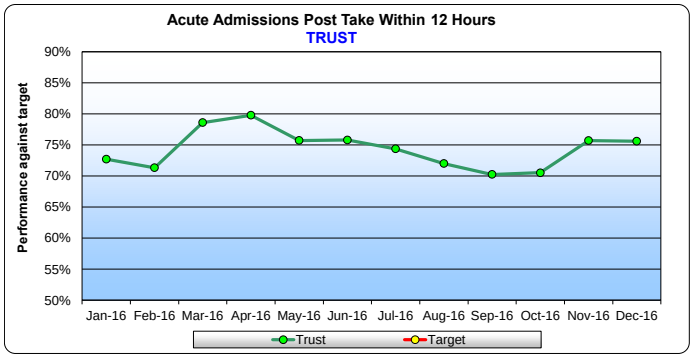
Compliments By Directorate	Dec-16	YTD
Acute & General Medicine	7	43
AHP	0	7
Child Health	1	8
Community Services	0	4
Elderly Medicine	1	31
Emergency Medicine	8	80
Estates and Facilities	1	8
General Surgery & Urology	0	39
Gynaecology/Obstetrics	4	24
Head & Neck	4	16
Human Resources	0	2
Nursing and Improvement	3	20
Ophthalmology	2	16
Radiology	0	6
Specialist Medicine	6	23
Theatres and Critical Care	3	17
Trauma & Orthopaedics	1	29
Unknown	0	6
Total	**41**	**379**

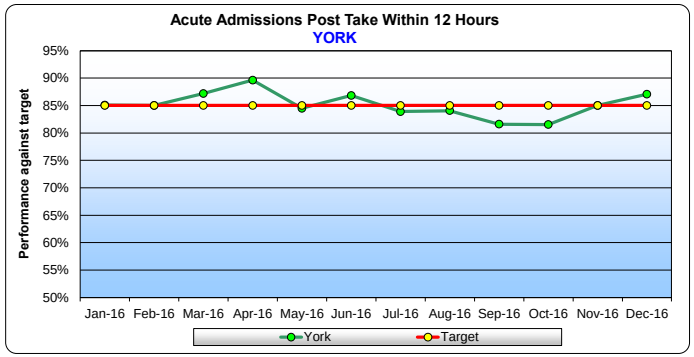
Note re compliment numbers: These include letters received by our Chief Executive and PALS. They are in addition to the large number of cards, letters and in-person thankyous which are received directly by our wards and departments.

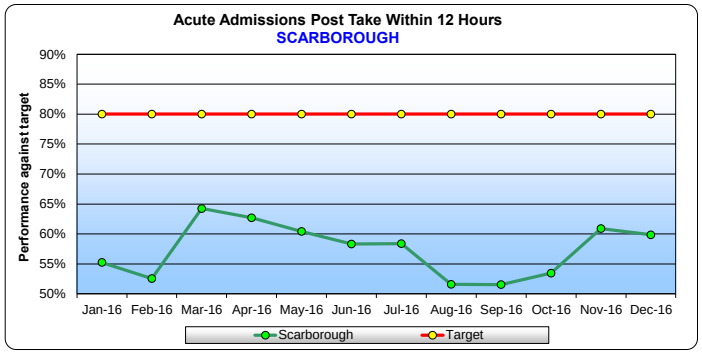


Quality and Safety: Care of the Deteriorating Patient

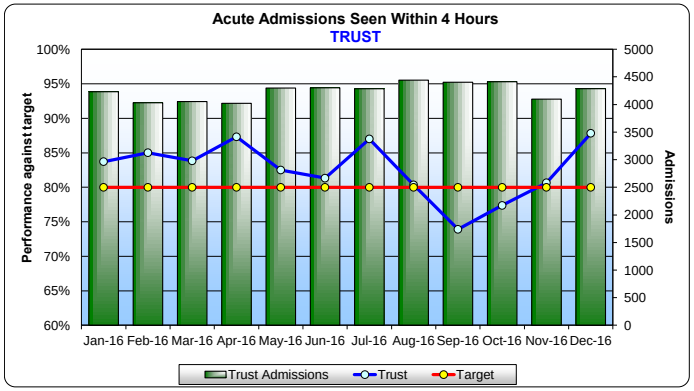
Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Oct	Nov	Dec
Care of the Deteriorating Patient on Acute Medical Assessment Units. Admissions - senior review within 12 hours of arrival (SCARBOROUGH)	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI	80%	57%	60%	54%	58%	53%	61%	60%
Care of the Deteriorating Patient on Acute Medical Assessment Units. Admissions - senior review within 12 hours of arrival (YORK)	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI	85%	85%	87%	83%	84%	82%	85%	87%

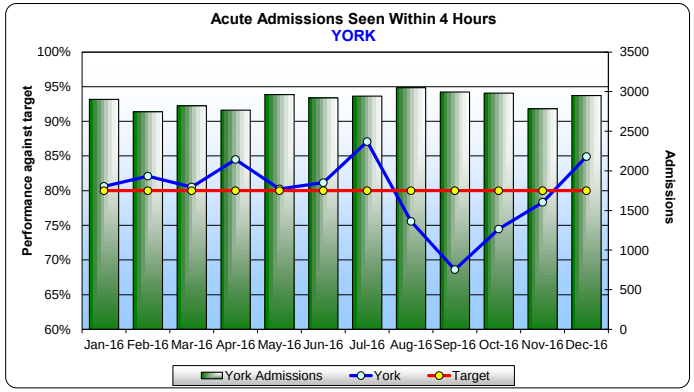


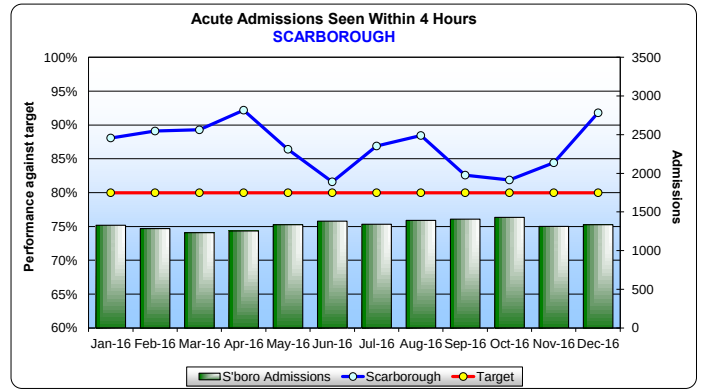




Care of the Deteriorating Patient: All acute medical, elderly medical and orthogeriatric (FNoF) admissions through AMU to be seen by a senior decision maker (registrar or nurse)	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI	**80% by site**	84.0%	83.7%	80.4%	81.7%	77.4%	80.7%	87.8%

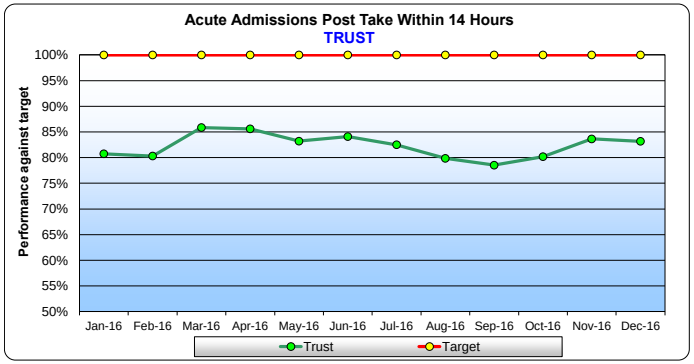


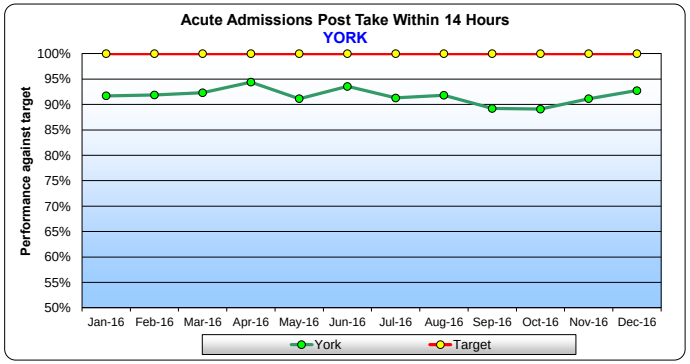


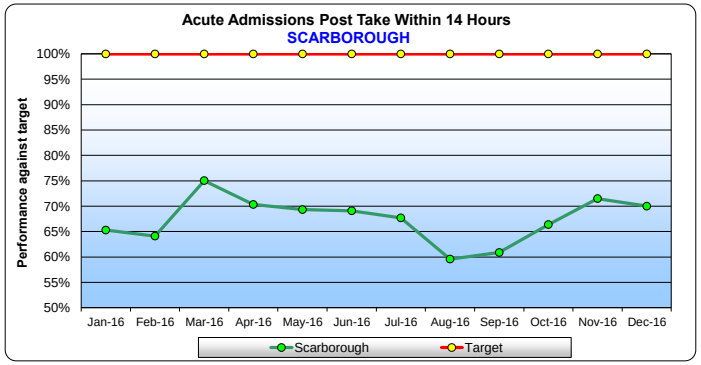


Quality and Safety: Care of the Deteriorating Patient

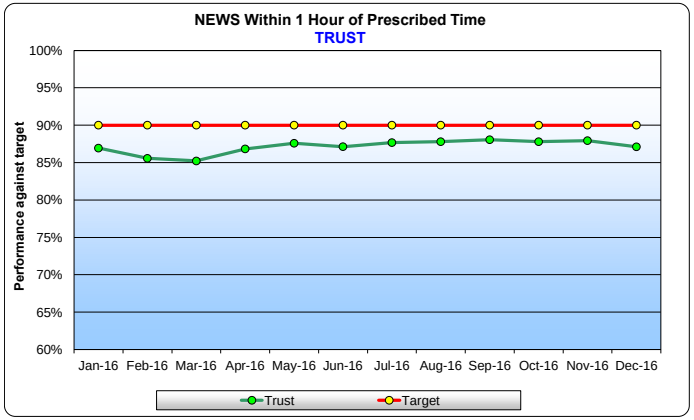
Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Oct	Nov	Dec
Care of the Deteriorating Patient on Acute Medical Assessment Units. Admissions - senior review within 14 hours of arrival - Royal College Standard - 100%	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI		82.3%	83.9%	80.3%	82.2%	80.2%	83.6%	83.2%

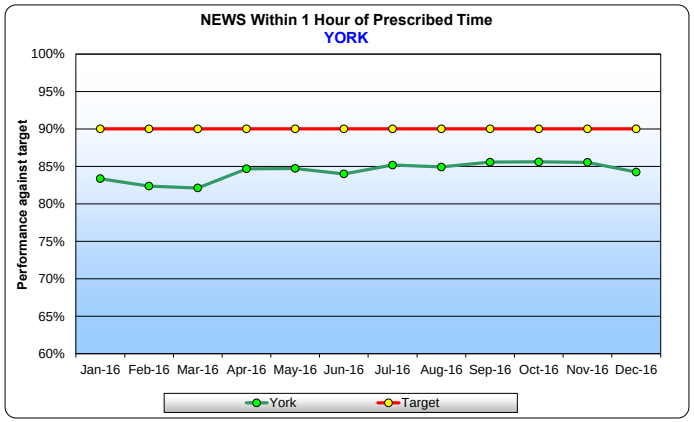


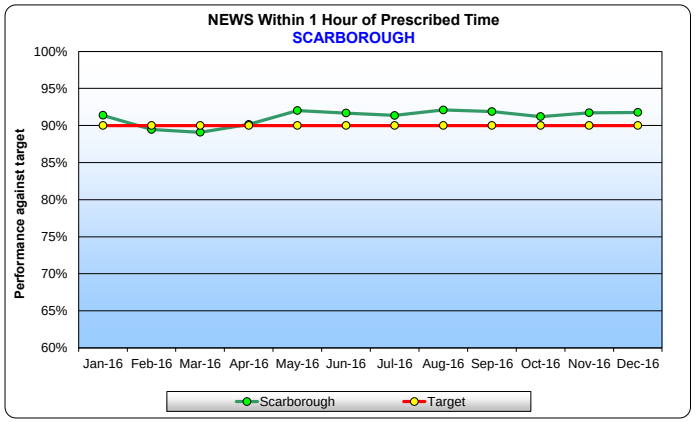




NEWS within 1 hour of prescribed time	None - Monitoring Only	85.9%	87.3%	87.9%	87.6%	87.8%	87.9%	87.1%







Measures of Harm

Serious Incidents (SIs) declared (source: Datix)
There were 14 SIs reported in December; York 6, Scarborough 3 & Community 5.
Clinical Incidents: 7; 6 York, 1 Scarborough.
Slips Trips & Falls: 2; 1 Scarborough & 1 Community.
Pressure Ulcers: 5; 1 Scarborough & 4 Community.

Patients Falls and Found on Floor (source: Datix)
Reduction in the number of patients who incur a fall while in hospital remains a priority for the Trust. During December there were 159 reports of patients falling at York Hospital, 68 patients at Scarborough and 31 patients within the Community Services (258 in total). For the same period last year there were a total of 281, however figures may increase as more investigations are completed.

Number of Incidents Reported (source: Datix)
The total number of incidents reported in the Trust during December was 1,182; 690 incidents were reported on the York site, 341 on the Scarborough site and 151 from Community Services.

Number of Incidents Awaiting Sign Off at Directorate Level (source: Datix)
At the time of reporting there were 768 incidents awaiting sign-off by the Directorate Management Teams.

Pressure Ulcers (source: Datix)
During December 57 pressure ulcers were reported to have developed on patients since admission to York Hospital, 34 pressure ulcers were reported to have developed on patients since admission to Scarborough and 31 pressure ulcers were reported as having developed on patients in our community hospitals or community care. These figures should be considered as approximations as not all investigations have been completed.

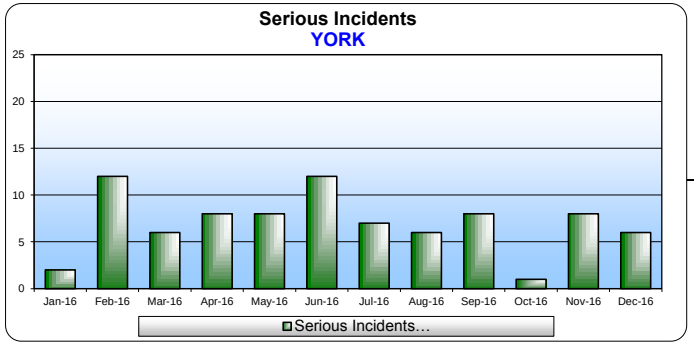
Degree of Harm: Serious/Severe or Death (source: Datix)
During December 4 patient incidents were reported which resulted in serious or severe harm or death. Numbers are subject to change as levels of harm are reviewed and investigations are completed.

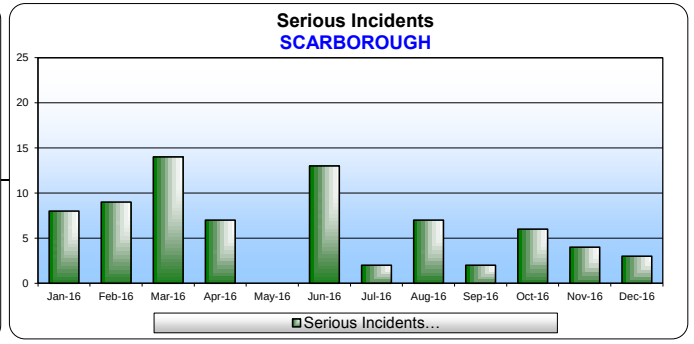
Medication Related Issues (source: Datix)
During December there was a total of 148 medication related incidents reported although this figure may change following validation.

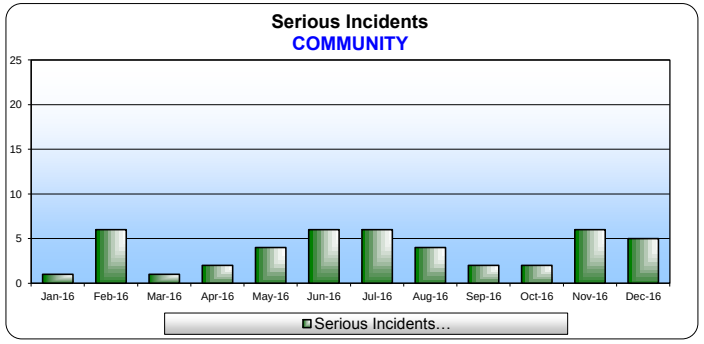
Never Events – No Never Events were declared during December.

Measures of Harm

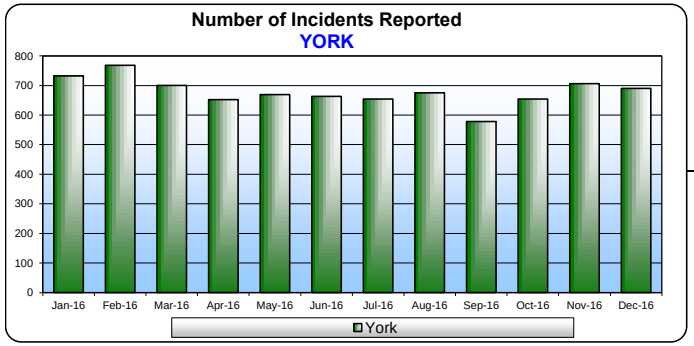
Indicator		Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Serious Incidents source: Risk and Legal	York	2	12	6	8	8	12	7	6	8	1	8	6
	Scarborough	8	9	14	7	0	13	2	7	2	6	4	3
	Community	1	6	1	2	4	6	6	4	2	2	6	5
Serious Incidents Delogged source: Risk and Legal (Trust)		0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

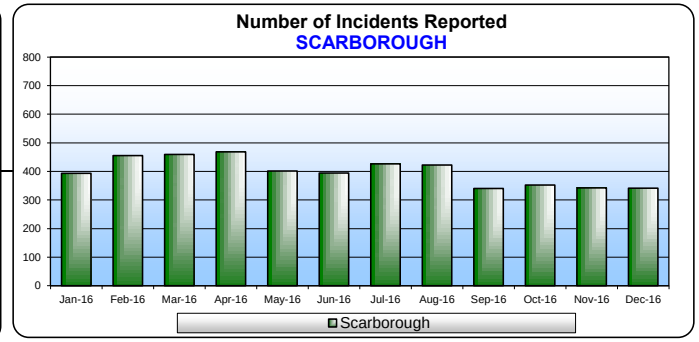


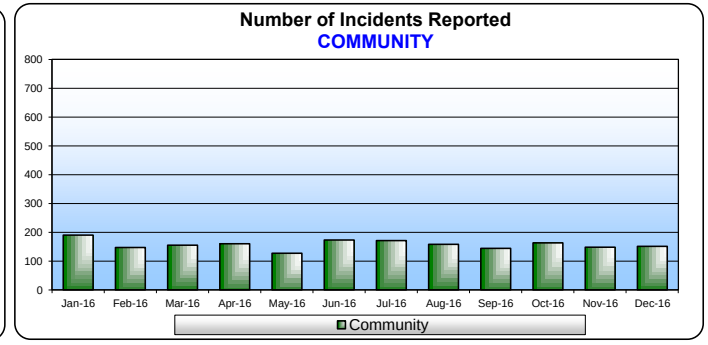




Indicator		Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Number of Incidents Reported source: Risk and Legal	York	732	768	700	652	669	663	654	675	578	654	706	690
	Scarborough	393	455	459	468	401	394	426	422	340	352	342	341
	Community	190	147	155	160	127	173	171	158	144	163	148	151
Number of Incidents Awaiting sign off at Directorate level		1344	1389	1348	987	780	724	686	763	813	752	670	768

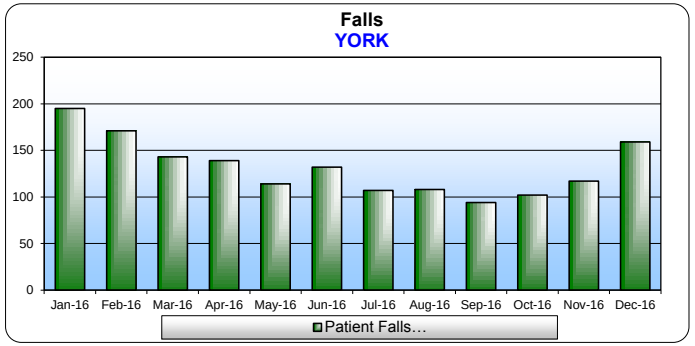


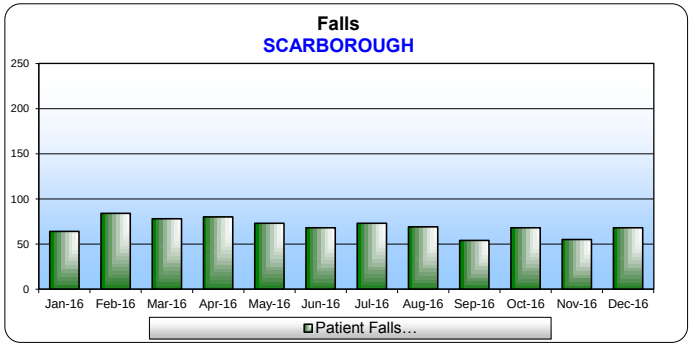


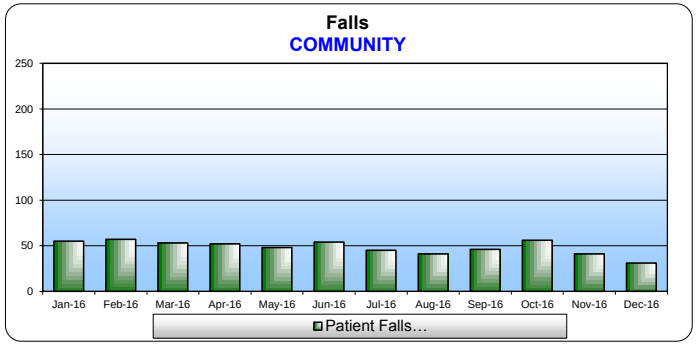


Measures of Harm

Indicator		Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Patient Falls source: DATIX	York	195	171	143	139	114	132	107	108	94	102	117	159
	Scarborough	64	84	78	80	73	68	73	69	54	68	55	68
	Community	55	57	53	52	48	54	45	41	46	56	41	31

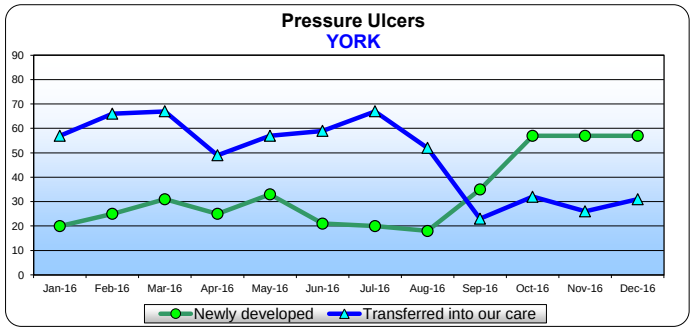


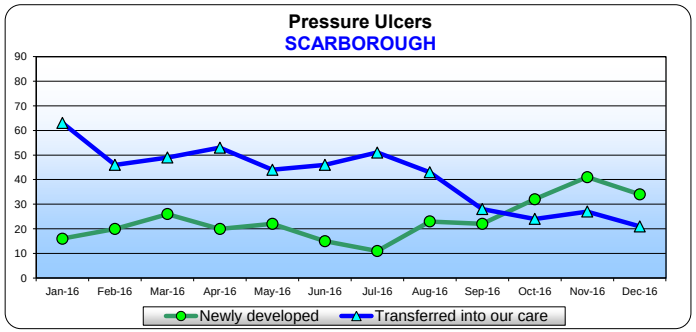


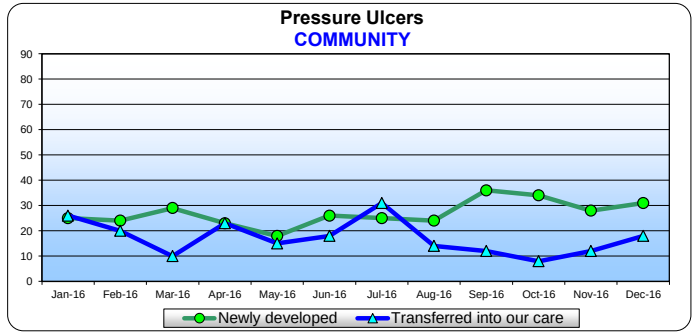


Note - Falls are reviewed retrospectively therefore totals will change month on month. Monthly figures will be refreshed each time the report is updated.
Totals include all degrees of harm, and incidents which have been 'Rejected' are excluded.

Indicator			Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Pressure Ulcers source: DATIX	York	Newly developed	20	25	31	25	33	21	20	18	35	57	57	57
		Transferred into our care	57	66	67	49	57	59	67	52	23	32	26	31
	Scarborough	Newly developed	16	20	26	20	22	15	11	23	22	32	41	34
		Transferred into our care	63	46	49	53	44	46	51	43	28	24	27	21
	Community	Newly developed	25	24	29	23	18	26	25	24	36	34	28	31
		Transferred into our care	26	20	10	23	15	18	31	14	12	8	12	18



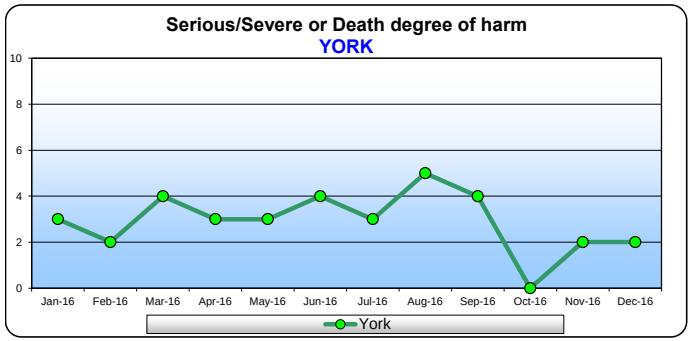


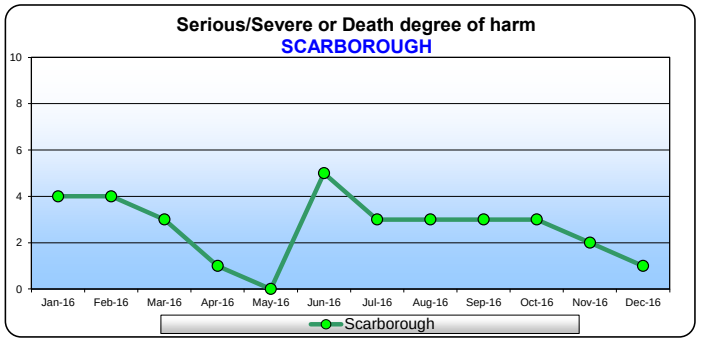


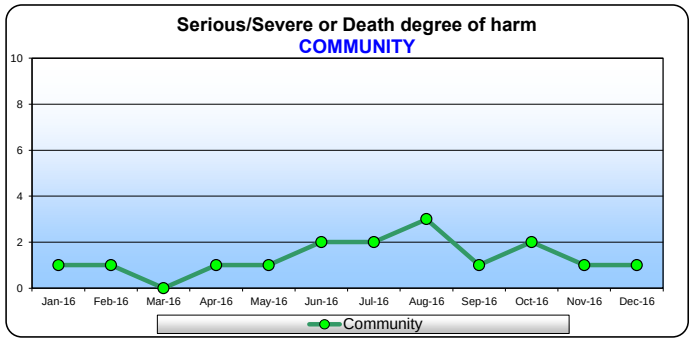
Note - Pressure Ulcers are reviewed retrospectively therefore totals will change month on month. Monthly figures will be refreshed each time the report is updated.
Totals include all degrees of harm, incidents which have been 'Rejected' are excluded as are pressure ulcers which have been categorised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

Measures of Harm

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

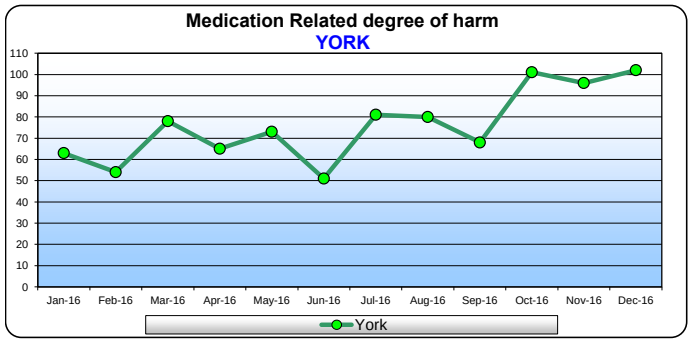


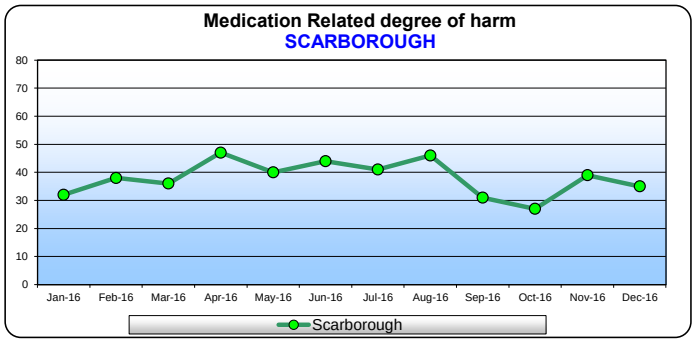


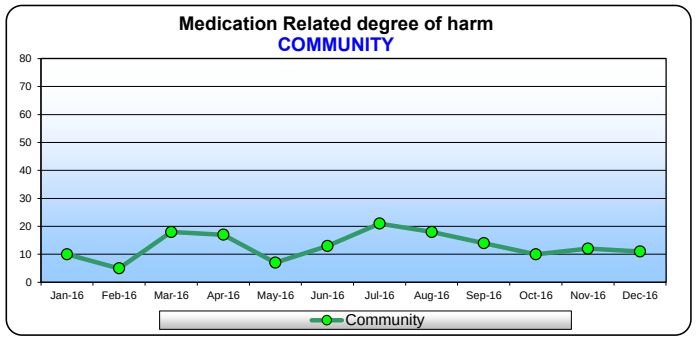


Indicator		Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Degree of harm: Medication Related Issues source: Datix	York	63	54	78	65	73	51	81	80	68	101	96	102
	Scarborough	32	38	36	47	40	44	41	46	31	27	39	35
	Community	10	5	18	17	7	13	21	18	14	10	12	11

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

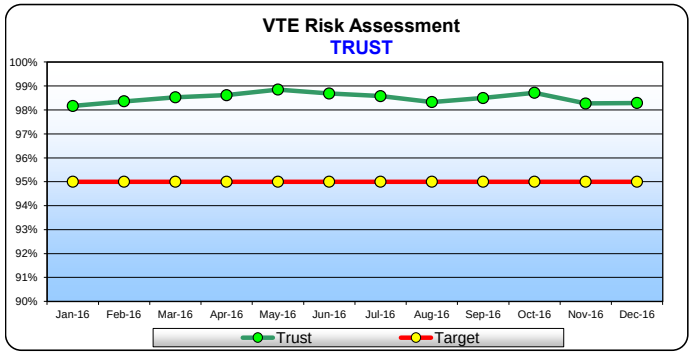


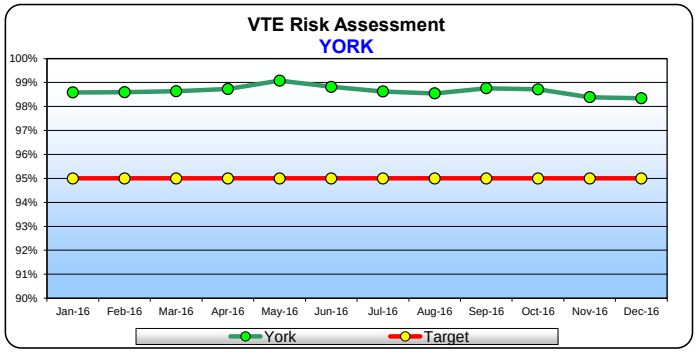


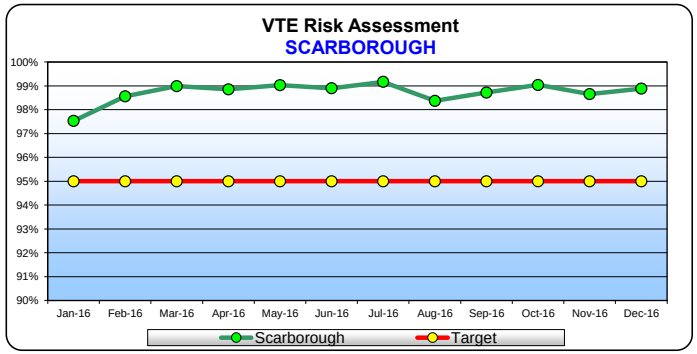


Measures of Harm

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







Never Events

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

Drug Administration

Omitted Critical Medicines
The audit of critical medicines missed during December indicated 2.18% for York and 2.90% for Scarborough.

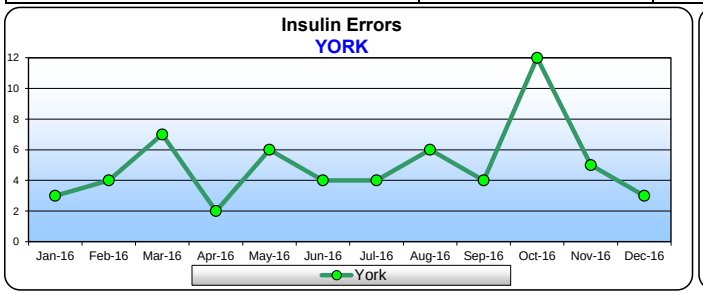
Prescribing Errors
There were 22 prescribing related errors in December; 16 from York, 6 from Scarborough and 0 from Community.

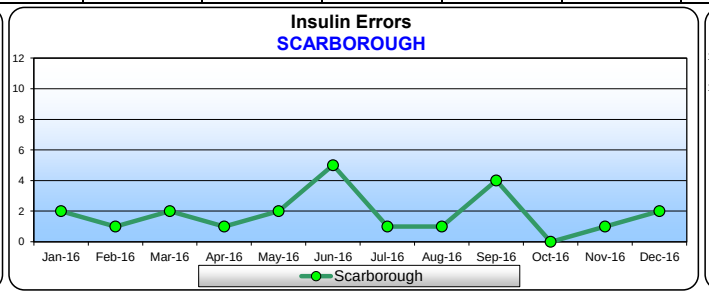
Preparation and Dispensing Errors
There were 24 preparation/dispensing errors in December; 16 from York, 6 from Scarborough and 2 from Community.

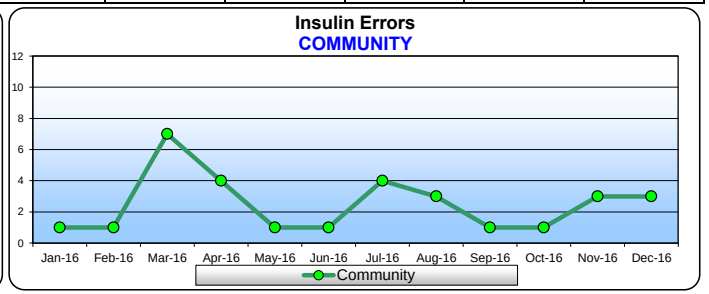
Administrating and Supply Errors
There were 54 administrating/supplying errors in December; 37 were from York, 10 from Scarborough and 7 from Community.

Drug Administration

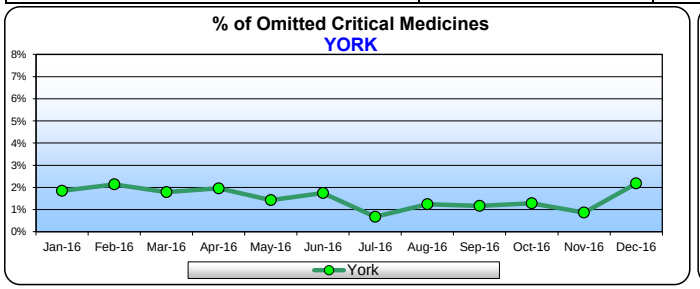
Indicator		Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Insulin Errors source: Datix	York	3	4	7	2	6	4	4	6	4	12	5	3
	Scarborough	2	1	2	1	2	5	1	1	4	0	1	2
	Community	1	1	7	4	1	1	4	3	1	1	3	3

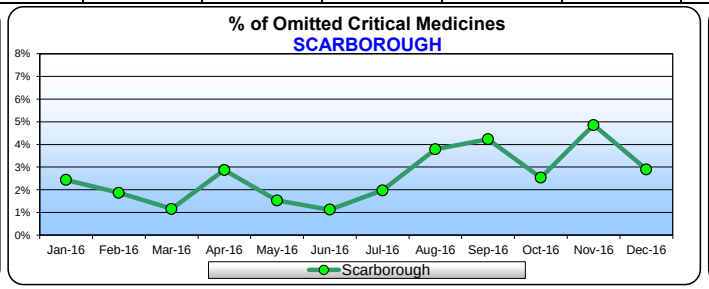


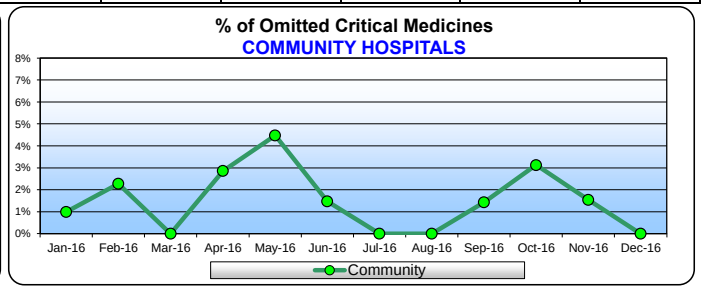




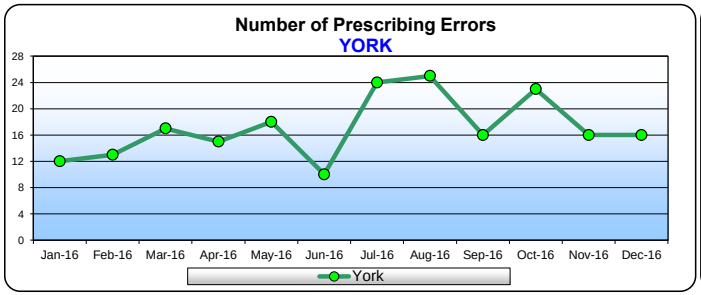
Indicator		Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Number of Omitted Critical Medicines source: Datix	York	9	10	8	9	6	8	3	5	5	6	4	10
	Scarborough	6	5	3	8	4	3	5	10	11	7	12	8
	Community Hospitals	1	2	0	2	3	1	0	0	1	2	1	0

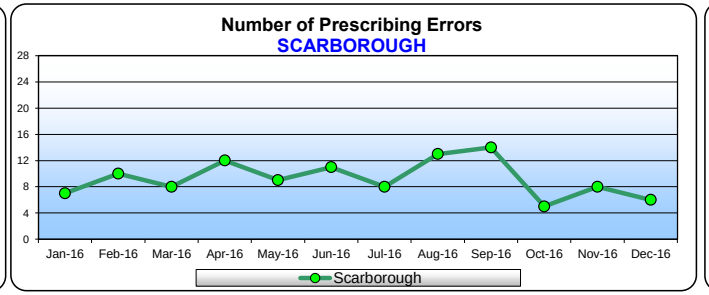


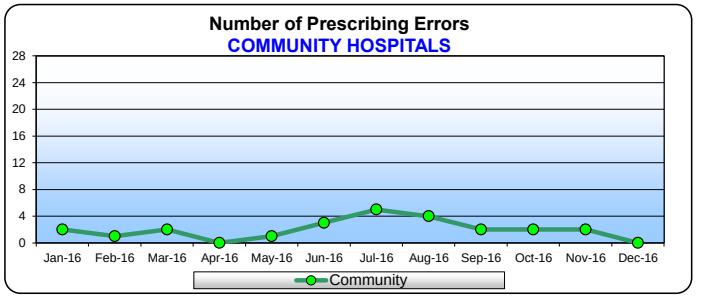




Indicator		Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Number of Prescribing Errors source: Datix	York	12	13	17	15	18	10	24	25	16	23	16	16
	Scarborough	7	10	8	12	9	11	8	13	14	5	8	6
	Community Hospitals	2	1	2	0	1	3	5	4	2	2	2	0

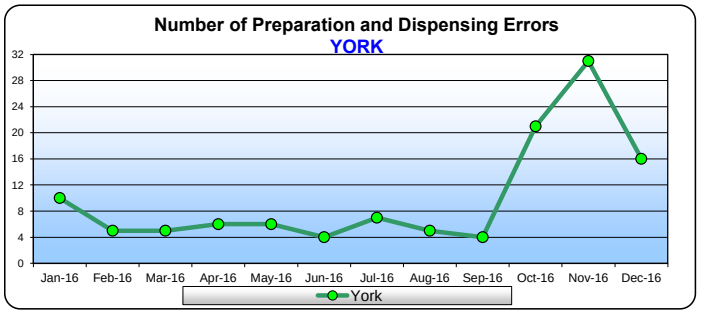


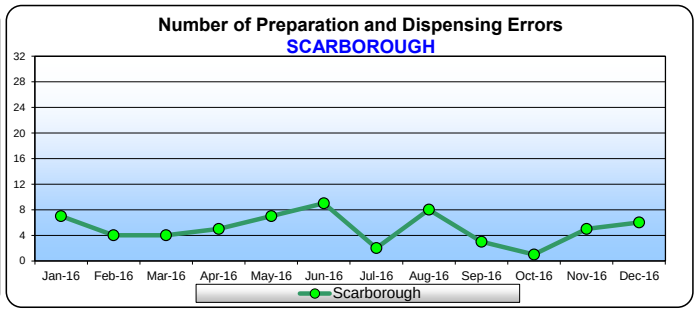


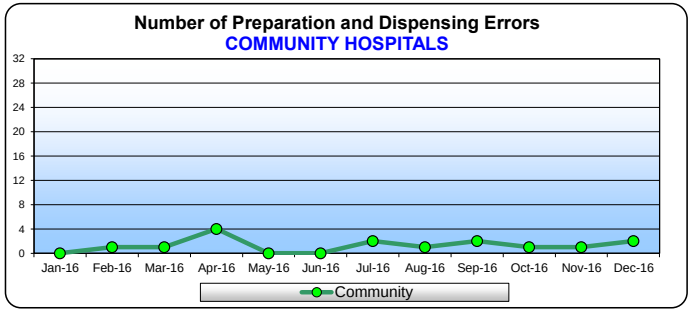


Drug Administration

Indicator		Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Number of Preparation and Dispensing Errors source: Datix	York	10	5	5	6	6	4	7	5	4	21	31	16
	Scarborough	7	4	4	5	7	9	2	8	3	1	5	6
	Community Hospitals	0	1	1	4	0	0	2	1	2	1	1	2

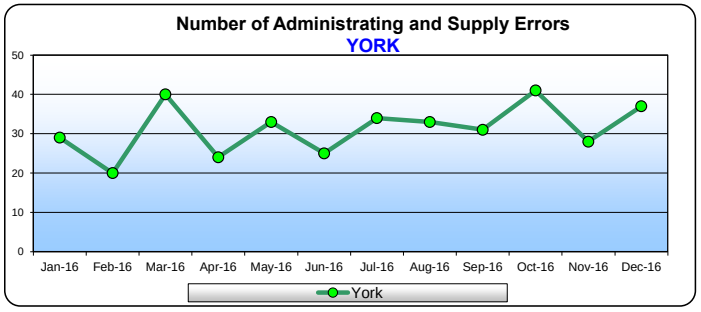


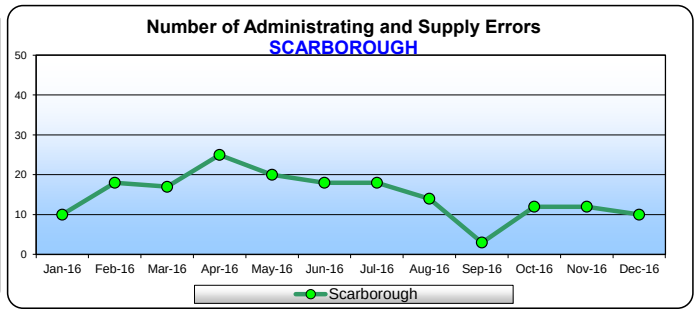


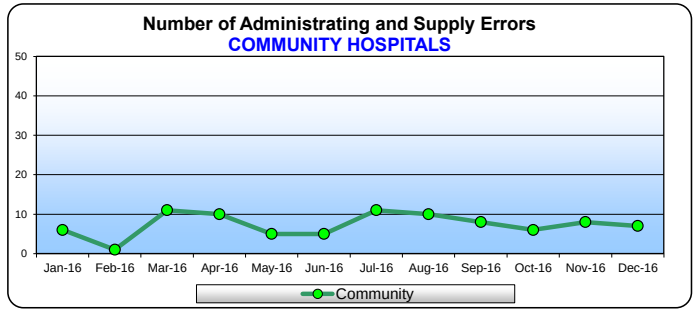


Note re increase in Dispensing Errors - Healthcare at Home have recently experienced a high turnover of staff which has contributed to the increase in errors as the service has mostly been delivered by locums. The vacancies are currently being recruited to and a new manager has been appointed. Trust Senior Pharmacy staff are also meeting with the Chief Pharmacist from Healthcare at Home on a weekly basis and they have provided an action plan that includes the review of all policies and processes. Trust Pharmacy staff are in the process of delivering training to their old and new staff to help to improve the situation.

Indicator		Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Administrating and Supply Errors source: Datix	York	29	20	40	24	33	25	34	33	31	41	28	37
	Scarborough	10	18	17	25	20	18	18	14	3	12	12	10
	Community Hospitals	6	1	11	10	5	5	11	10	8	6	8	7







Measures of Harm: Safety Thermometer

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

Harm Free Care

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

·York: 96.9%
·Scarborough: 94.2%
·Community Hospitals: 87.9%
·Community care: 95.4%

Harm from Catheter Associated Urinary Tract Infection

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

·York: 0.7%
·Scarborough: 1.4%
·Community Hospitals: 1.5%
·Community Care: 0.9%

VTE

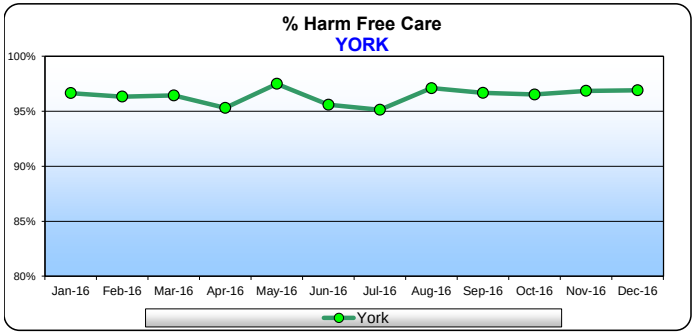
The percentage of patients affected by VTE as measured by the Department of Health definition, monthly measurement of prevalence:

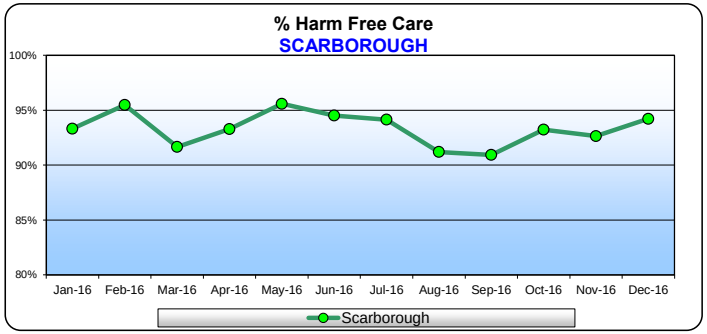
·York: 0.3%
·Scarborough: 0.7%
·Community Hospitals: 3.0%
·Community Care: 0.7%

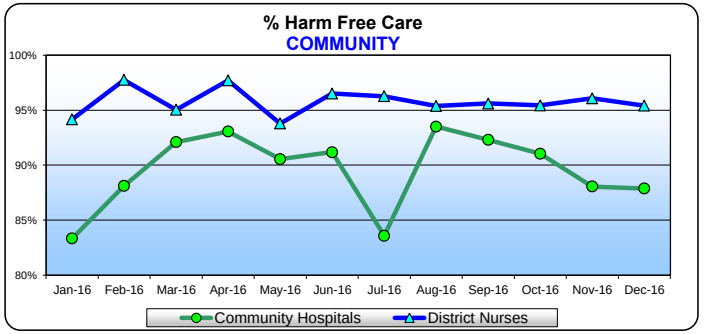
Safety Thermometer

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

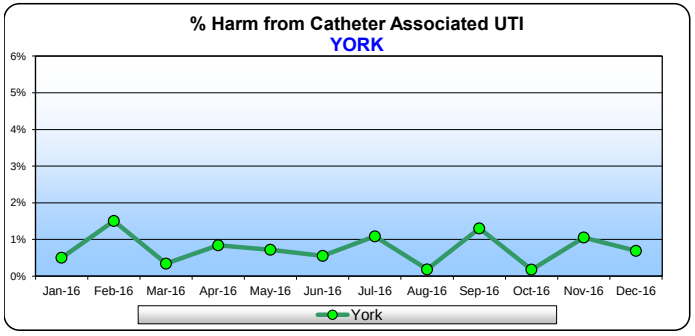
Indicator		Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
% of Harm Free Care source: Safety Thermometer	York	96.7%	96.3%	96.4%	95.3%	97.5%	95.6%	95.1%	97.1%	96.7%	96.5%	96.8%	96.9%
	Scarborough	93.3%	95.5%	91.7%	93.3%	95.6%	94.5%	94.1%	91.2%	90.9%	93.2%	92.6%	94.2%
	Community Hospitals	83.3%	88.1%	92.1%	93.1%	90.5%	91.2%	83.6%	93.5%	92.3%	91.0%	88.1%	87.9%
	District Nurses	94.2%	97.8%	95.0%	97.7%	93.8%	96.5%	96.3%	95.4%	95.6%	95.4%	96.1%	95.4%

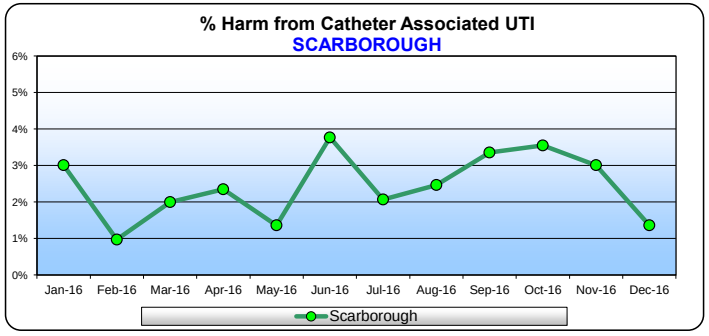


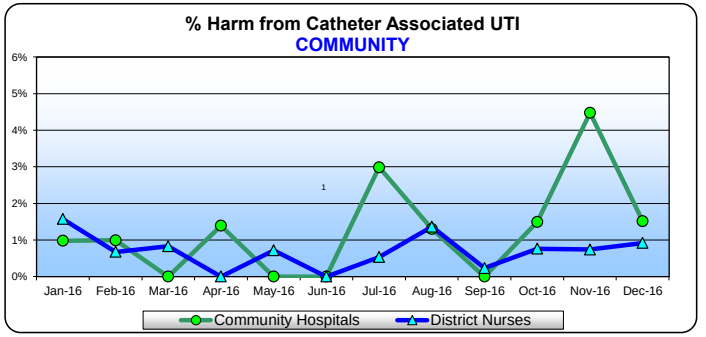




Indicator		Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
% of Harm from Catheter Associated Urinary Tract Infection source: Safety Thermometer	York	0.5%	1.5%	0.3%	0.8%	0.7%	0.6%	1.1%	0.2%	1.3%	0.2%	1.1%	0.7%
	Scarborough	3.0%	1.0%	2.0%	2.3%	1.4%	3.8%	2.1%	2.5%	3.4%	3.5%	3.0%	1.4%
	Community Hospitals	1.0%	1.0%	0.0%	1.4%	0.0%	0.0%	3.0%	1.3%	0.0%	1.5%	4.5%	1.5%
	District Nurses	1.6%	0.7%	0.8%	0.0%	0.7%	0.0%	0.5%	1.4%	0.2%	0.8%	0.7%	0.9%



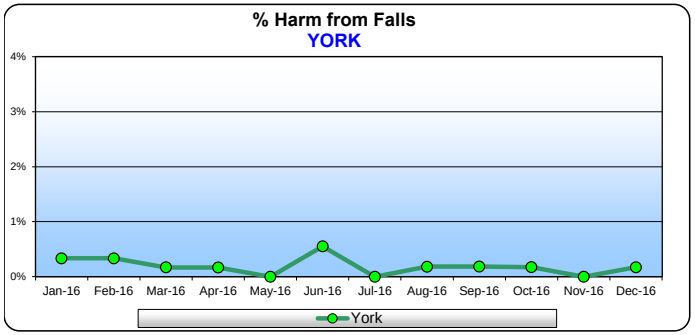


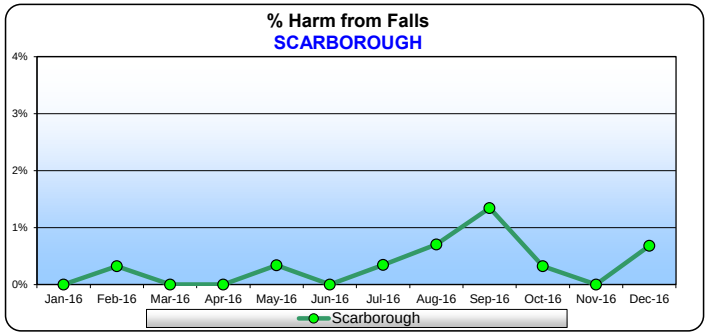


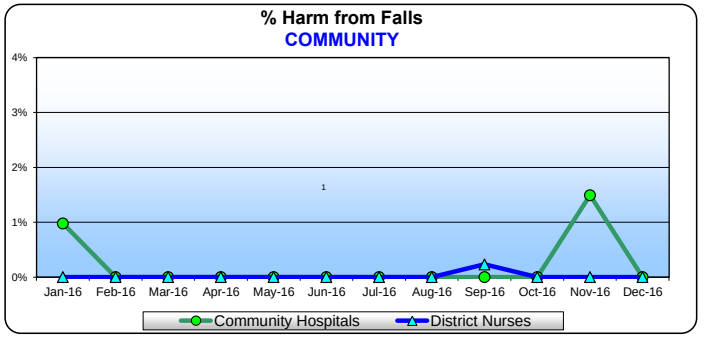
Safety Thermometer

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

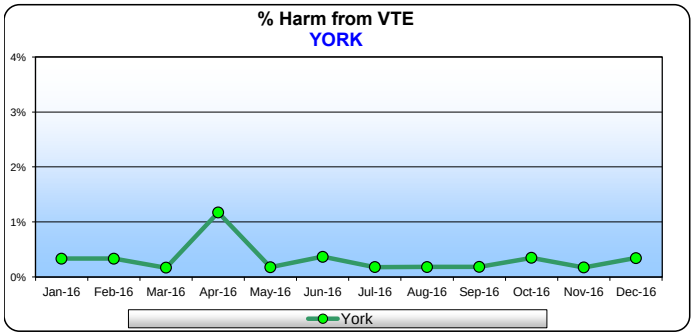
Indicator		Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
% of Harm from Falls source: Safety Thermometer	York	0.3%	0.3%	0.2%	0.2%	0.0%	0.6%	0.0%	0.2%	0.2%	0.2%	0.0%	0.2%
	Scarborough	0.0%	0.3%	0.0%	0.0%	0.3%	0.0%	0.3%	0.7%	1.3%	0.3%	0.0%	0.7%
	Community Hospitals	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.5%	0.0%
	District Nurses	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%

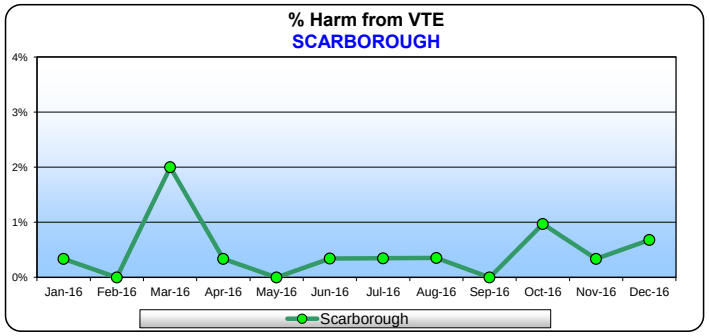


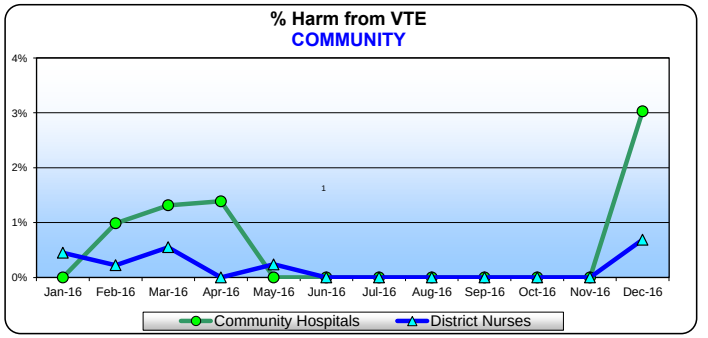




Indicator		Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
% of VTE source: Safety Thermometer	York	0.3%	0.3%	0.2%	1.2%	0.2%	0.4%	0.2%	0.2%	0.2%	0.3%	0.2%	0.3%
	Scarborough	0.3%	0.0%	2.0%	0.3%	0.0%	0.3%	0.3%	0.4%	0.0%	1.0%	0.3%	0.7%
	Community Hospitals	0.0%	1.0%	1.3%	1.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.0%
	District Nurses	0.5%	0.2%	0.6%	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.7%



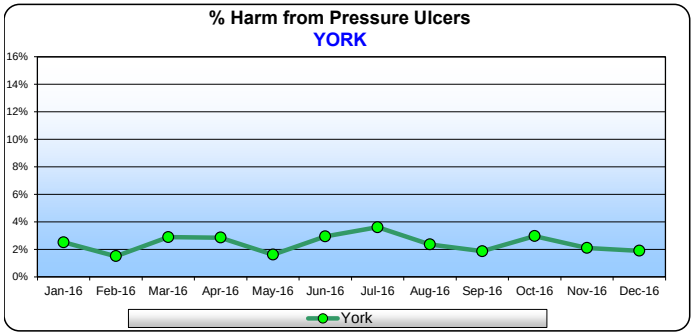


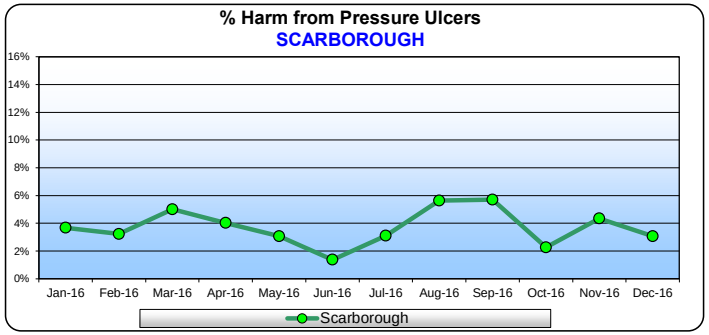


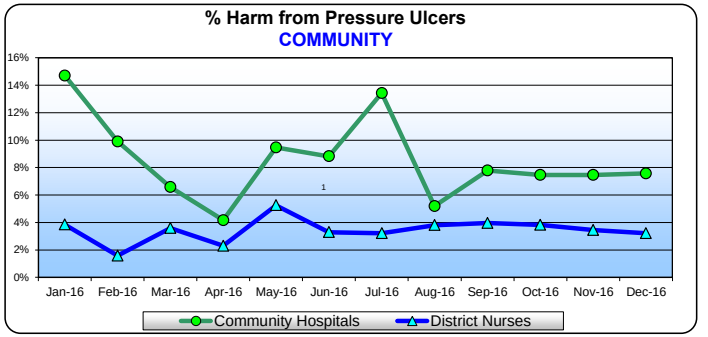
Safety Thermometer

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

Indicator		Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
% of Pressure Ulcers source: Safety Thermometer	York	2.5%	1.5%	2.9%	2.9%	1.6%	2.9%	3.6%	2.4%	1.9%	3.0%	2.1%	1.9%
	Scarborough	3.7%	3.2%	5.0%	4.0%	3.1%	1.4%	3.1%	5.6%	5.7%	2.3%	4.3%	3.1%
	Community Hospitals	14.7%	9.9%	6.6%	4.2%	9.5%	8.8%	13.4%	5.2%	7.8%	7.5%	7.5%	7.6%
	District Nurses	3.8%	1.6%	3.6%	2.3%	5.3%	3.3%	3.2%	3.8%	4.0%	3.8%	3.4%	3.2%







Mortality

Indicator	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sep 14	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15	Jan 15 - Dec 15	Apr 15 - Mar 16	Jul 15 - Jun 16
SHMI – York locality	93	93	95	98	99	97	96	95	93	94	95	96
SHMI – Scarborough locality	104	105	107	108	109	107	108	107	107	108	107	106
SHMI – Trust	**97**	**98**	**99**	**102**	**103**	**101**	**101**	**99**	**99**	**99**	**100**	**99**

Definition

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

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

Analysis of Performance

The latest SHMI report indicates the Trust to be in the 'as expected' range. The July 2015 - June 2016 SHMI saw a 1 point decrease for the Trust and Scarborough, and a 1 point increase for York. Trust - 99, York 96 and Scarborough 106.

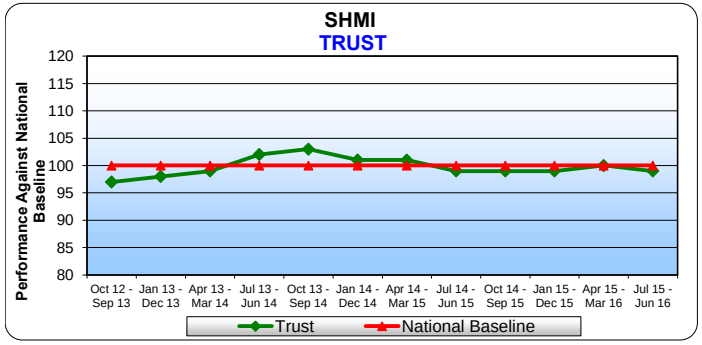
There were a total of 214 inpatients deaths across the Trust in December, including 64 at Scarborough and 132 at York. This is a 13.2% increase for the Trust compared with December 2015 (189 inpatient deaths). Year to date there have been a total of 1,568 inpatient deaths across the Trust compared to 1,517 YTD 2015/16. This is a 3.4% increase year on year.

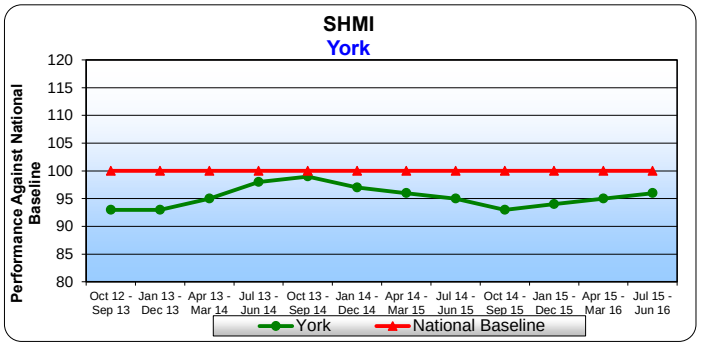
There were a total of 30 deaths in ED in December, this is the highest monthly Trust total for the past 4 years. 20 of the ED deaths occurred in the last 14 days of December. 18 deaths occurred in York Emergency Department and 12 occurred in Scarborough Emergency Department in December. In December 2015 there were 17 deaths in York ED and 4 in Scarborough ED. Year to date there have been a total of 146 ED deaths across the Trust compared to 147 YTD 2015/16.

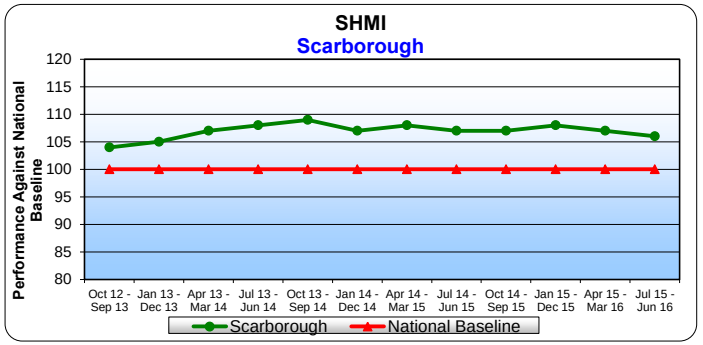
Mortality

York Teaching Hospital NHS
NHS Foundation Trust

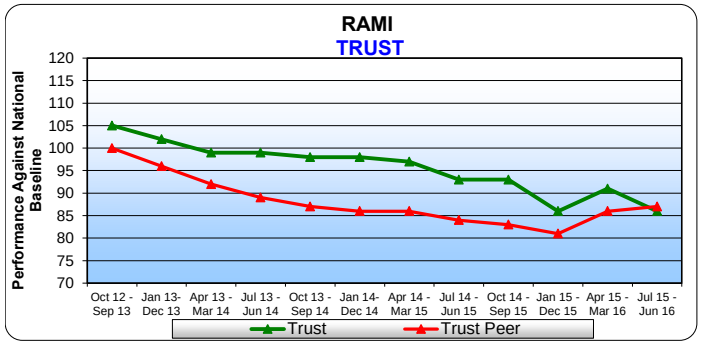
Indicator	Consequence of Breach (Monthly unless specified)	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15	Jan 15 - Dec 15	Apr 15 - Mar 16	Jul 15 - Jun 16
Mortality – SHMI (TRUST)	**Quarterly:** General Condition 9	101	101	99	99	99	100	99
Mortality – SHMI (YORK)	**Quarterly:** General Condition 9	97	96	95	93	94	95	96
Mortality – SHMI (SCARBOROUGH)	**Quarterly:** General Condition 9	107	108	107	107	108	107	106

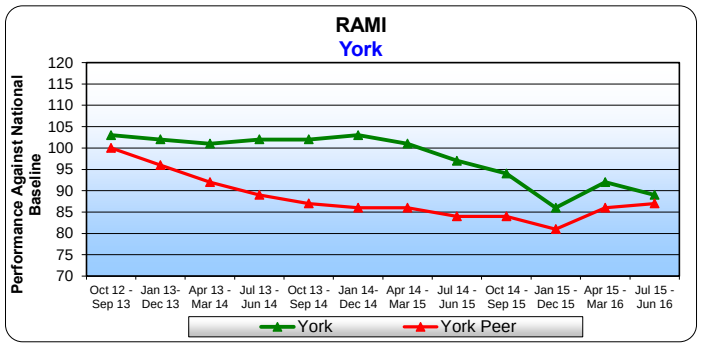


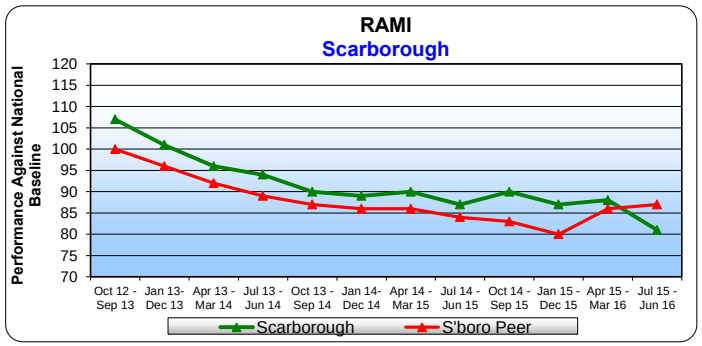




Indicator	Consequence of Breach (Monthly unless specified)	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15	Jan 15 - Dec 15	Apr 15 - Mar 16	Jul 15 - Jun 16
Mortality – RAMI (TRUST)	**none - monitoring only**	98	97	93	93	86	91	86
Mortality – RAMI (YORK)	**none - monitoring only**	103	101	97	94	86	92	89
Mortality – RAMI (SCARBOROUGH)	**none - monitoring only**	89	90	87	90	87	88	81



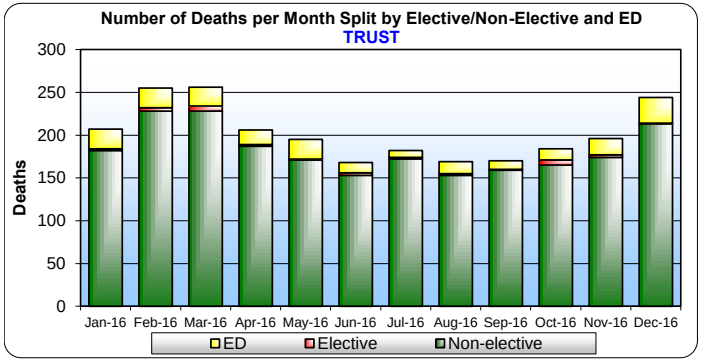


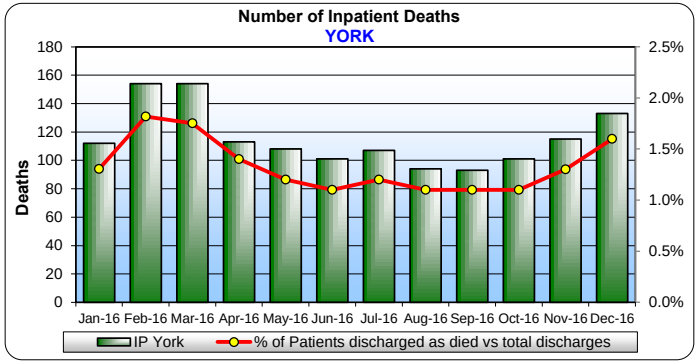


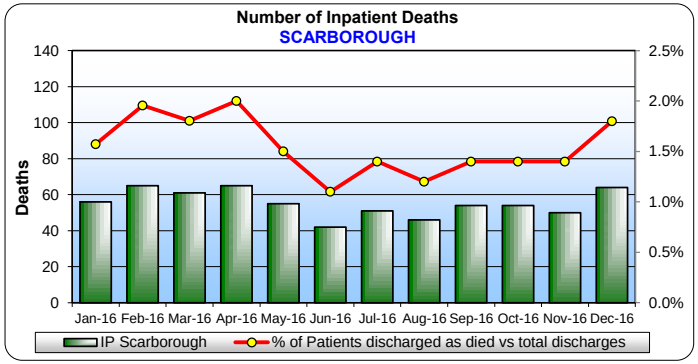
Mortality

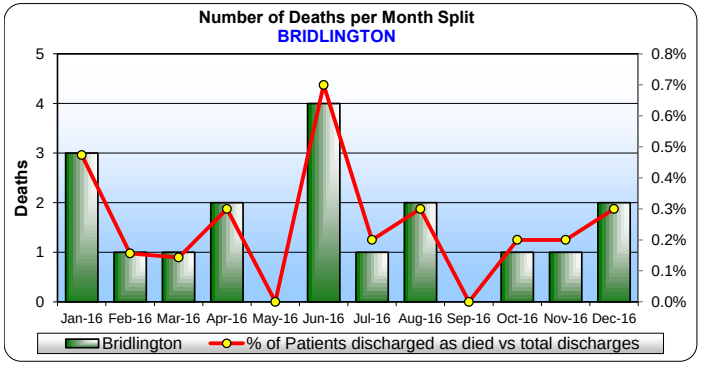
York Teaching Hospital NHS
NHS Foundation Trust

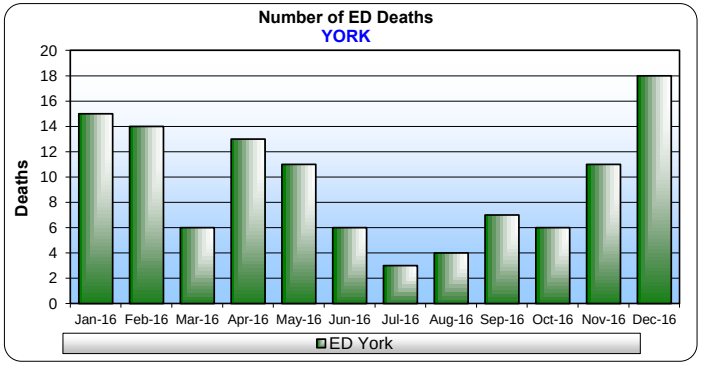
Indicator	Consequence of Breach (Monthly unless specified)	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Oct	Nov	Dec
Number of Inpatient Deaths	None - Monitoring Only	650	517	489	0	171	177	214
Number of ED Deaths	None - Monitoring Only	68	52	32	0	13	19	30

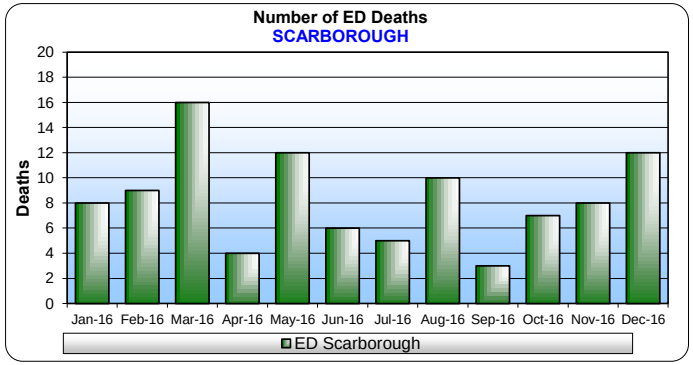


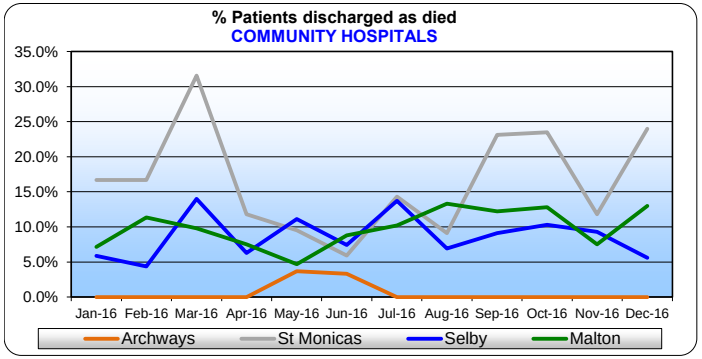


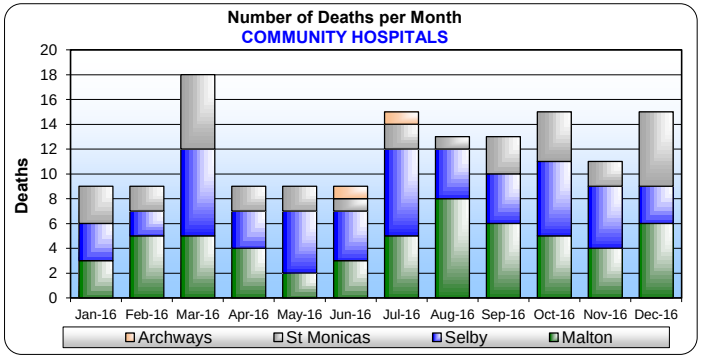












Month	Malton	Selby	St Monicas	Archways	Brid
Jan-16	3	3	3	0	3
Feb-16	5	2	2	0	1
Mar-16	5	7	6	0	1
Apr-16	4	3	2	0	2
May-16	2	5	2	0	0
Jun-16	3	4	1	1	4
Jul-16	5	7	2	1	1
Aug-16	8	4	1	0	2
Sep-16	6	4	3	0	0
Oct-16	5	6	4	0	1
Nov-16	4	5	2	0	1
Dec-16	6	3	6	0	2

Patient Safety Walkrounds – December 2016

Date	Location	Participants	Actions & Recommendations
27/09/2016	Therapy Directorate – Main MSK Physio Department, Orthotic Department and Psychological Medicine Department, the Old Chapel Bootham	Diane Palmer –Deputy Director Mel Liley – Directorate Manager Vicki Adams – Head of Therapies Sue Sharp – Head of Orthotics Liz Anderson – Head of Psychological Medicine Philip Ashton –Non – Executive Director	Main MSK Physiotherapy Gym concerns not considered as extensive refurbishment will start shortly. No patient safety concerns highlighted during the visit to the other areas.
15/11/2016	Outpatients, York Hospital	Diane Palmer – Deputy Director Tariq Hoth – Clinical Director Gemma Ellison – Directorate Manager Pauline Guyan – Matron	There have been two incidents recently (no harm) whereby patients were called into the clinic review room but the wrong patients responded. Action – Sister has reiterated the importance of the ID Policy to staff. The case notes storage trolleys are very heavy and a potential hazard to staff. Action – to consider alternatives or modifications. Patients are left (in-patients without escort) outside of the cardiac ultrasound room while they are awaiting investigations. Action – to discuss the need for risk assessment with Matrons.
17/11/2016	Ann Wright Ward and Stroke Unit Scarborough Hospital	Diane Palmer- Deputy Director Edward Jones – Clinical Director Suzie King – Matron Jennie Adams – Non Executive Director	Ann Wright Ward The Dementia Room at the end of the ward needs a review and investment in infrastructure. Action – Patient Safety Manager to work with Estates to consider options. Stroke Unit It is difficult to get a senior medical review of all patients over a weekend. Action – CD is currently working with Acute Medicine CD to review senior medical rotas. The ward is for rehabilitation not acute care, although patients with acute neurological deficit (not stroke) are often admitted to the ward. Action – Matron to discuss with Bed Manger. The bottom of the Fire Exit ramp has restricted access to bins and cages being stored by the Laboratory Directorate. Action – Deputy Director to raise concern with Laboratory DM.
07/12/2016	Pathology, York Hospital	Bev Geary- Director Neil Todd – Clinical Director Paul Sudworth – Directorate Manager Libby Raper – Non Executive Director	Report to follow.
07/12/2016	Maternity Services –Hawthorne Ward, Delivery Suite, Midwifery Led Unit, O&G Clinic, Women's Unit, Colposcopy, Early Pregnancy Unit, Antenatal Clinic, Antenatal Day Assessment, Scarborough Hospital	Ed Smith –Deputy Medical Director Nicola Dean – Clinical Director Liz Ross – Head of Midwifery Kim Hinton – Directorate Manager Freya Oliver – Matron Sue Symington- Chair	Women's Unit Patients diagnosed with ectopic pregnancy can stay pre-operatively on the unit if stable, however they are moved to ED for safety if they are unstable; they get an in-patient bed post-operatively. The ED stay is recognised as less than ideal from a quality perspective but does provide rapid access to support if necessary. EPAU is not available over a weekend (although NICE recommendation is for a 7 day service) as activity at Scarborough at Scarborough does not justify this. It can be an issue for women waiting for scans. MLU Decisions about the future of the MLU are pending. Labour Ward Room 1 needs refurbishment. Action – business case to be reviewed and pursued. Hawthorne Unit Not visited as very busy.
08/12/2016	Theatres, Outpatients and Lloyd Ward, Bridlington Hospital	Sue Rushbrook – Director Tariq Hoth – Clinical Director Gemma Ellison – Directorate Manager Pauline Guyan – Matron Philip Ashton – Non Executive Director	Report to follow.

YORK - MATERNITY DASHBOARD			Measure	No Concerns (Green)	Of Concern (Amber)	Concerns (Red)	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Activity	Births	Bookings	1st m/w visit	≤302	303-329	≥330	309	276	319	294	294	280	297	252	186			
		Bookings <13 weeks	No. of mothers	≥90%	76%-89%	≤75%	88.7%	90.4%	84.6%	80.6%	83.7%	82.9%	83.5%	85.3%	84.9%			
		Bookings ≥13 weeks (exc transfers etc)	No. of mothers	< 10%	10.1%-19.9%	>20%	4.2%	3.6%	4.7%	4.1%	6.8%	6.8%	4.0%	4.4%	2.2%			
		Bookings ≥ 13wks seen within 2 wks	No. of mothers	≥90%	76%-89%	≤75%	92.30%	80.00%	66.70%	50.00%	85.00%	78.90%	83.30%	72.70%	50.00%			
		Births	No. of babies	≤295	296-309	≥310	249	292	282	291	290	298	303	258	282			
		No. of women delivered	No. of mothers	≤295	296-310	≥311	245	291	279	288	284	296	297	248	280			
	Closures	Homebirth service suspended	No. of suspensions	0-3	4-6	7 or more	0	0	0	0	0	0	0	0	0			
		Women affected by suspension	No. of women	0	1	2 or more	0	0	0	0	0	0	0	0				
		Community midwife called in to unit	No. of times	3	4-5	6 or more	10	2	4	5	5	9	5	4				
		Maternity Unit Closure	No. of closures	0		1 or more	0	0	0	0	0	0	1	0	0			
		SCBU at capacity of intensive cots	No. of times	0	1	2 or more	2	6	4	5	0	0	0	0	0			
		SCBU no of babies affected	No. of babies affected	0		1 or more	1	0	2	0	0	0	0	0	0			

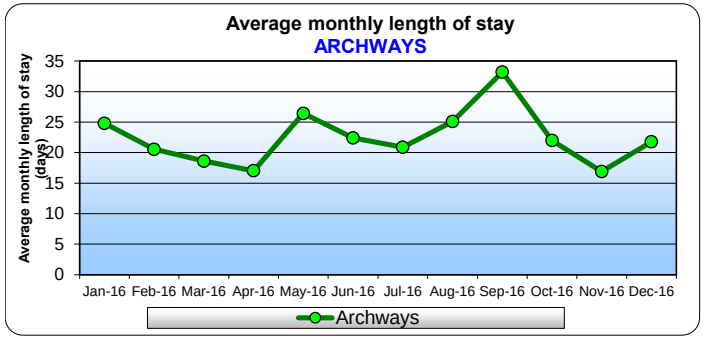
Workforce	Staffing	M/W per 1000 births	Ratio	≥35.0	35-31	≤31.0	28	28	31	28	28	28	28	28	29			
		1 to 1 care in Labour	CPD	≥100%		<100%	72.7%	74.6%	74.9%	73.6%	72.9%	67.9%	76.8%	75.0%	80.0%			
		L/W Co-ordinator supernumary %	Shift Handover Sheets	≥100%		<100%	67.0%	63.0%	60.0%	61.2%	55.0%	43.0%	56.0%	60.0%	58.0%			
		Consultant cover on L/W	av. hours/week	40		≤39	76	76	76	76	76	76	76	76	76			
		Anaesthetic cover on L/W	av.sessions/week	10		≤9	10	10	10	10	10	10	10	10	10			
		Supervisor : M/w ratio 1 :	Ratio	15	16-18	≥19	12	12	12	12	12	12	12	12	12			

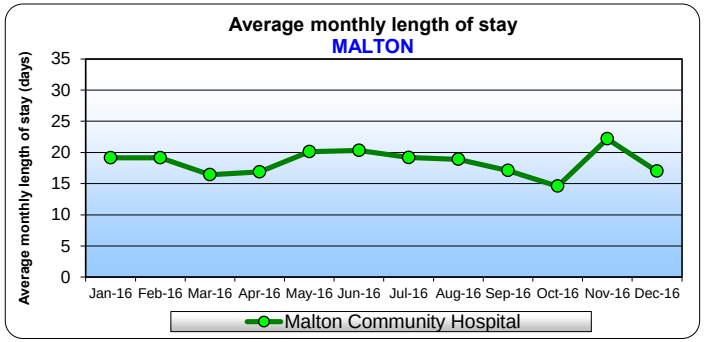
Clinical Indicators	Neonatal/Maternal	Normal Births	No. of svd - %	≥60.6%	60.5-55%	<55%	68.1%	62.8%	65.0%	66.1%	66.0%	63.1%	62.6%	59.2%	66.5%			
		Assisted Vaginal Births	No. of instr. Births - %	≤13.2	13.3-17.9%	≥18%	9.4%	9.6%	12.2%	12.8%	11.3%	12.5%	14.5%	14.9%	11.1%			
		C/S Births	Em & elect - %	≤26%	26.1-27.9%	>28%	22.9%	27.1%	22.6%	21.2%	23.6%	24.7%	23.2%	27.0%	21.8%			
		Eclampsia	No. of women	0		1 or more	0	0	0	0	0	0	0	0	0			
		Undiagnosed Breech in Labour	No. of women	2 or less	3-4	5 or more	0	0	0	1	0	0	0	3	0			
		HDU on L/W	No. of women	3 or less	4	5 or more	17	14	7	14	8	29	20	15	17			
		BBA	No. of women	2 or less	3-4	5 or more	1	2	6	3	3	1	2	2	1			
		Diagnosis of HIE	No. of babies	0	1	2 or more	0	0	0	1	0	0	1	0	0			
	Morbidity	Neonatal Death	No of babies	0		1 or more	0	0	0	1	0	0	0	0	0			
		Antepartum Stillbirth	No. of babies	0	1	2 or more	1	1	1	1	0	1	0	0	1			
		Intrapartum Stillbirths	No. of babies	0		1 or more	0	0	0	0	0	0	0	0	0			
	Risk Management	Breastfeeding Initiation rate	% of babies feeding at birth	>74.4%	74.3-70.1%	<70%	80.8%	76.6%	74.2%	76.7%	74.3%	75.7%	78.1%	69.0%	78.2%			
		Smoking at time of delivery	% of women smoking at del.	<11%	12-14%	>15%	9.4%	12.7%	10.4%	8.7%	10.2%	10.5%	8.4%	10.1%	10.0%			
		SI's	No. of Si's declared	0		1 or more	1	1	0	1	0	1	0	1	0			
		PPH > 1.5L	No. of women	2 or less	3-4	5 or more	9	9	4	9	3	9	10	4	6			
		PPH > 1.5L as % of all women	% of births				3.7%	2.9%	1.4%	3.1%	1.1%	3.0%	3.4%	1.6%	2.1%			
		Shoulder Dystocia	No. of women	2 or less	3-4	5 or more	3	2	3	3	1	1	1	1	3			
		3rd/4th Degree Tear	% of tears (vaginal births)	≤2.5%	2.6- 3.9%	≥4%	0.5%	1.5%	1.8%	3.0%	2.2%	1.3%	3.0%	2.6%	3.6%			
	New Complaints	Informal	No. of Informal complaints	0	1-4	5 or more	1	0	1	3	2	0	1	0	0			
		Formal	No. of Formal complaints	0	1-4	5 or more	1	0	2	3	3	1	0	1	0			

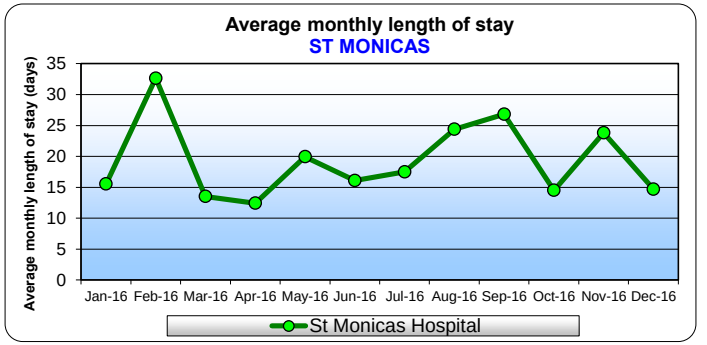
SCARBOROUGH - MATERNITY DASHBOARD			Measure	No Concerns (Green)	Of Concern (Amber)	Concerns (Red)	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Activity	Births	Bookings	1st m/w visit	≤210	211-259	≥260	174	198	212	193	217	194	160	195	108			
		Bookings <13 weeks	No. of mothers	≥90%	76%-89%	≤75%	88.5%	86.9%	83.5%	88.6%	92.6%	84.0%	88.8%	90.8%	92.6%			
		Bookings ≥13 weeks (exc transfers etc)	No. of mothers	< 10%	10%-20%	>20%	7.5%	11.1%	10.8%	8.3%	4.6%	11.3%	6.3%	6.7%	7.4%			
		Bookings ≥ 13wks seen within 2 wks	No. of mothers	≥90%	76%-89%	≤75%	77%	100%	83%	63%	90%	100%	90%	54%	75%			
		Births	No. of babies	≤170	171-189	≥190	118	148	134	135	141	154	135	112	140			
		No. of women delivered	No. of mothers	≤170	171-189	≥190	115	148	134	135	140	152	133	111	139			
	Closures	Homebirth service suspended	No. of suspensions	0-3	4-6	7 or more	2	1	0	0	1	0	0	0	0			
		Women affected by suspension	No. of women	0	1	2 or more	0	0	0	0	0	0	0	0	0			
		Community midwife called in to unit	No. of times	3	4-5	6 or more	0	0	0	0	1	0	0	0	0			
		Maternity Unit Closure	No. of closures	0		1 or more	0	0	0	0	0	0	0	0	0			
		SCBU at capacity	No. of times	0	1	2 or more	9	5	8	3	11	7	8	1	0			
		SCBU no of babies affected	No. of babies affected	0		1 or more	0	0	2	1	6		0	2	0			
Workforce	Staffing	M/W per 1000 births	Ratio	≥35.0	35-31	≤31.0	39.4	38.3	38.1	38.0	38.8	38.5	40.2	41.0	41.0			
		1 to 1 care in Labour	CPD	≥100%		<100%	89.6%	84.0%	85.1%	85.9%	87.1%	92.8%	92.5%	84.7%	89.9%			
		L/W Co-ordinator supernumary %	Shift Handover Sheets	≥100%		<100%	87%	80%	85%	81%	91%	70%	89%	85%	66%			
		Consultant cover on L/W	av. hours/week	40		≤39	40	40	40	40	40	40	40	40	40			
		Anaesthetic cover on L/W	av.sessions/week	10		≤9	3	3	3	3	3	3	3	3	3			
		Supervisor : M/w ratio 1 :	Ratio	15	16-18	≥19	12	12	12	12	12	12	12	12	12			
Clinical Indicators	Neonatal/Maternal	Normal Births	No. of svd - %	≥60.6%	60.5-55%	<55%	66.9%	74.3%	63.2%	67.4%	70.9%	72.4%	67.2%	61.9%	66.4%			
		Assisted Vaginal Births	No. of instr. Births - %	≤13.2	13.3-17.9%	≥18%	11.3%	9.5%	7.5%	8.1%	7.1%	5.3%	7.5%	14.4%	10.8%			
		C/S Births	Em & elect - %	≤26%	26.1-27.9%	>28%	22.6%	16.2%	29.9%	24.4%	22.1%	22.4%	25.6%	24.3%	23.0%			
		Eclampsia	No. of women	0		1 or more	0	0	0	0	0	0	0	0	0			
		Undiagnosed Breech in Labour	No. of women	2 or less	3-4	5 or more	0	0	0	0	2	1	0	0	0			
		HDU on L/W	No. of women	3 or less	4	5 or more	1	4	2	8	4	5	2	1	1			
		BBA	No. of women	2 or less	3-4	5 or more	1	1	1	3	3	1	2	4	1			
		Diagnosis of HIE	No. of babies	0	1	2 or more	1	0	0	0	0	0	0	0	0			
	Morbidity	Neonatal Death	No of babies	0		1 or more	0	0	0	1	0	0	0	1	0			
		Antepartum Stillbirth	No. of babies	0	1	2 or more	0	2	0	0	1	0	0	0	1			
		Intrapartum Stillbirths	No. of babies	0		1 or more	0	0	0	0	0	0	0	0	0			
	Risk Management	Breastfeeding Initiation rate	% of babies feeding at birth	>74.4%	74.3-70.1%	<70%	58.3%	60.8%	61.9%	60.7%	57.9%	55.3%	63.2%	64.0%	58.3%			
		Smoking at time of delivery	% of women smoking at del.	<11%	12-14%	>15%	23%	20%	22%	20%	18%	25%	18%	23%	17%			
		SI's	No. of Si's declared	0		1 or more	0	0	0	1	0	0	1	1	0			
		PPH > 1.5L	No. of women	2 or less	3-4	5 or more	2	3	1	6	1	5	2	0	0			
		PPH > 1.5L as % of all women	% of births				2	2	0	4	1	3	2	0	0			
		Shoulder Dystocia	No. of women	2 or less	3-4	5 or more	2	1	0	2	0	0	2	1	2			
		3rd/4th Degree Tear	% of tears (vaginal births)	≤2.5%	2.6- 3.9%	≥4%	2.2%	1.6%	0.0%	2.0%	2.7%	3.3%	1.0%	1.2%	0.0%			
	New Complaints	Informal	No. of Informal complaints	0	1-4	5 or more	0	0	0	0	1	2	1	1	0			
		Formal	No. of Formal complaints	0	1-4	5 or more	1	1	0	2	1	0	0	0	1			

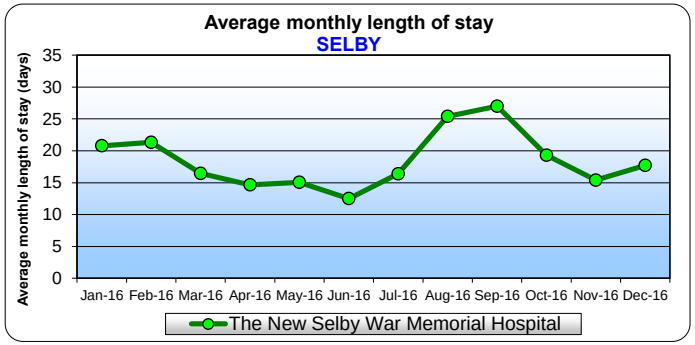
Community Hospitals

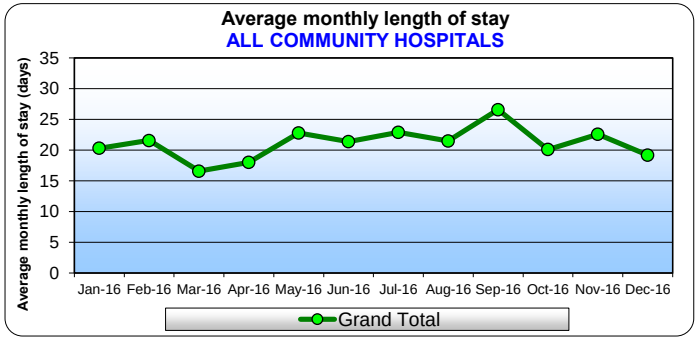
Indicator	Hospital	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Oct	Nov	Dec
Community Hospitals average length of stay (days) Excluding Daycases	**Archways**	21.1	21.7	26.2	19.9	22.0	16.9	21.8
	Malton Community Hospital	18.2	18.8	18.5	18.6	14.6	22.2	17.0
	St Monicas Hospital	18.9	16.4	22.7	17.2	14.5	23.8	14.7
	The New Selby War Memorial Hospital	19.5	14.1	23.0	17.7	19.3	15.4	17.7
	Total	22.8	20.6	23.7	20.7	20.1	22.6	19.2





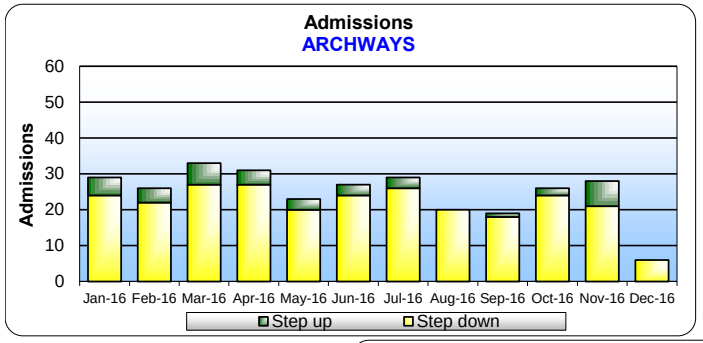


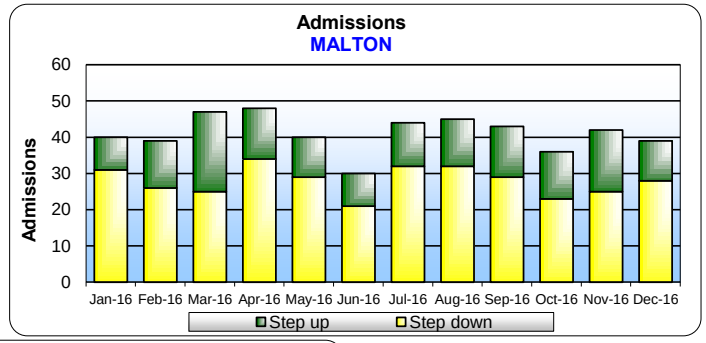


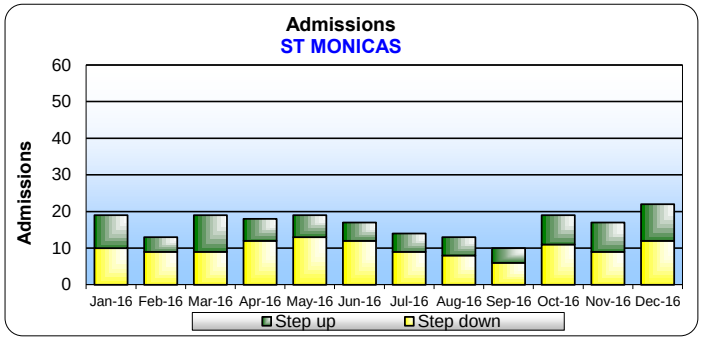


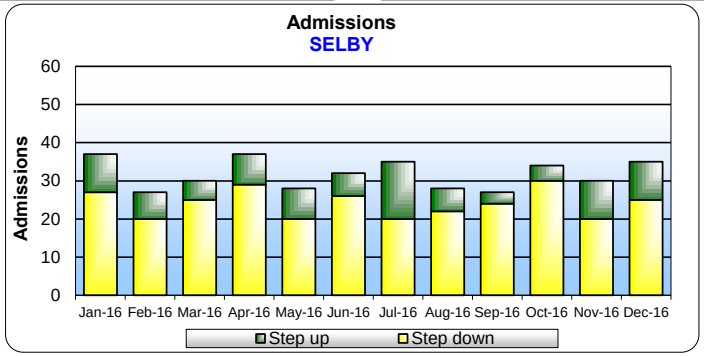
Community Hospitals

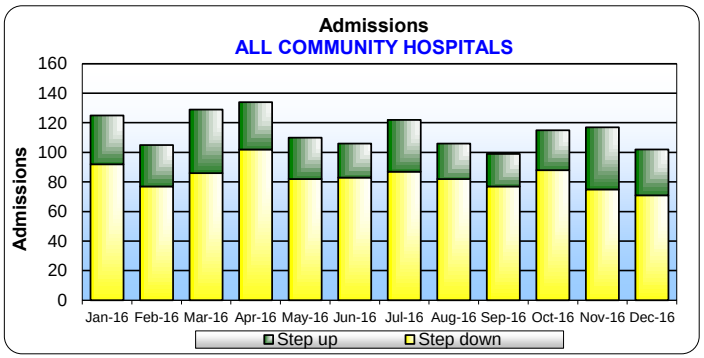
Indicator	Hospital		Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Oct	Nov	Dec
Community Hospitals admissions Please note: Patients admitted to Community Hospitals following a spell of care in an Acute Hospital have the original admission method applied, i.e. if patient is admitted as a non-elective their spell in the Community Hospital is also non-elective.	**Archways**	**Step up**	15	10	4	9	2	7	0
		Step down	73	71	64	51	24	21	6
	Malton Community Hospital	**Step up**	44	34	39	41	13	17	11
		Step down	82	84	93	76	23	25	28
	St Monicas Hospital	**Step up**	23	17	14	26	8	8	10
		Step down	28	37	23	32	11	9	12
	The New Selby War Memorial	**Step up**	22	22	24	24	4	10	10
		Step down	72	75	66	75	30	20	25
	Total	**Step up**	104	83	81	100	27	42	31
		Step down	255	267	246	234	88	75	71











Quality and Safety: Misc

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Oct	Nov	Dec
All Patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days	Non-payment of costs associated with cancellation and non- payment or reimbursement (as applicable) of re-scheduled episode of care	**0**	4	13	2	0	1	1	0
No urgent operation should be cancelled for a second time	£5,000 per incidence in the relevant month	**0**	0	0	0	0	0	0	0
Sleeping Accommodation Breach	£250 per day per Service User affected	**0**	3	0	0	0	0	0	0
% Compliance with WHO safer surgery checklist	No financial penalty	**100%**	100%	100%	100%	100%	100%	100%	100%
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	**99%**	99.9%	99.9%	99.9%	To follow	99.9%	To follow	To follow
Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	**95%**	99.0%	98.8%	98.8%	To follow	98.2%	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%**	4.1%	5.0%	5.8%	n/a	4.2%	2.8%	n/a
Delayed Transfer of Care – All patients medically fit for discharge and issued a 'notification notice' as per joint protocol for the transfer of care	As set out in Service Condition 3 and General Condition 9	**Set baseline in Q1 and agree trajectory**	Monthly Provider Report						
Trust waiting time for Rapid Access Chest Pain Clinic	General Condition 9	**99%**	100.0%	100.0%	100.0%	94.9%	100.0%	87.5%	100.0%
Stroke Performance against Sentinel Stroke National Audit Programme (SSNAP)	As set out in Service Condition 3 and General Condition 9	**Best Practice Standards**	Quarterly summary of performance against SSNAP indicators as submitted to RCP. Stroke service exception action plan to be produced and tabled at sub CMB quarterly.						
Number/Percentage women who have seen a midwife by 12 weeks and 6 days (as per IPMR definition)	General Condition 9	**90%**	99.2%	99.8%	99.8%	99.8%	99.5%	100.0%	100.0%
Number/Percentage of maternity patients recorded as smoking by 12 weeks and 6 days that are referred to a smoking cessation service subject to patient consent	General Condition 9	**95%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
All Red Drugs to be prescribed by provider effective from 01/04/15, subject to agreement on list	Recovery of costs for any breach to be agreed via medicines management committee	**100% list to be agreed**	CCG to audit for breaches						
All Amber Drugs to be prescribed as per shared care guidelines from 01/04/15	Recovery of costs for any breach to be agreed via medicines management committee	**100% list to be agreed**	CCG to audit for breaches						

D2

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 January 2017

Medical Director's Report

Action requested/recommendation

Board of Directors are requested to:

- Be aware of progress with the Influenza Campaign
- Note the latest report from the National Reporting and Learning System
- Welcome consultants new to the Trust
- Note progress with NatSSIPs/LocSSIPs
- Be aware of National Cardiac Arrest Audit 6 monthly report – York Hospital

Summary

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

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

Implications for equality and diversity

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

Reference to CQC outcomes

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

Progress of report	This report is only written for the Board of Director's.
Risk	No additional risks have been identified other than those specifically referenced in the paper.
Resource implications	None identified.
Owner	Mr Jim Taylor, Medical Director
Author	Diane Palmer, Deputy Director of Patient Safety
Date of paper	January 2017
Version number	1

Board of Directors – 25 January 2017

Medical Director's Report

1. Introduction and Background

In the report this month:

Patient Safety-

- progress with the Influenza Campaign
- update summary report from the NRLS

Clinical Effectiveness-

- consultants new to the Trust
- progress with NatSSIPs/LocSSIPs
- National Cardiac Arrest Audit – 6 monthly report (York Hospital)

2. Patient Safety

2.1 Influenza Campaign - update

The campaign commenced on 3 October 2016 running up to and including 31 December 2016. Previous updates have outlined the operational detail of the campaign. The following information summarises achievement against the plan.

Statistics:

- Total number of Frontline Health Care Workers vaccinated = **4232**
- This equates to an overall uptake of = **69%**
- To achieve the CQUIN target and receive 100% of funds allocated we were required to vaccinate **4607** staff, ie.75% of frontline health care workers, the Trust shortfall being **375** staff overall.

Uptake by staff group:

- Doctors = **536** (**63%**)
- Qualified Nurses = **1353** (**58%**)
- All other professionally qualified clinical staff = 705 (**69%**)
- Support to clinical staff = 1638 (**85%**)

Outcome:

An achievement of 69% vaccine uptake suggests that the Trust will receive 50% of allocated funds since we've met the 65% - 74% milestone.

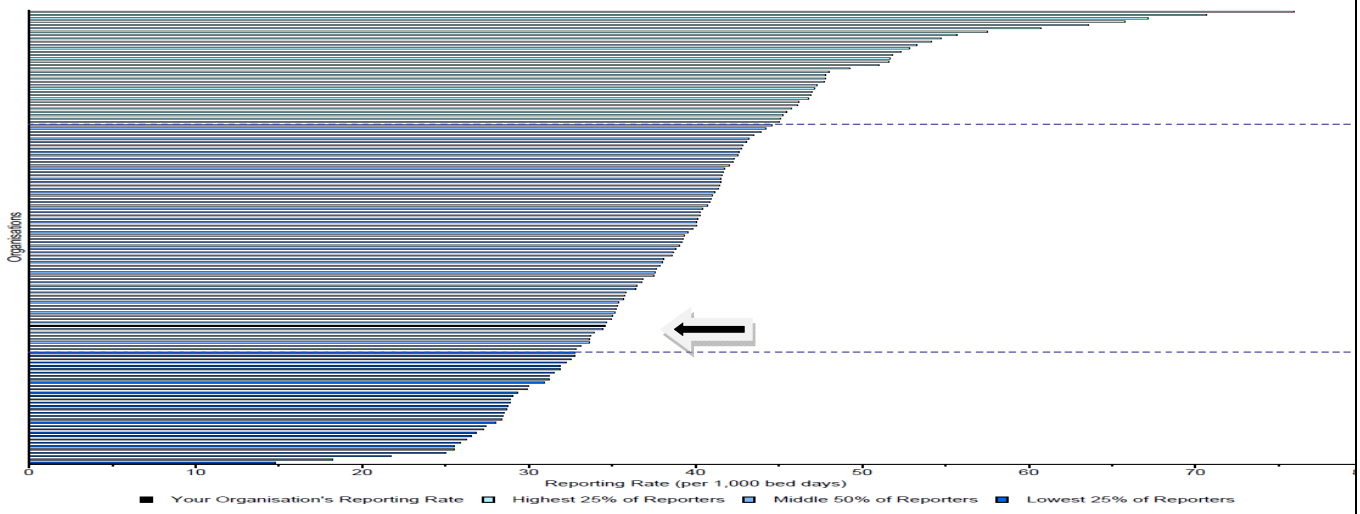
It is worth noting that whilst the target to vaccinate 75% of frontline health care workers was not achieved, the 2016 campaign has considerably improved upon the December 2015 figure where the Trust achieved an overall vaccine uptake of 46.5%.

Improvement is seemingly directly related to the significant change made to the delivery of the

campaign. For example, the distribution of personal invitations to all defined frontline health care workers, the super clinic and peer vaccinator programme, and the availability of a bespoke database to track those vaccinated enabling the Occupational Health Service to remind staff to attend for vaccine. Notwithstanding the determination to improve, diligence and effort of all those closely involved in the planning and delivery of the campaign.

2.2 National Reporting and Learning System (NRLS) – update report

The NRLS update on incidents reported by the Trust between 01 October 2015 to 31 March 2016 is summarised below. During the reporting period the Trust reported 6,058 incidents, which is in the middle range of reporting range when compared to similar acute trusts, as illustrated on the chart below.

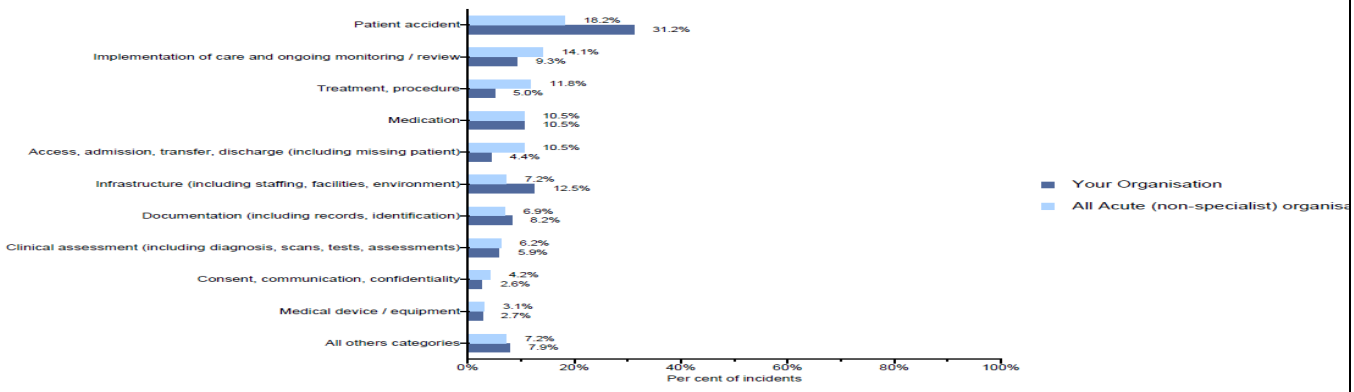


The median reporting rate for this cluster is 39.31 incidents per 1,000 bed days.

Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are.

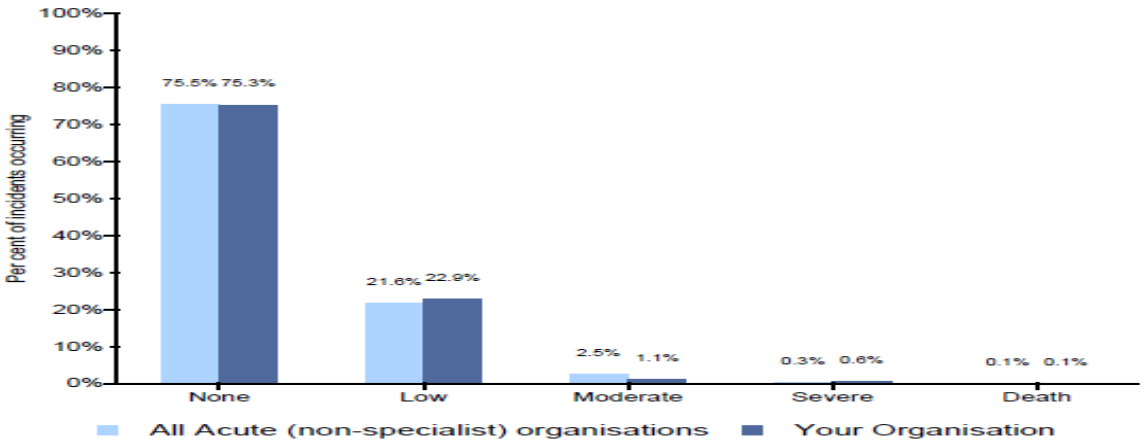
What types of incidents are reported in your organisation?

Figure 2: Top 10 incident types



If your reporting profile looks different from similar organisations, this could reflect differences in reporting culture, the type of services provided or patients cared for could also be pointing you to high risk areas. The response system is more important than the reporting system.

Figure 3: Incidents reported by degree of harm for Acute (non-specialist) Organisations



Degree of harm

	None	Low	Moderate	Severe	Death
Your figures:	4,559	1,388	65	38	8

3. Clinical Effectiveness

3.1 Consultants new to the Trust

The following consultants jointed the Trust in November:

Nadeem Ahmed
Locum Consultant Surgery
Scarborough

Sarah Martin
Paediatric Consultant
Scarborough

3.2 National/ Local Safety Standards for Invasive Procedures (Nat/LocSSIPs)

The development of NatSSIPs / LocSSIPs is a NHS England initiative to develop standards for all invasive procedures as a result of national and local learning from never events, serious incidents, & near misses.

Components of NatSSIPs:
Organisational

1) Governance and audit
2) Documentation of invasive procedures
3) Workforce
4) Scheduling and list management
5) Handovers and information transfer

Sequential

6) Procedural verification and site marking
7) Safety briefing
8) Sign in
9) Time out

10) Prosthesis verification
11) Prevention of retained foreign objects
12) Sign out
13) Debriefing

NatSSIPs set out the parameters against which local providers can review their local protocols (LocSSIPs).

Work to date at York Teaching Hospital:

- Attendance of central NatSSIPs conference in London (Dib Bandy – Cons Surgeon & Laura Powell – DDM General Surgery)
- Adrian Evans – leading on the project
- Steering Group developed to oversee progress and action plan
- CDs identified representatives from all the specialties involved in invasive procedures
- Invasive procedures (Trust-wide) identified
- Review of never events serious incidents
- Agreement on identified invasive procedures across the specialties.

Work for immediate action:

- Review of existing policies, possibly amend with standardised changes supported through practice training – formation of LocSSIPs.

Work for future action:

- Audit
- Review LocSSIPs.

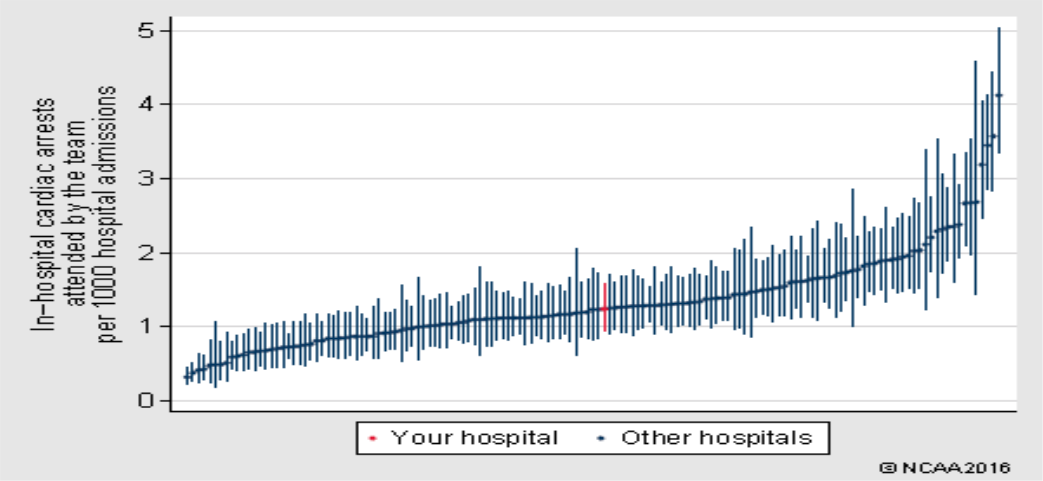
3.3 National Cardiac Arrest Audit – 6 monthly report (York Hospital)

Period	Total number of admissions to your hospital ^	Total number of 2222 calls solely for cardiac arrest	Total number of reported cardiac arrests attended by the team that met the scope of NCAA	Total number of reported cardiac arrests attended by the team that met the scope of NCAA *(in-hospital only)*	Number individu *(in-hosp only)*
01/04/2016 - 30/09/2016	50,970	65	65	63	61

Note:
^Total includes elective, non-elective and day cases

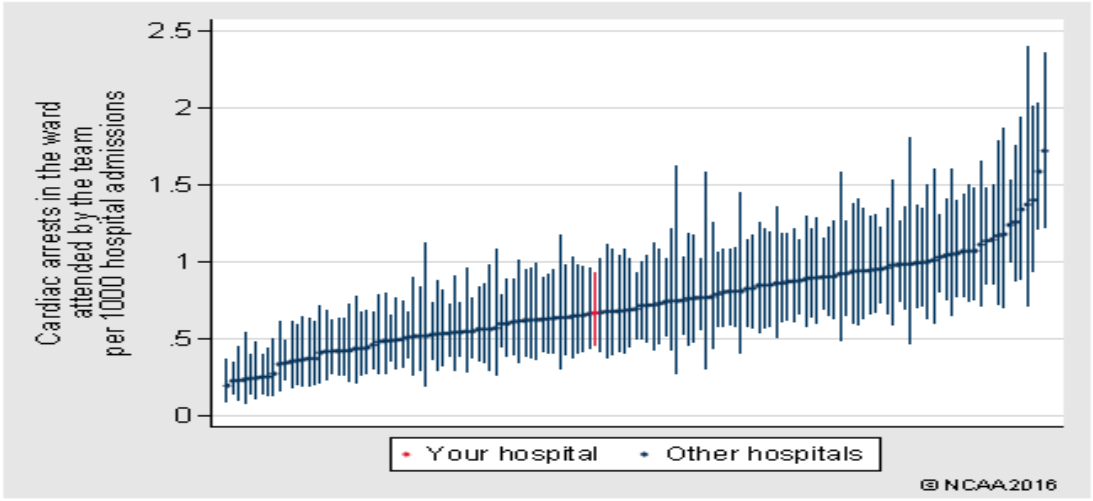
Rate of in-hospital cardiac arrests

The following graph presents the reported number of in-hospital cardiac arrests attended by the team pre-hospital arrests are excluded) per 1,000 hospital admissions for adult, acute hospitals in NCAA.

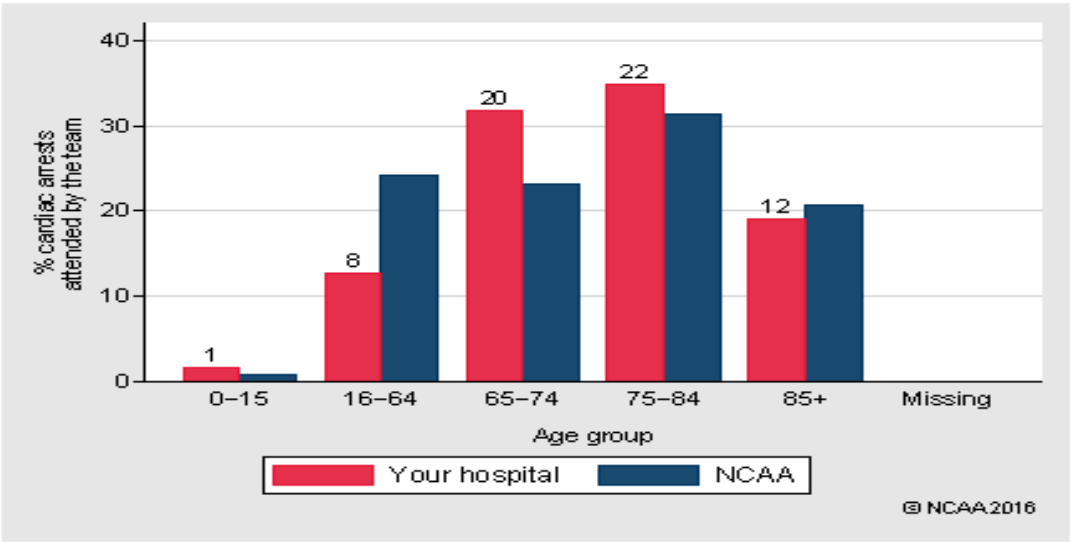


Rate of cardiac arrests - ward

The following graph presents the reported number of in-hospital cardiac arrests attended by the team wh
location of arrest was ward per 1,000 hospital admissions for adult, acute hospitals in NCAA.

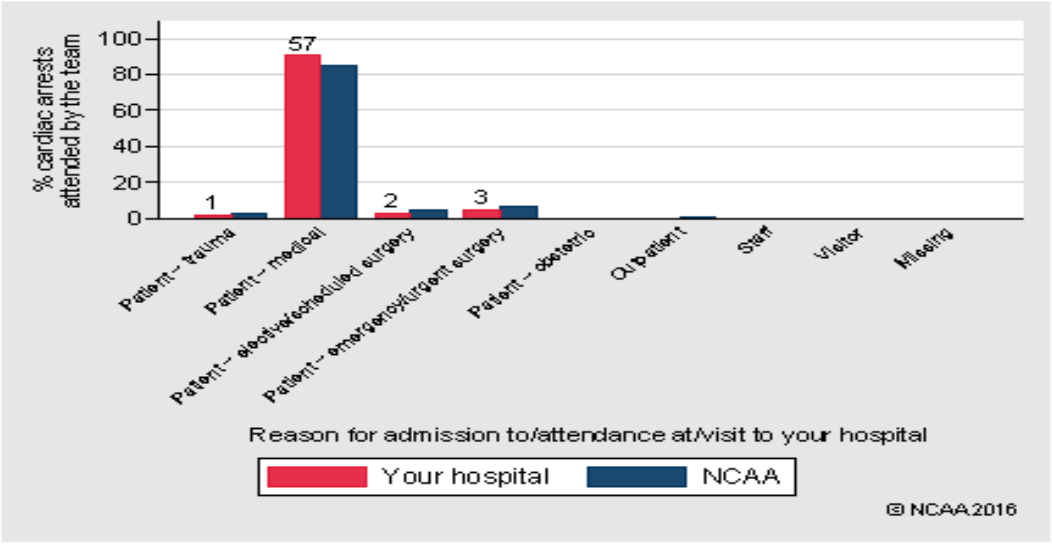


Age

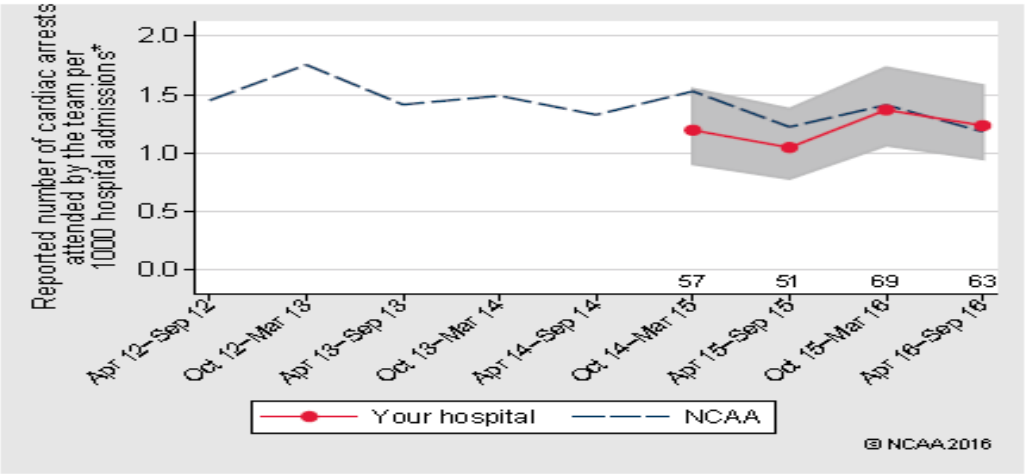


Note: n = 0 estimated age (included)

Reason for admission to/attendance at/visit to your hos

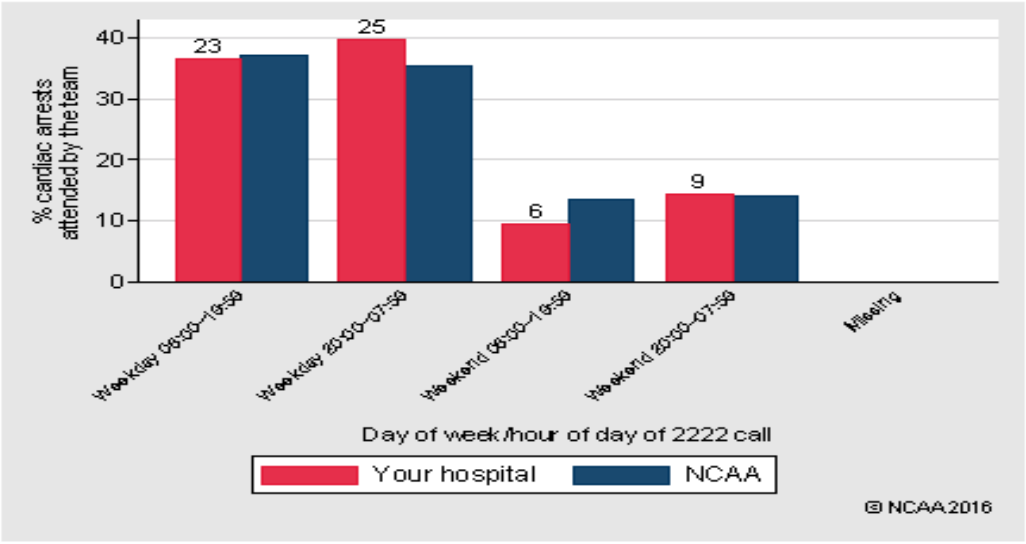


Rate of cardiac arrests attended by the team per 100 hospital admissions - trended



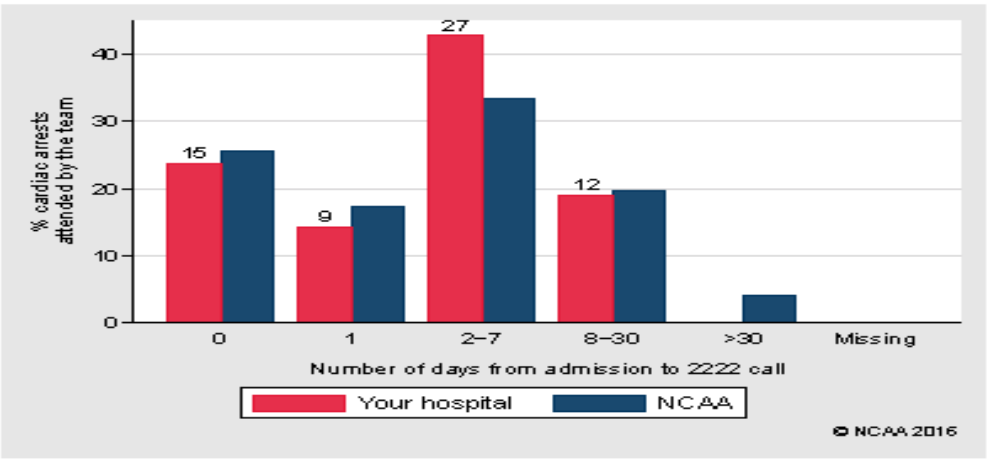
*Total includes elective, non-elective and day cases

Day of week/hour of day of cardiac arrests attended by the team

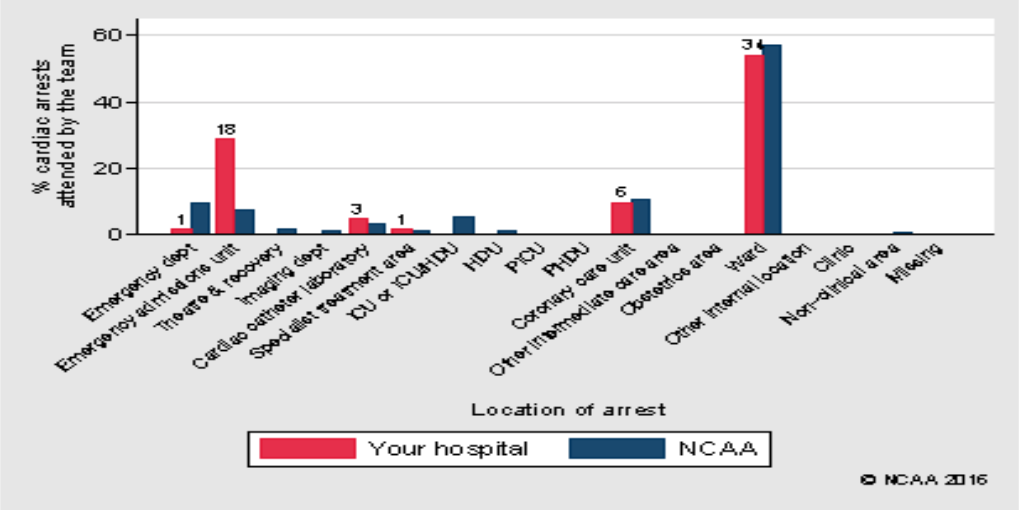


Weekday: Monday 08:00-Saturday 07:59. Weekend: Saturday 08:00-Monday 07:59

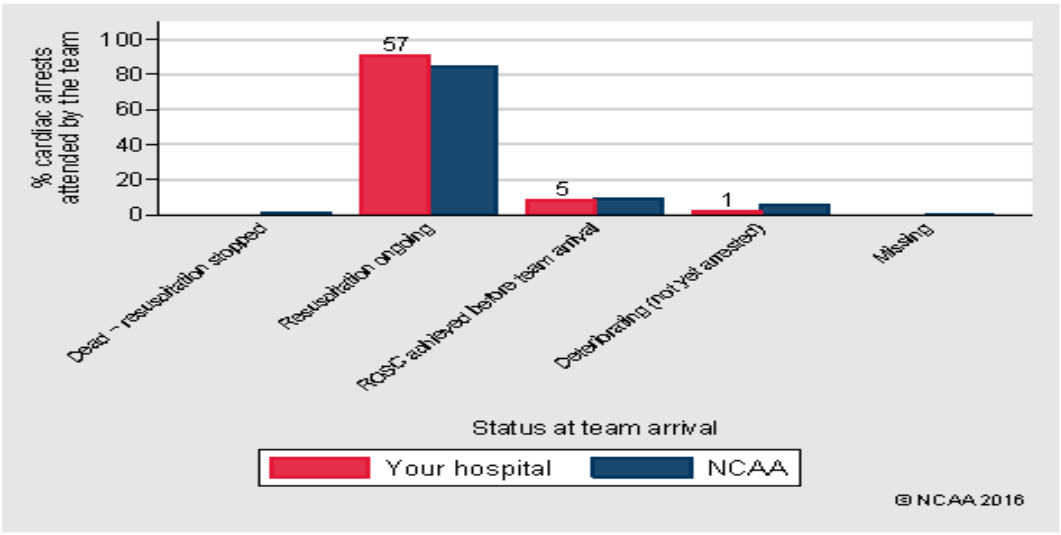
Number of days from admission to cardiac arrests attended by the team



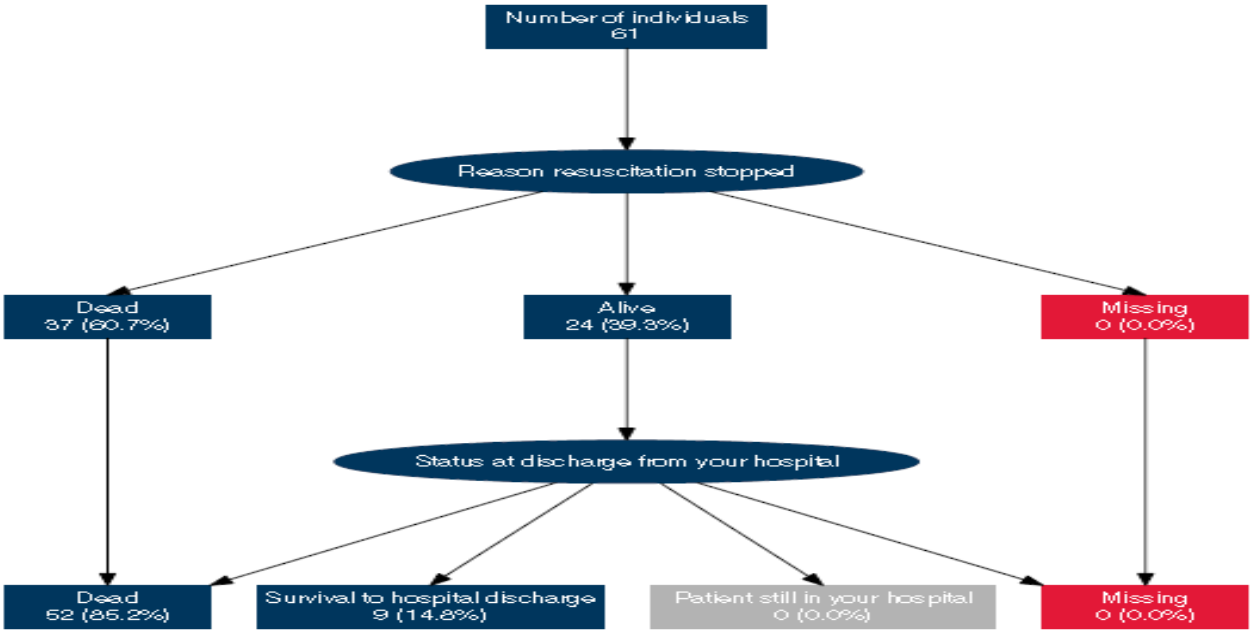
Location of arrest



Status at team arrival

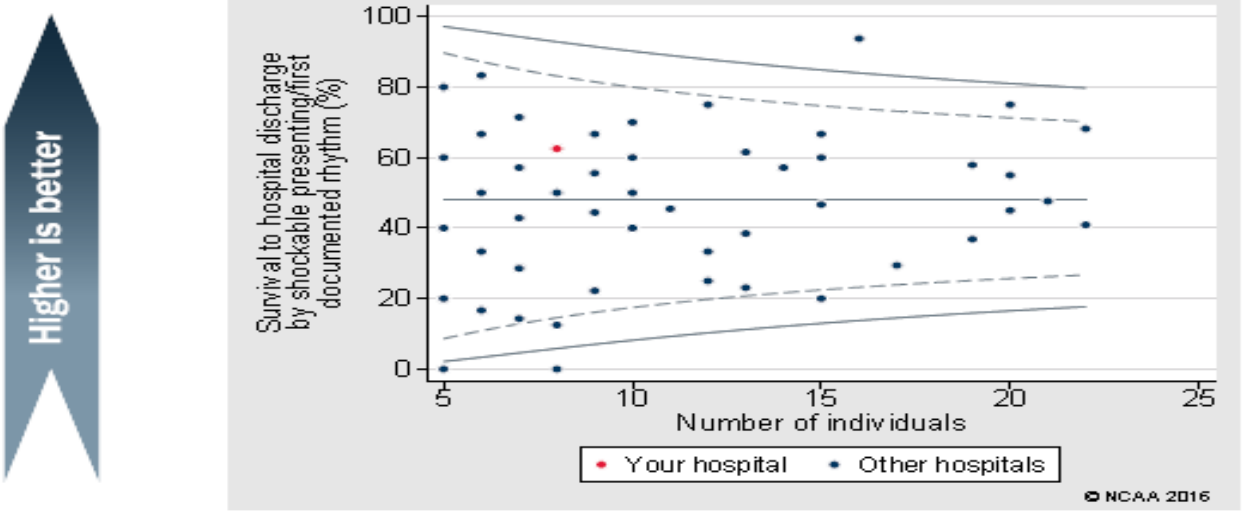


Outcome flow

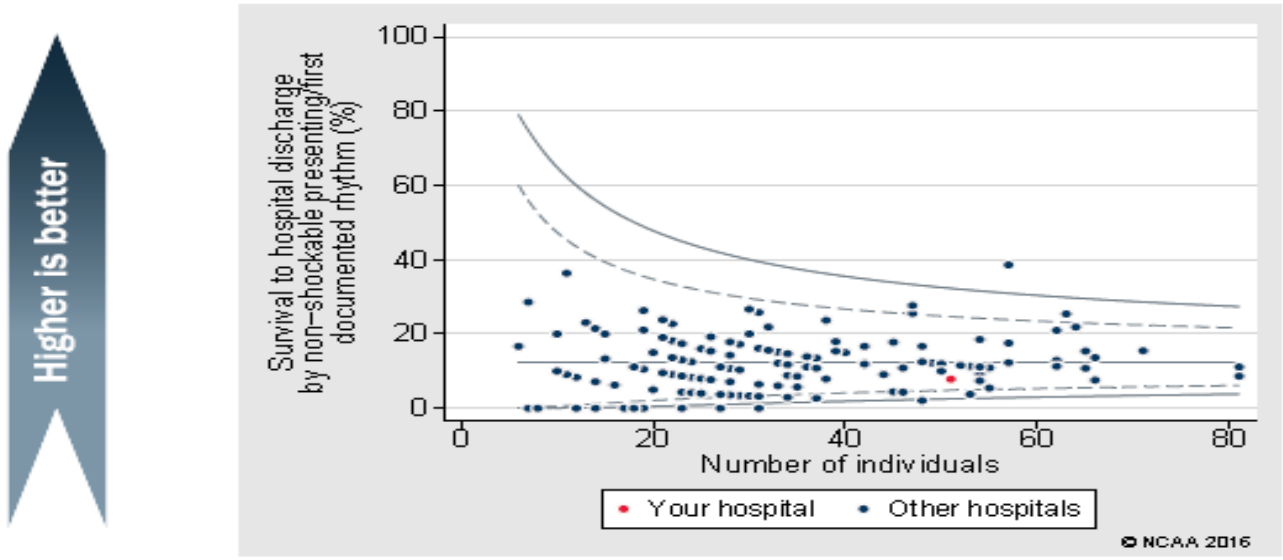


Note: All percentages shown in this flow are calculated from the overall number of individuals

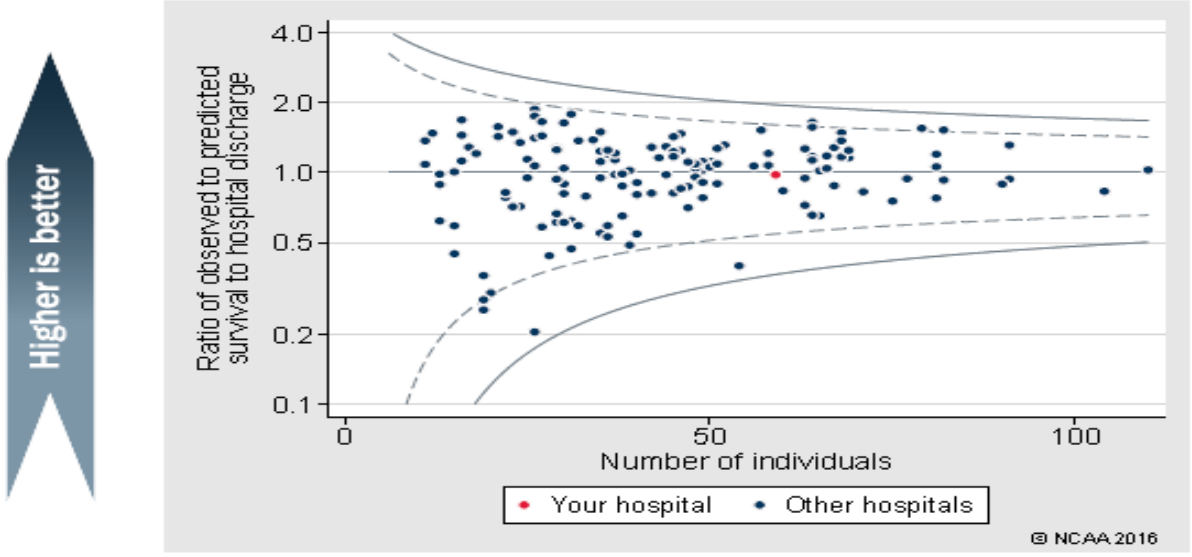
Survival to hospital discharge by shockable presenting/fi documented rhythm



Survival to hospital discharge by non-shockable presenti first documented rhythm



Funnel plot of observed to predicted survival to hospi discharge



4. Recommendations	
Board of Directors are requested to: • Be aware of progress with the Influenza Campaign • Note the latest report from the National Reporting and Learning System • Welcome consultants new to the Trust • Note progress with NatSSIPs/LocSSIPs • Be aware of National Cardiac Arrest Audit 6 monthly report – York Hospital	
Author	**Diane Palmer, Deputy Director of Patient Safety**
Owner	**James Taylor, Medical Director**
Date	**January 2017**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 January 2017

Safe Nurse and Midwifery Staffing Report

Action requested/recommendation

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

Executive Summary

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

The planned ward reconfiguration took place on 12th December 2016, as a result, for this month only, some of the data is presented pre and post reconfiguration; due to the wards change in function and/or change in staffing model. Ward 15 re-opened as a winter escalation ward and is excluded from reporting from 12th December 2016. On 15th December 2016 Archways closed and data provided in this report reflects the position up to this date and will not be reported in the future.

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

Following the ward reconfiguration on the York Hospital site in December 2016, work is now underway to realign the cost centres, budgets and staffing into the correct wards. As a result of this it is not possible to provide an accurate vacancy position for the York site nor the nursing dashboards at this stage.

In terms of Bridlington, Community and Scarborough, at the end of December 2016, there were 51.36fte RN vacant posts and 20.32 fte Care Staff. Of these, 19.99fte RN posts and 33.43fte Care Staff posts have been recruited and the individuals will commence in post over the coming months. The remaining RN vacancy position is 31.37fte and – 13.43fte for Care Staff.

Recruitment across the Nursing workforce continues across all grades. Attendance at recruitment fairs at York in December has resulted a number of September 2017 nursing graduates accepting posts with the Trust. Further attendance at Recruitment fairs is expected in January 2017. Further Care Staff recruitment has been scheduled throughout 2017.

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

There are no references to CQC outcomes

Progress of report	First presentation
Risk	No risk
Resource implications	Resources implication detailed in the report
Owner	Beverley Geary, Chief Nurse
Author	Nichola Greenwood, Nursing Workforce Projects Manager
Date of paper	January 2017
Version number	Version 1

Board of Directors – 25 January 2017

Safe Nurse and Midwifery Staffing Report

1. Introduction and background

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

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

The planned ward reconfiguration took place on 12th December 2016, as a result, for this month only, some of the data is presented pre and post reconfiguration; due to the wards change in function and/or change in staffing model. Ward 15 re-opened as a winter escalation ward and is excluded from reporting from 12th December 2016. On 15th December 2016 Archways closed and data provided in this report reflects the position up to this date and will not be reported in the future.

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

2. High level data by site

	Day		Night	
Site Name	**Average fill rate - registered nurses/ midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/ midwives (%)**	**Average fill rate - care staff (%)**
Archways Intermediate Care Unit	100.0%	90.7%	83.3%	93.3%
Bridlington and District Hospital	78.6%	88.1%	63.2%	204.8%
Malton Community Hospital	81.9%	112.9%	100.0%	100.0%
Scarborough General Hospital	89.5%	100.1%	96.3%	109.0%
Selby And District War Memorial Hospital	92.9%	104.5%	87.1%	119.4%
St Helens Rehabilitation Hospital	98.4%	90.3%	100.0%	100.0%
St Monicas Hospital	92.9%	109.4%	100.0%	109.7%
White Cross Rehabilitation Hospital	98.4%	93.5%	100.0%	87.1%
York Hospital	92.4%	108.3%	97.3%	113.7%

3. Care Hours per Patient Day

	Care Hours Per Patient Day (CHPPD)			
	Cumulative count over the month of patients at 23:59 each day	**Registered midwives/ nurses**	**Care Staff**	**Overall**
Archways Intermediate Care Unit	156	3.7	3.6	7.3
Bridlington and District Hospital	1184	3.6	4.1	7.7
Malton Community Hospital	743	2.2	3.4	5.6
Scarborough General Hospital	8666	4.1	2.8	6.8
Selby and District War Memorial Hospital	630	2.7	2.6	5.2
St Helen's Rehabilitation Hospital	571	2.8	2.4	5.2
St Monica's Hospital	307	3.0	4.1	7.1
White Cross Rehabilitation Hospital	630	2.5	2.2	4.7
York Hospital	16812	3.8	2.8	6.6

4. Exceptions

There were 4 wards where RN staffing during the day fell below 80% in December. These wards were Chestnut in Scarborough, Kent and Waters in Bridlington and Ward 29 in York all due to staff being redeployed to support other wards during periods of low occupancy and dependency.

There were 3 wards where RN planned staffing levels fell below 80% on night shifts. These wards were Kent, Lloyd and Waters in Bridlington all due to low bed occupancy; resulting in staff being redeployed to other wards.

A detailed exception breakdown is detailed below.

Enhanced Supervision

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

Community	**Bridlington**	**Scarborough**		**York**	
St Monicas	Johnson	Ann Wright	Beech	AMU	Ward 16
		Graham	Chestnut	Ward 17	Ward 23
		Maple	Oak	Ward 25	Ward 26
		Stroke		Ward 28	Ward 32
				Ward 35	Ward 36/ASU
				Ward 37	Ward 39

Provision of Safe Ward Cover

The Matrons are responsible for ensuring staffing levels are as safe as possible throughout the day and night. This means that staffing is assessed throughout the day and for out of

hours and weekends, effective and safe plans are implemented. This does result in staff moving from their base wards on occasions, and where necessary, increased numbers of Care Staff to support the shortfall of registered nurses or increased Registered Nurses when the acuity of patients requires additional support. These wards are:

Bridlington	Community	Scarborough	York	
Waters	Fitzwilliam	Ann Wright	CCU	Ward 15
	Selby	Ash	Ward 17	Ward 23
		Beech	Ward 25	Ward 26
		Chestnut	Ward 28	Ward 32
		CCU	Ward 33	Ward 34
		Duke of Kent	Ward 39	

Across York and Scarborough sites, the effective management of the roster for long day efficiencies and annual leave does result at times in wards being fractionally overstaffed to ensure all staff work their contracted hours. This has occurred during December on ICU and ASU in York.

Bed Occupancy

Chestnut in Scarborough, Lloyd and Kent and Waters wards at Bridlington and Ward 29 in York changed their ratio of registered and unregistered staff according to bed occupancy, with staff being deployed to other ward areas. On occasions Kent ward was closed when there were no patients requiring overnight stay. Waters Ward has reduced its bed numbers resulting in RNs being redeployed to other wards and additional care staff being utilised.

ESA and Ward 16 at York opened additional bed capacity at times on a weekend resulting in higher than planned staffing.

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

5. Vacancies by Site

Following the ward reconfiguration on the York Hospital site in December 2016, work is now underway to realign the cost centres, budgets and staffing into the correct wards. As a result of this it is not possible to provide an accurate vacancy position for the York site nor the nursing dashboards at this stage.

In terms of Bridlington, Community and Scarborough, at the end of December 2016, there were 51.36fte RN vacant posts and 20.32 fte Care Staff. Of these, 19.99fte RN posts and 33.43fte Care Staff posts have been recruited and the individuals will commence in post over the coming months. The remaining RN vacancy position is 31.37fte and – 13.43fte for Care Staff.

Recruitment across the Nursing workforce continues across all grades. Attendance at recruitment fairs at York in December has resulted a number of September 2017 nursing graduates accepting posts with the Trust. Further attendance at Recruitment fairs is expected in January 2017. Further Care Staff recruitment has been scheduled throughout 2017.

6. Recommendation	
The Board of Directors is asked to receive the exception report for information.	
7. References and further reading	
National Quality Board. "*How to ensure the right people, with the right skills, are in the right place at the right time - A guide to nursing, midwifery and care staffing capacity and capability".* 2013 **Lord Carter Report** *"Operational productivity and performance in English acute hospitals: Unwarranted variations*". 2016	
Author	**Nichola Greenwood, Nursing Workforce Projects Manager**
Owner	**Beverley Geary, Chief Nurse**
Date	**January 2017**

Fill rate indicator return

Staffing: Nursing, midwifery and care staff

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/

Comments

A ward reconfiguration took place on 12th December resulting the following changes: AMU split into AMU and AMB. These are reported as AMU up 11th December and then as separate wards from 12th December. Ward G1 changed to a Head & Neck ward on 12th December. The report therefore provides G1 from 1st - 11th December under its former speciality - Gynaecology and then from 12th December under its new clinical specialty. Ward 15 closed on 11th December 2016. Archways closed on 15th December

Only complete sites your organisation is accountable for				Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
Hospital Site Details		Main 2 Specialties on each ward		Registered		Care Staff		Registered		Care Staff									
Hospital Site name	Ward 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 (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Ann Wright	430 - GERIATRIC MEDICINE		1116	894	930	960	682	682	341	660	80.1%	103.2%	100.0%	193.5%	546	2.9	3.0	5.9
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Ash	100 - GENERAL SURGERY		930	960	930	892.5	682	682	0	0	103.2%	96.0%	100.0%	-	395	4.2	2.3	6.4
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Beech	300 - GENERAL MEDICINE		1488	1344	1302	1392	1023	1034	682	748	90.3%	106.9%	101.1%	109.7%	971	2.4	2.2	4.7
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Cherry	326 - ACUTE INTERNAL MEDICINE	300 - GENERAL MEDICINE	1860	1692	1488	1422	1705	1474	1364	1254	91.0%	95.6%	86.5%	91.9%	647	4.9	4.1	9.0
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Chestnut	301 - GASTROENTEROLOGY	300 - GENERAL MEDICINE	1488	1164	1116	1188	682	682	682	803	78.2%	106.5%	100.0%	117.7%	848	2.2	2.3	4.5
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Coronary Care Unit	320 - CARDIOLOGY		2325	2047.5	930	757.5	1364	1320	341	429	88.1%	81.5%	96.8%	125.8%	546	6.2	2.2	8.3
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Duke of Kent	420 - PAEDIATRICS		1627.5	1515	465	480	682	814	341	198	93.1%	103.2%	119.4%	58.1%	305	7.6	2.2	9.9
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Graham	430 - GERIATRIC MEDICINE		930	888	744	948	682	682	341	660	95.5%	127.4%	100.0%	193.5%	566	2.8	2.8	5.6
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Hawthorn	501 - OBSTETRICS		744	744	372	372	682	682	0	0	100.0%	100.0%	100.0%	-	389	3.7	1.0	4.6
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Holly	110 - TRAUMA & ORTHOPAEDICS		1116	990	930	936	682	671	682	671	88.7%	100.6%	98.4%	98.4%	529	3.1	3.0	6.2
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Intensive Therapy Unit	192 - CRITICAL CARE MEDICINE	100 - GENERAL SURGERY	2790	2452.5	465	450	1705	1672	0	0	87.9%	96.8%	98.1%	-	141	29.3	3.2	32.4
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Lilac	101 - UROLOGY		1830	1680	1860	1717.45	1023	968	1023	836	91.8%	92.3%	94.6%	81.7%	746	3.5	3.4	7.0
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Maple	100 - GENERAL SURGERY		2325	1965	1162.5	1440	1364	1298	682	693	84.5%	123.9%	95.2%	101.6%	620	5.3	3.4	8.7
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Oak	430 - GERIATRIC MEDICINE		1488	1320	2046	1902	1023	913	1023	1188	88.7%	93.0%	89.2%	116.1%	931	2.4	3.3	5.7
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Stroke	328-STROKE MEDICINE		1116	1080	744	642	1023	869	341	407	96.8%	86.3%	84.9%	119.4%	486	4.0	2.2	6.2
BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Johnson	430 - GERIATRIC MEDICINE		930	876	1302	1272	682	682	341	451	94.2%	97.7%	100.0%	132.3%	725	2.1	2.4	4.5
BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Kent	110 - TRAUMA & ORTHOPAEDICS		1162.5	855	930	772.5	682	297	0	297	73.5%	83.1%	43.5%	-	114	10.1	9.4	19.5
BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Lloyd	100 - GENERAL SURGERY		600	525	740	352.5	165	77	0	11	87.5%	47.6%	46.7%	-	19	31.7	19.1	50.8
BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Waters	430 - GERIATRIC MEDICINE	101 - UROLOGY	930	592.5	930	1042.5	682	341	341	638	63.7%	112.1%	50.0%	187.1%	326	2.9	5.2	8.0
YORK HOSPITAL - RCB55	11	100 - GENERAL SURGERY	101 - UROLOGY	1512	1458	900	756	682	649	682	671	96.4%	84.0%	95.2%	98.4%	882	2.4	1.6	4.0
YORK HOSPITAL - RCB55	14	100 - GENERAL SURGERY	101 - UROLOGY	1704	1623	1116	1086	1083	999	682	638	95.2%	97.3%	92.2%	93.5%	712	3.7	2.4	6.1
YORK HOSPITAL - RCB55	15 (until 11th December)	120 - ENT		660	660	495	472.5	363	352	121	132	100.0%	95.5%	97.0%	109.1%	307	3.3	2.0	5.3
YORK HOSPITAL - RCB55	16	100 - GENERAL SURGERY		2028	2004	924	1512	1364	1353	682	935	98.8%	163.6%	99.2%	137.1%	886	3.8	2.8	6.6

Only complete sites your organisation is accountable for				Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
Hospital Site Details		Main 2 Specialties on each ward		Registered		Care Staff		Registered		Care Staff									
Hospital Site name	Ward 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 (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
YORK HOSPITAL - RCB55	17	420 - PAEDIATRICS		1488	1434	372	414	1023	1111	341	297	96.4%	111.3%	108.6%	87.1%	395	6.4	1.8	8.2
YORK HOSPITAL - RCB55	23	430 - GERIATRIC MEDICINE		1627.5	1552.5	1395	1725	682	682	1023	1298	95.4%	123.7%	100.0%	126.9%	922	2.4	3.3	5.7
YORK HOSPITAL - RCB55	25	430 - GERIATRIC MEDICINE		1302	1254	1116	1266	682	682	1023	1188	96.3%	113.4%	100.0%	116.1%	713	2.7	3.4	6.2
YORK HOSPITAL - RCB55	26	430 - GERIATRIC MEDICINE		1537.5	1384.5	1095	1288.5	682	704	1023	1078	90.0%	117.7%	103.2%	105.4%	914	2.3	2.6	4.9
YORK HOSPITAL - RCB55	28	110 - TRAUMA & ORTHOPAEDICS		1674	1476	930	1152	682	715	682	803	88.2%	123.9%	104.8%	117.7%	901	2.4	2.2	4.6
YORK HOSPITAL - RCB55	29	110 - TRAUMA & ORTHOPAEDICS	103-BREAST SURGERY	1728	1347	864	762	682	627	561	528	78.0%	88.2%	91.9%	94.1%	372	5.3	3.5	8.8
YORK HOSPITAL - RCB55	31	370 - MEDICAL ONCOLOGY		2092.5	1822.5	930	870	682	682	341	341	87.1%	93.5%	100.0%	100.0%	525	4.8	2.3	7.1
YORK HOSPITAL - RCB55	32	320 - CARDIOLOGY	361 - NEPHROLOGY	1518	1398	878	1056	682	693	1023	1012	92.1%	120.3%	101.6%	98.9%	840	2.5	2.5	5.0
YORK HOSPITAL - RCB55	33	301 - GASTROENTEROLOGY	301 - GASTROENTEROLOGY	1488	1254	1116	840	682	671	1023	946	84.3%	75.3%	98.4%	92.5%	627	3.1	2.8	5.9
YORK HOSPITAL - RCB55	34	340 - RESPIRATORY MEDICINE		1488	1422	1116	1050	682	726	1023	1001	95.6%	94.1%	106.5%	97.8%	902	2.4	2.3	4.7
YORK HOSPITAL - RCB55	35	430 - GERIATRIC MEDICINE		1302	1182	1116	1170	682	682	1023	1023	90.8%	104.8%	100.0%	100.0%	915	2.0	2.4	4.4
YORK HOSPITAL - RCB55	37	430 - GERIATRIC MEDICINE		1095	990	1927.5	3037.5	682	682	682	1650	90.4%	157.6%	100.0%	241.9%	589	2.8	8.0	10.8
YORK HOSPITAL - RCB55	39	430 - GERIATRIC MEDICINE	430 - GERIATRIC MEDICINE	1302	1092	1116	1422	682	682	682	968	83.9%	127.4%	100.0%	141.9%	693	2.6	3.4	6.0
YORK HOSPITAL - RCB55	36 - Acute Stroke Unit	328-STROKE MEDICINE	430 - GERIATRIC MEDICINE	1488	1506	1302	1326	1023	1023	1023	1155	101.2%	101.8%	100.0%	112.9%	650	3.9	3.8	7.7
YORK HOSPITAL - RCB55	Acute Medical Unit (until 11th December)	326 - ACUTE INTERNAL MEDICINE		1650	1515	1320	1237.5	968	924	726	825	91.8%	93.8%	95.5%	113.6%	612	4.0	3.4	7.4
YORK HOSPITAL - RCB55	Acute Medical Unit (from 12th December)	326 - ACUTE INTERNAL MEDICINE	430 - GERIATRIC MEDICINE	1500	1327.5	1200	1252.5	880	858	660	770	88.5%	104.4%	97.5%	116.7%	548	4.0	3.7	7.7
YORK HOSPITAL - RCB55	AMB	326 - ACUTE INTERNAL MEDICINE	430 - GERIATRIC MEDICINE	1500	1275	1200	1050	880	704	660	616	85.0%	87.5%	80.0%	93.3%	575	3.4	2.9	6.3
YORK HOSPITAL - RCB55	Coronary Care Unit	320 - CARDIOLOGY		1860	1747.5	330	180	1364	1210	0	0	94.0%	54.5%	88.7%	-	194	15.2	0.9	16.2
YORK HOSPITAL - RCB55	Extended Stay Area	100 - GENERAL SURGERY		1065	997.5	502.5	472.5	484	440	0	132	93.7%	94.0%	90.9%	-	398	3.6	1.5	5.1
YORK HOSPITAL - RCB55	G1 (until 11th December)	502 - GYNAECOLOGY		588	486	264	240	242	242	242	242	82.7%	90.9%	100.0%	100.0%	221	3.3	2.2	5.5
YORK HOSPITAL - RCB55	G1 (from 12th December)	120 - ENT	502 - GYNAECOLOGY	960	948	480	432	660	638	220	220	98.8%	90.0%	96.7%	100.0%	382	4.2	1.7	5.9
YORK HOSPITAL - RCB55	G2	501 - OBSTETRICS		1116	1050	558	546	682	660	341	341	94.1%	97.8%	96.8%	100.0%	592	2.9	1.5	4.4
YORK HOSPITAL - RCB55	G3	501 - OBSTETRICS		744	720	372	372	682	660	0	0	96.8%	100.0%	96.8%	-	138	10.0	2.7	12.7
YORK HOSPITAL - RCB55	Intensive Care Unit	192 - CRITICAL CARE MEDICINE		5580	5377.5	465	510	4092	3949	341	330	96.4%	109.7%	96.5%	96.8%	407	22.9	2.1	25.0
ARCHWAYS INTERMEDIATE CARE UNIT	Archways	925 - COMMUNITY CARE SERVICES		300	300	450	408	330	275	165	154	100.0%	90.7%	83.3%	93.3%	156	3.7	3.6	7.3
MALTON COMMUNITY HOSPITAL - RCBL8	Fitzwilliam	925 - COMMUNITY CARE SERVICES		1162.5	952.5	1627.5	1837.5	682	682	682	682	81.9%	112.9%	100.0%	100.0%	743	2.2	3.4	5.6
SELBY AND DISTRICT WAR MEMORIAL HOSPITAL - RCB07	Inpatient Unit	925 - COMMUNITY CARE SERVICES		1162.5	1080	1162.5	1215	682	594	341	407	92.9%	104.5%	87.1%	119.4%	630	2.7	2.6	5.2
ST HELENS REHABILITATION HOSPITAL - RCBTV	St Helens	430 - GERIATRIC MEDICINE		930	915	1162.5	1050	682	682	341	341	98.4%	90.3%	100.0%	100.0%	571	2.8	2.4	5.2
ST MONICAS HOSPITAL - RCB05	St Monicas	925 - COMMUNITY CARE SERVICES		630	585	795	870	341	341	341	374	92.9%	109.4%	100.0%	109.7%	307	3.0	4.1	7.1
WHITE CROSS REHABILITATION HOSPITAL - RCBP9	Whitecross Court	430 - GERIATRIC MEDICINE		930	915	1162.5	1087.5	682	682	341	297	98.4%	93.5%	100.0%	87.1%	630	2.5	2.2	4.7
	Total			75508.5	68635.5	51146.5	52904.95	45270	43096	27566	31339					29699			

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 January 2017

Director of Infection Prevention Quarterly Infection Prevention and Control Report Q3

Action requested/recommendation

The Board of Directors are asked to:

- Receive the Infection Prevention (IP) report for Q3
- Support the recommendation for provision of a proactive HPV programme and decant space to enable deep cleaning and high level disinfection
- Note the actions taken to improve the governance and reporting of water safety

Summary

As required by legislative and regulatory requirements, the Trust continues to acknowledge its responsibility to provide safe and effective infection prevention practice with the aim of reducing harm from avoidable infection that occurs either as a direct result of intervention or from contact with the healthcare setting.

This report summarises performance against these requirements and aims to provide assurance of progress against interventions initiated to reduce the increased incidence of HCAI.

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

Regulation 12 of the Fundamental Standard – Safe care and treatment: (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Progress of report	Quality and Safety Committee
Risk	None
Resource implications	None
Owner	Beverley Geary, Chief Nurse, Director of Infection Prevention and Control (DIPC)
Author	Vicki Parkin Deputy DIPC
Date of paper	January 2017
Version number	Version 1

Board of Directors – 25 January 2017

Director of Infection Prevention and Control (DIPC) Quarterly Report

1. Introduction

As required by legislative and regulatory requirements, the Trust continues to acknowledge its responsibility to provide safe and effective infection prevention practice with the aim of reducing harm from avoidable infection that occurs either as a direct result of intervention or from contact with the healthcare setting.

This report summarises performance against these requirements and aims to provide assurance of progress against interventions initiated to reduce the increased incidence of HCAI.

The impact of infection prevention interventions reported in Q2 continue to have a positive impact on Healthcare Associated Infection (HCAI) in particular MSSA bacteraemia and *Clostridium difficile infection* (CDI) although December had high incidence in all reported HCAI compared to Q2 and the same period 2015/16. Data presented in section 7 outline impact and progress.

Two significant outbreaks occurred in Q3; Carbapenamase -producing Enterobacteriaceae (CPE) and Infuenza A. The outbreak of MRSA in SCBU reported in Q2 was declared closed.

2. Outbreaks

Carbapenamase -producing Enterobacteriaceae (CPE)
Carbapenems are a powerful group of broad spectrum antibiotics. In many cases, these are the last effective defence against infections caused by multi-resistant bacteria of which CPE is one. Resistance to carbapenems has emerged and is beginning to spread, new antibiotics need to be developed to counter bacteria with this type of resistance. Good infection prevention practice in environments that are fit for purpose are key to preventing their spread, reducing harm to patients and maintaining Organisational reputation.

2 linked cases of CPE occurred on ward 33 during November. Subsequent screening in line with national guidance of all ward and Renal Unit contacts revealed no further cases. The index case was a carrier admitted with CPE, transmission to a second case resulted in bacteraemia that was treated successfully.

Outbreak control measures were initiated immediately and the ward was closed to admissions for 4 weeks due to the level of screening required with restricted access to staff. The extended period of closure enabled de-cluttering, some key environmental improvements and high level disinfection (HPV). The collaboration and adherence to best practice kept the outbreak limited to 2 cases.

Influenza
6 cases of Influenza type A occurred on ward 37 during December leading to ward closure with enhanced surveillance and respiratory precautions initiated. 2 deaths occurred which are being investigated through the SI process.

All patients and staff were given prophylaxis and vaccination where appropriate. Urgent Fit Testing in the use of respirator masks was arranged to ensure protection of staff.

A recommendation from the outbreak investigation was that the Trust should consider Influenza vaccination for all long stay patients. This was be discussed at the Infection Prevention Operational Group and action to address this was agreed.

MRSA in SCBU at York
The outbreak of MRSA colonisation reported in Q2 was declared closed on the 10 November following no further cases since 12.9.16. Key learning points from the outbreak were consistent and rigorous compliance with infection prevention practice, appropriate use of personal protective equipment and improved communication

3. Norovirus Multiagency Group

Following the extended Nororvirus outbreak in 2016, the group continues to meet to evaluate compliance with the pathway and identify risk to secondary care. The Assistant Director of Nursing for Community is developing a structure with primary care leads to enable care, management and support for patients aimed at preventing hospital admission.

Communications leads have developed and disseminated key public messages aimed at preventing introduction of the virus into hospitals.

NYCC and City of York Council have now developed a policy advising their staff of safe assessment of patients in hospital who are fit for discharge but need care packages. Historically patients were not assessed when on closed ward prolonging their stay and re-exposing them to infection.

Whilst much has been achieved it is anticipated that true impact and benefit may not be felt until next winter when all initiatives should be developed and embedded.

4. High Level Disinfection (HPV)

In response to increased incidence of *Clostridium difficile* infection, delivery of the proactive HPV programme was completed to the high risk areas on the York site. Delivery was unachievable on the Scarborough site due to lack of decant space. The following summarised risk and recommendations for the success of future programmes:

Learning and Outcome

- Identifying an areas designated as the decant ward for the whole of the programme at the earliest point in the year is key to operational planning and delivery.
- Making that ward available at the earliest point in the year is equally essential and should drive the programme.
- The plan became delayed due to not having staff to move patients, equipment and clean areas before HPV.
- Some evidence of cleaning being rushed and not to the required standard, again due to staffing levels.
- When a problem was encountered in one area there were no contingency arrangements to be able to shift the focus onto another area.

The following actions are recommended to support provision of future HPV programmes:

- A group of senior staff will be designated to develop and lead the programme in its

entirety. This group of staff must have backing and support from Directorate leads.
- Regular reviews along with contingency alternatives to maintain the plan will be delivered to schedule at each stage.
- The programme should start as early in the year as possible to avoid the risk of running out of time pre winter escalation capacity requirements.
- A single group of staff designated to assist at all levels of the programme should be trained to the correct standard in HPV decontamination, this would take some of the pressure away from matrons and nursing staff.

5. Water Safety

Following a review of the Trust compliance with water safety standards and legislation, a report from Hydrop, (the Trust`s external water safety auditors) and an internal review by the Head of Medical Engineering was commissioned. This identified a number of urgent actions that are required:

Actions and Outcomes:

The audit is to be discussed at the next Water Safety Group and an action plan for remedial action developed.

1. The Completed action plan then requires regular review by Heads of Estates and Facilities for York and Scarborough sites and periodical review at Water Safety Group until all actions are closed off and the Trust has full management control.
2. The Premises Assurance Model Self-Assessment for York and Scarborough will then need updating to reflect the Trusts refreshed compliance position.

The membership and Terms Of Reference of the current Water Safety group are now under review to:

- Identify opportunities to elect new chair on an annual basis.
- Confirm membership to ensure key individuals such are core members of the group and
- Clarify the reporting and governance arrangements of the group.

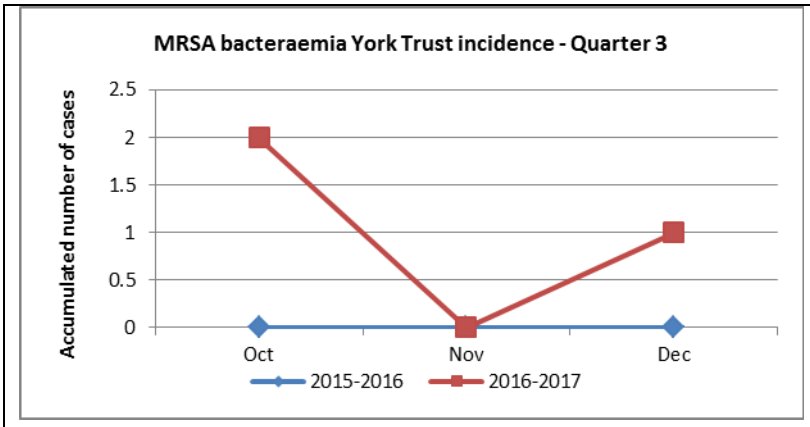
Progress and compliance will be overseen by the Trust Infection Prevention Steering Group.

6. HCAI incidence and performance

Data below describes HCAI incidence in Q3.

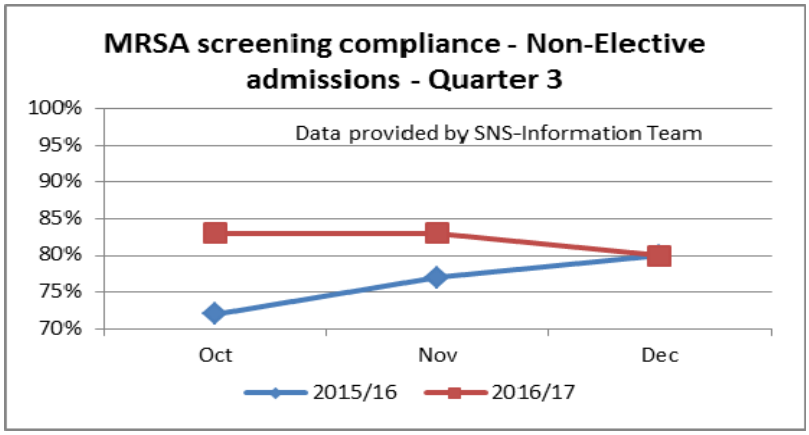
MRSA Bacteraemia:

3 cases in the quarter bringing incidence to 7. Post infection review has highlighted most cases were high risk patients requiring invasive devices, heavily colonised with MRSA.



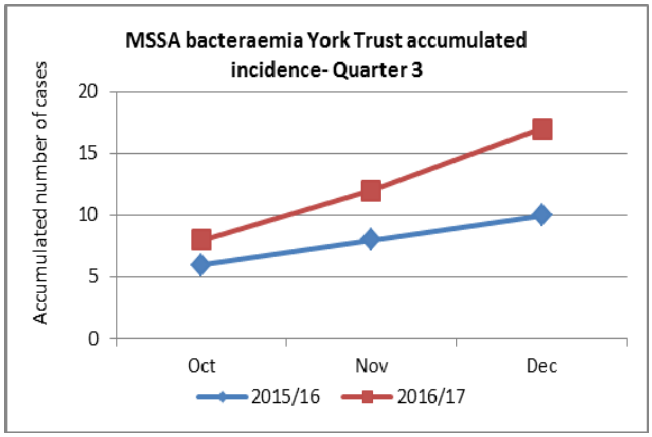
MRSA Screening Compliance

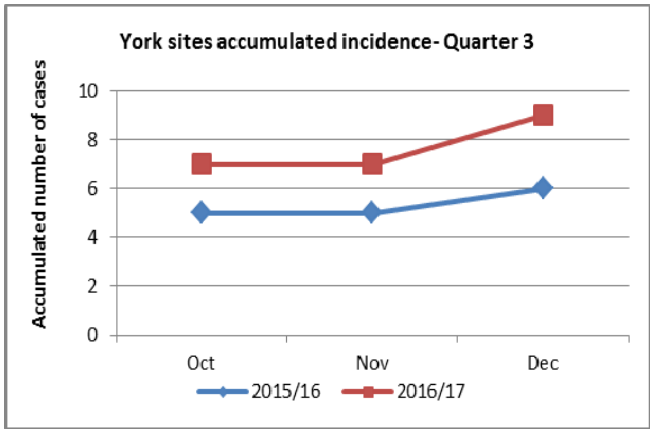
Following refinement of MRSA emergency screening data criteria, compliance has improved but dropped during December

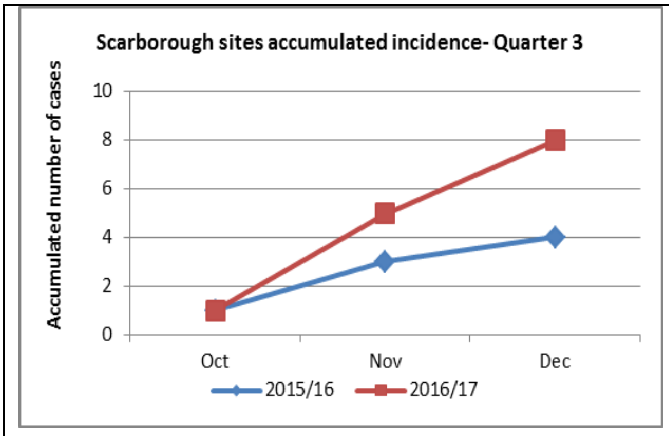


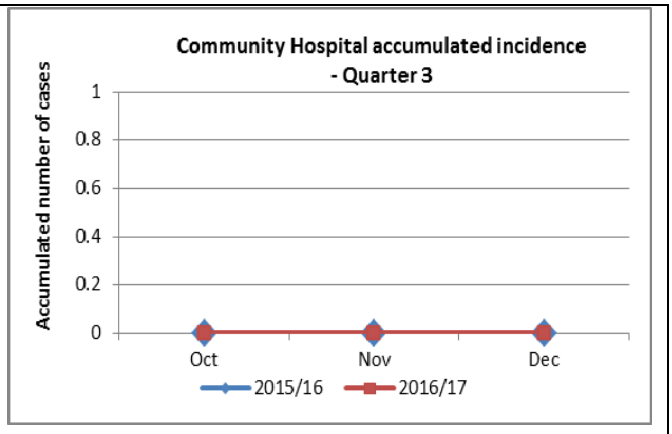
MSSA Bacteraemia:

Current Incidence is 17 cases compared with 10 cases for the same period last year with high incidence in December. Post infection review has shown affected patients to be high risk with significant co-morbidities particularly serious skin conditions e.g cellulits, lower extremity ulcers.



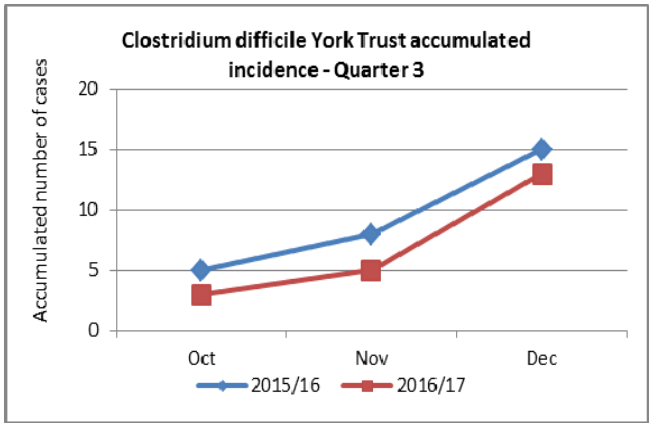


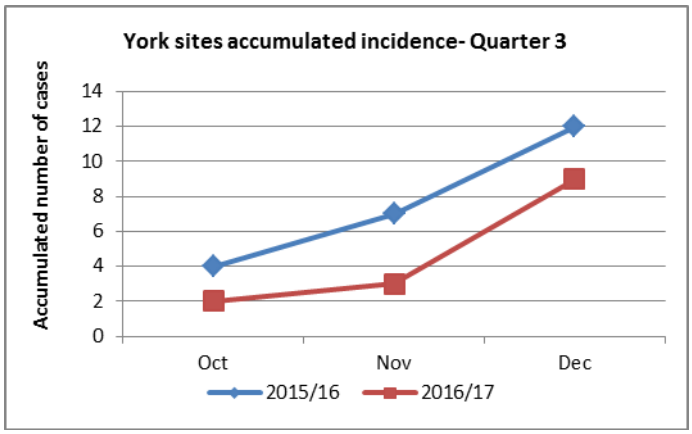


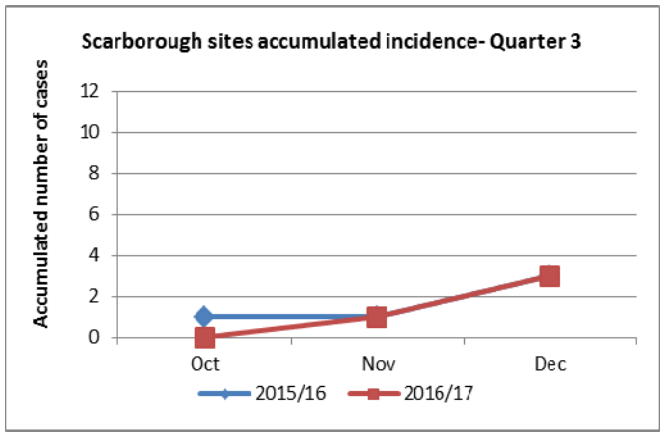


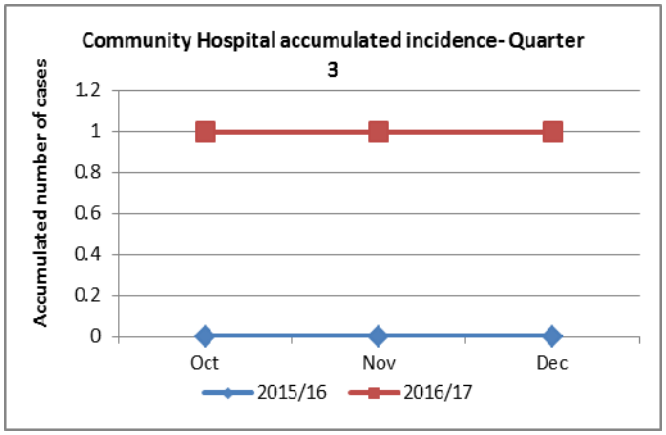
***Clostridium difficile* infection (CDI):**

Incidence is 13 cases compared with 15 cases for the same period last year placing the Trust below trajectory; considered to be the impact of improved antimicrobial and clinical sampling. Post infection review has shown good compliance with CDI management standards and 11cases with no lapses in care for the year to date.

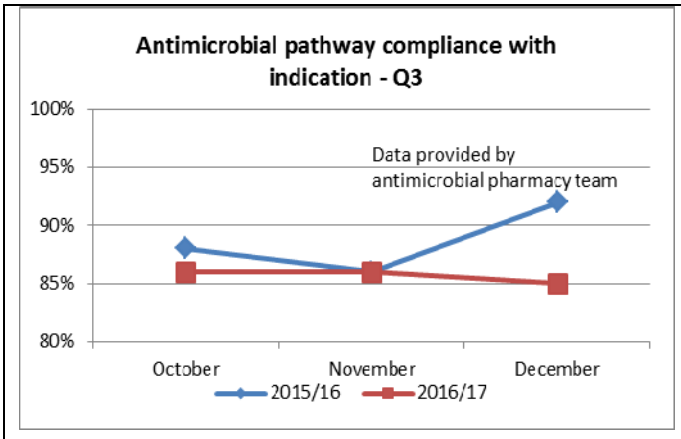


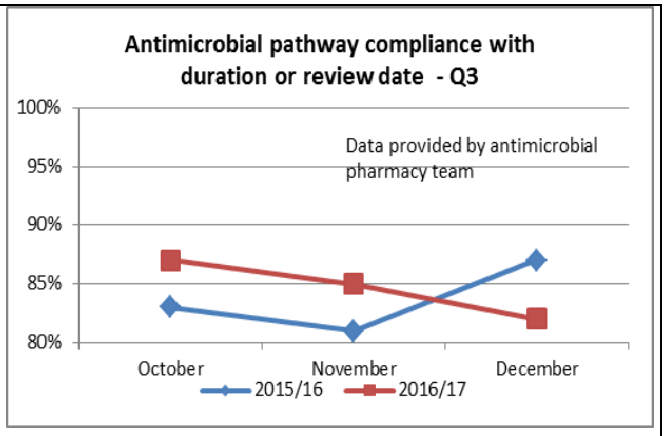






Antimicrobial Stewardship:
Data below demonstrate improved compliance with HCAI reduction as a result





7. Conclusion

Interventions to reduce HCAI incidence continue to be implemented and compliance audited in addition to PIR. Incidence in the last month of Q3 has increased. Probable contributors are acuity and co-morbidities of patients.

8. Recommendation

The Board of Directors are asked to:

- Receive the Infection Prevention (IP) report for Q3
- Support the recommendation for provision of a proactive HPV programme and decant space to enable deep cleaning and high level disinfection
- Note the actions taken to improve the governance and reporting of water safety

9. References and further reading

Relevant Legislation and Guidance:

- The Health and Social Care Act 2008:Code of Practice on the prevention and control of infections and related guidance, updated July 2015
- NICE Infection and Prevention Quality Standard 61 April 2014
- Epic 3: National Evidence-Based Guidelines for Preventing Healthcare Associated Infections in NHS Hospitals in England 2014

Author	**Vicki Parkin, Deputy DIPC**
Owner	**Beverley Geary, Chief Nurse, DIPC**
Date	**January 2017**

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 January 2017

Maternity Services Annual Report

Action requested/recommendation

The Board of Directors is asked to accept this report as an annual summary of the maternity services activity in 2016.

Summary

The Trust provides Maternity services to 5600 women a year. The attached annual report is a summary of the work undertaken during 2016.

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

Implications for equality and diversity

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

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

Reference to CQC regulations

9,10,12,13,14,15,16,17,18

Progress of report	Obstetrics and Gynaecology Clinical Governance Forum 13 December 2016 (discussed in meeting and

	shared electronically following meeting) Quality and Safety Committee
Risk	No risk
Resource implications	No resources implications
Owner	Beverley Geary. Chief Nurse
Author	Liz Ross. Head of Midwifery Nicola Dean. Clinical Director
Date of paper	January 2017
Version number	1

Board of Directors – 25 January 2017

Maternity Services Annual Report

1. Introduction and background

The Maternity service undertakes 5600 bookings and 5000 births per year across community and two main Hospital sites in York and Scarborough. It covers antenatal, intrapartum and postnatal care, including antenatal and newborn screening, community midwives, homebirths, antenatal outpatients and antenatal education.

The service is predictable and there has been no significant increase in this activity in recent years

Careful planning of Maternity service is required to deliver safe, high quality care for women; to have a positive experience with a high level of satisfaction.
The aim of the directorate is to;

- make service improvements
- provide choice of birthplace; as close to home as is safe and sustainable to do so
- promote healthy lifestyles
- promote confident parenting
- have a highly trained workforce to deliver high quality, safe and effective services.

This report appended summarises the activity undertaken by Maternity services from January to December 2016. Achievements and challenges have been recognised within the report with plans outlined to continue to provide a safe quality service whilst aiming to continually improve and develop in line with local, regional and national priorities.

2. Executive summary

Patient experience
Service user engagement has increased in 2016 with a new group of recent service users called ‘mums voices’. They plan to input into the national maternity review recommendations ‘Better Births’ and link into the Maternity Services Liaison Committee.

A new Facebook page commenced called ‘York and Scarborough Bumps 2 Babies’ providing information and updates for service users through social media.

Changes made following user feedback include recommencing face to face parent education from January 2017 in York and Selby (already provided in Scarborough) and plans to review and refresh on line parent education in 2017

Delivering high quality patient care

In 2016 a service review was undertaken of the York site and a 1 year review of Scarborough site. These reports and resulting action plans were submitted to the board. Work continues to achieve the actions, recommendations from the Kirkup report are included in the plans.

Work continues with the Yorkshire and Humber Clinical Network towards the national ambition to reduce stillbirths. I am pleased to report that we have seen a reduction in stillbirths by 50% in 2015 and 2016 from previous years. Stillbirth care bundles have been implemented across site with a focussed strategy to reduce smoking in pregnancy implemented at Scarborough site.

Perinatal mental health is high on our agenda as suicide remains a leading cause of maternal death in pregnancy and up to 12 months following birth. NHS England has set plans to provide more support for pregnant women and new mums suffering mental illness. Perinatal mental health training for midwives is planned to commence in 2017.

The 2016 National Maternity review 'Better Births' report sets out wide-ranging proposals designed to make care safer and give women greater control and more choices. Prevention and public health have an important role to play, as smoking is still the single biggest identifiable risk factor for poor birth outcomes. Obesity among women of reproductive age is increasingly linked to risk of complications during pregnancy and health problems of the child. There are a number of national actions to be undertaken however local actions to achieve the recommendations in this report are being worked towards and have been submitted to the Clinical Network.

Measuring high quality patient care
The development of the regional maternity dashboard has enabled services in Yorkshire and the Humber to benchmark and share learning.
A national maternity dashboard is awaited following the 'Better Births' report which will provide the ability to make much wider comparisons and learn from others.

At York there has been a reduction in third and fourth degree tears achieved in 2016 with work continuing to reduce the number of women affected by major obstetric haemorrhage

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Antenatal and Newborn screening continues to increase with progress made in 2016 towards submitting and achieving KPIs. Data collection remains a challenge for the service to submit some KPIs and ensure accurate data.

A workforce review is currently being undertaken to ensure the workforce remains relevant and responsive to national and local provision. An on call midwife rota has been supported in response to an identified shortfall in staffing levels at periods of high activity and acuity on Labour Ward at York site. Increasing Maternity Support Workers in community is being worked towards to support the community midwives with their caseloads, which remain above recommended levels. Monitoring of NICE red flag events has commenced, each case is reported on DATIX and reviewed at the weekly risk meeting.

The Local Supervising Authority Midwifery Officer (LSAMO) annual audit took place on 9 November 2016. Verbal feedback provided on the day was very positive; it was recognised the Supervisors of Midwives team are effective in their role and have worked hard to address issues highlighted in last year's audit. The final report is awaited.

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The charter aims to improve RCM members' health, safety and wellbeing at work so they are able to provide high quality maternity care for women and their families. York is shortlisted

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Legislative processes are moving forward to remove supervision of midwives from statute in April 2017. There is concern nationally regarding the impact of this and the removal of the NMC Midwives Rules and Standards once statute is removed. In order to maintain support to midwives following this a senior midwife on call rota is planned to take place of the Supervisors of midwives rota. This will begin in April 2017 whilst a new model of supervision is awaited from NHS England.

3. Conclusion

A lot of progress has been made in 2016 in order to improve and mitigate risk in maternity services including;

- a reduction of stillbirths
- a reduction of third and fourth degree tears
- an increase in recent service user feedback and engagement
- completion of a bereavement suite at Scarborough
- the development of a hyperemesis pathway and enhanced recovery to improve efficiency and patient experience
- achieving significant progress in delivering the antenatal and newborn screening service
- commencing a midwife on call rota to support the Labour Ward at York
- developing strategies from staff feedback to improve staff experience
- supporting research studies
- developing and extending skills of midwives and maternity support workers

Whilst we celebrate our achievements we recognise there are challenges and work continues with the aim to continually improve and deliver high quality, safe and effective services across sites.

4. Recommendation

The Board of Directors is asked to accept this report as an annual summary of the maternity services activity in 2016.

5. References

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https://www.rcm.org.uk/sites/default/files/Birthrate%20Plus%20Report_1.pdf

York Teaching Hospital NHS
NHS Foundation Trust

Maternity services annual report
January to December 2016

Owner	Beverley Geary. Chief Nurse
Author	Liz Ross. Head of Midwifery Nicola Dean. Clinical Director
Date of paper	January 2017
Version number	1

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- promote confident parenting
- have a highly trained workforce to deliver high quality, safe and effective services.

Midwifery workforce strategy

A review of the maternity workforce strategy is currently underway to ensure the workforce remains relevant and takes into consideration changes to national and local provision.

Overall trust wide midwife staffing ratios are within national recommendations of 1 Midwife per 29.5 births for Hospital and Midwifery Led Units, however there is a difference on each site with Scarborough having a higher ratio than York. This is due to Scarborough site being smaller which requires a minimum level of staff on duty.

Trust midwife ratio per births	York site	Scarborough site
1 Midwife : 29 births	1: 31 (Below recommendations)	1: 23 (Above recommendations)

A Birthrate plus intrapartum acuity tool is completed every 4 hours on both Labour Wards and evidences a shortfall in required staffing levels at York site in periods of high activity and high acuity. There are more women now in high risk groups giving birth (this is a local and national picture) as women are pregnant with co-morbidities such as cardiac disease (a leading cause of maternal death. MBRRACE report 2016), asthma and epilepsy, increasing age (over 40), obesity, smoking and substance misuse.
A midwife on call rota has commenced to support staffing and safety on the Labour Ward at York site.

Increased safeguarding cases impact on community caseloads which are currently above national recommendations. Maternity support workers have been introduced with plans to increase to support the midwives with their workload.

A third of midwives are over the age of 50 years. We have seen a change this year with more midwives under 40 and working part time hours than previously. There are a number of staff in senior positions who are due to retire in the next 2 years and succession planning is in place with a band 6 to 7 development programme.

NICE published ‘safe midwifery staffing for maternity settings’ in February 2015, however

without any guidance on how to apply this until very recently. The RCM have also recently published some guidance for staffing of maternity services (December 2016), both publications are being considered.

Maternity 'red flag' events are now reported via DATIX and discussed at the weekly risk meeting.

Aspirational roles that the service are considering with a view to develop are:

- Consultant midwife (recommended Safer childbirth 2007)
- Perinatal mental health midwife (NICE recommendation)
- Public health midwife and substance misuse midwife (NICE)
- Multiple birth midwife (TAMBA and NICE recommendation)

A bereavement midwife post, recommended by SANDS and RCM is due to be in place in March 2017.

3.2 **Medical staffing**

The medical staff are managed by a Clinical Director, covering both sites with a deputy clinical director on each Hospital site.

Integration of senior medical staff is being helped by sessions being undertaken by some consultants on the opposite site. Both areas now have resident consultants to cover some nights, to allow more senior decision making out of hours and less reliance on registrar grade doctors. Nationally, there are now fewer registrars which is recognised as causing challenges both nationally and regionally.

Risks and plans to mitigate risks

- Fewer registrars leaving gaps in rota.

Medical agency is used frequently to fill the gaps, this is at a high cost to the Directorate.

3.3 **Staff experience**

Staff involvement

A listening exercise took place at York site in December 2015 (reported in January 2016) by a member of the ODIL team. The results were shared with staff in the York site service review; Staffing levels, health and wellbeing, staff behaviours and inflexibility of rosters were concerned raised by the staff who took part in this.

Actions taken following this feedback;

- Staff meeting took place in April 2016 to involve staff in finding ways of working differently to support Labour Ward at York with increasing high acuity of women and periods of high activity. From this meeting actions taken are;
    - On call midwife rota for Labour Ward (commenced September 2016)
    - Increase core staff on Labour Ward to support newly qualified and staff new to area.
    - Increase length of rotation to increase skills and experience in different areas. To have a different rotation for newly qualified midwives to improve their experience and support.

- Development of skills and review the role of the Maternity support worker
- Consider nursing roles to support midwives e.g. theatre roles
- Elective caesarean sections on Labour Ward (elective caesarean section list to commence in February 2017 staffed separately with a view to move this to main theatre when possible)
- Reduce length of stay on Labour Ward
- Signed commitment to the RCM 'Caring for you' charter (June 2016)
- Increase administration support (increased Ward clerk cover out of hours commenced in 2016)
- Continue timely recruitment of staff when vacancies occur

Follow up staff meeting November 2016 took place to feedback on current staffing position and progress made from actions taken above.

RCM (Royal College of Midwives) Caring for you charter (signed commitment June 2016 by the Head of Midwifery and RCM Health and Safety representative).

The charter aims to improve RCM members' health, safety and wellbeing at work so they are able to provide high quality maternity care for women and their families.

A survey was carried out by the RCM during March 2016 questioning midwives, maternity support workers and student midwives about their health and safety at work. This showed that midwives are feeling under intense pressure to be able to meet the demands of the service resulting in high levels of stress and burnout. Poor workplace cultures also impact on the quality of care women and families receive.

The 'Caring for You' Campaign aims to improve staff wellbeing by implementing a local action plan. This will include ensuring that maternity staff have access to flexible working and a positive culture around working time and taking breaks. Committing to a zero tolerance policy on undermining and bullying behaviours and enabling maternity staff to access both physical and emotional support.

These commitments will help to nurture a compassionate and supportive workplace that cares for maternity staff so that they can care for women effectively.

York maternity services were are one of the first maternity services to sign up to the 'Caring for You' Charter in June 2016 and have been shortlisted for an RCM award in 2017 for the actions they have taken so far which include;

- RCM representative to be involved in the Trust review of the e-roster policy.
- A fair and equitable system for staff to swap shifts.
- Pro-active support throughout the unit for staff to take rest periods;
  - Allocated breaks/breaks board
  - Staff encouraged to take responsibility for ensuring they take a break during a shift
  - Access to drinks in the workplace; Tea/coffee/water
- Raise awareness about undermining behaviours and bullying and effect on work colleagues;
  - Consider repeat listening exercise in 2017 (with ODIL) and training to implement restorative practice.
  - RCM workshop on undermining behaviours planned for March 2017
  - Head of Midwifery and Clinical Director to reinforce expectations of professional behaviours (and encourage staff to report poor behaviour)

    - Work with Occupational health on implementing ways to support staff during a shift (Mood assessment)
    - Consider behaviour advocate roles in the workplace
- Occupational Health support with health and wellbeing of staff;
    - Health checks offered for all midwives and nursing support staff in Maternity. Staff supported to attend. Senior staff attendance to encourage others.
    - To take part in the staff stress assessment in 2017
    - Publicise psychological therapies for staff to access e.g. mindfulness apps, massage, exercise classes, reflexology sessions in maternity (financially supported by the RCM)
- Improve staff morale; positive feedback boards, nominate staff for Trust star awards, monthly Supervisors of midwives staff star award, RCM Facebook group to share articles and information.

Staff Friends and Family results 2016

Comments were received regarding lack of understanding and support from managers. Although the numbers were relatively small, actions are planned in 2017 to develop a supportive culture in the workplace as follows;

- undermining behaviours workshop March 2017
- ODIL support re listening exercise and training to implement restorative practice
- Occupational Health support to implement an approach to improve support on a shift by shift basis and support with staff wellbeing.
- Key messages to staff from senior management regarding expectations of professional behaviours.
- Work with the new Safer working guardian to improve access to and 'independent' support for staff to speak out.

Staff training and development:

Succession planning continues with band 6 to 7 development opportunities on both Labour Wards. An annual review of maternity training has taken place and priorities set for 2017;

Plans for 2017 include:

- Perinatal mental health training (New)
- Professional behaviours (New)
- Smoking cessation – very brief advice (repeat and updated)

Improving safety through training

Maternity were successful in a recent application to Health Education England to improve maternity safety through training. The Trust will receive £80,000 as a one-off allocation of funding for 2016/17. Emergency maternity MDT training has been prioritised and will include emergencies in the community setting and neonatal life support.

Risk Management

Service reviews
An internal review of the service was undertaken on the York site and was completed in March 2016. A year on review of Scarborough site was completed in April 2016.

These reports detailed the service and risk management processes and were submitted to Trust Board in 2016.

Actions identified from the York report have been reviewed and updated in October 2016 at the executive Performance Assurance meeting.
Actions from the Scarborough site report are due to be reviewed in 2017; which include actions taken from recommendations in the Kirkup report.

Maternity Dashboard

The Yorkshire and Humber regional Maternity dashboard has completed its first year and is now under review. A national dashboard is being developed following a recommendation in the National Maternity review 'Better Births' 2016.
The regional dashboard provides valuable information to enable services to compare and share information, care provision and learning.

Organisational dashboard;

The organisational dashboard reports from each site in order to identify site specific risks.
Red areas on the **York dashboard** are;

- York midwifery staffing level below national recommendations
- One to one care in labour and supernumerary status of the Labour Ward co-ordinator is lower than we would want (which is a reflection of the staffing levels)
- Post partum haemorrhage of more than 1.5 litres is higher than preferred with a high provision of high dependency care on labour ward a reflection of this.
- Third and fourth degree tear rate has improved in 2016, however the rate for assisted birth remains higher than we would want. Personal reflections of the cases undertaken, senior support for junior doctors is in place and recent agreement to purchase specialist 'episcissors-60' endorsed by NICE and fulfil the RCOG green top guidelines to achieve the recommended degree angle cut for an episiotomy. Research has shown a 20 to 50% reduction in obstetric anal sphincter injuries (3rd and 4th degree tears) from the use of these scissors.

Scarborough dashboard red areas are;

- Special care baby unit at capacity meaning babies and pregnant women are transferred out of Scarborough. This has improved in 2016 as babies are now readmitted to Duke of Kent Ward and not SCBU.
- Anaesthetic consultant cover for Labour Ward is below national recommendations. A business case has been approved to increase from 3 to 5 dedicated sessions weekly. This has not yet been implemented due to on-going anaesthetic recruitment issues. Once in place a review to take place to identify need for any further increase in sessions.
- Breast feeding initiation rate is lower and smoking at time of delivery rate is much higher on Scarborough site than York site (actions to address this are detailed in this report)

Plans to mitigate the risks are to;

- review the impact of the midwife on call for York Labour Ward
- develop skills of maternity support worker to support the midwives
- increase the number of maternity support workers in community
- commence a separately staffed elective caesarean section list at York site
- improve proactive management, continue MDT case discussion and individual

reflection on management of postpartum haemorrhage
- purchase recommended spiscissors-60 to reduce third and fourth degree tear rates
- review plans to increase consultant anaesthetist cover at Scarborough site
- continue with Baby Clear project and work towards UNICEF BFI new standards

The Maternity dashboard provides robust data which is analysed and used by the directorate to improve the service locally. The regional dashboard provides an opportunity to benchmark against similar units and learn from each other.

Following discussion and agreement at the O&G Clinical Governance forum and Performance Assurance meeting Maternity services have ceased submitting data for the national maternity safety thermometer as it was not found to be useful.

DATIX reporting
Maternity services have a good level of DATIX reporting ranging from 105 to 140 DATIX each month. All are reviewed at the weekly maternity risk meeting which includes a discussion regarding NICE red flag events and duty of candour.

The themes from DATIX reporting in 2016 have been;
- Unavailability of scan slots within the recommended time frame (to comply with perinatal institute guidance for management of babies identified at risk of growth restriction)
    - Business case agreed for resource for extra scan slots (issue with capacity remains due to inability to deliver funded extra capacity as a result of sonographer recruitment issues)
    - New assessment of fetal growth guideline published in September 2016 with reviewed and updated criteria for referral for USS.
    - Midwife trained to carry out growth scans (Scarborough site), second midwife due to commence training in 2017.
- Problem with bleep system coverage at Scarborough site
    - Mobile phones issued to staff to be carried alongside bleep as a backup system. New aerials and coaxial cable are now installed (December 2016)
- Post partum haemorrhage over 1500 mls
    - Audit of all PPH undertaken in 2016, presented at clinical governance meeting.
    - All cases are reviewed and discussed at weekly risk meeting
    - Individual staff reflection of care provided for each case has commenced
    - Early recognition, escalation and call for senior support encouraged and reinforced during emergency training days and live skills drills on Labour Ward
    - Use of drugs to reduce and prevent haemorrhage reviewed.
- Staff shortages (exacerbated by unexpected delay in newly qualified midwives commencing in Sept/October)
    - On call midwife for Labour Ward implemented
    - Timely recruitment of midwifery staff and agreement for substantive contracts for newly qualified for a set period.
    - Planned work to build a supportive culture in York Labour Ward.
- NICE red flag incidents related to staff shortages. All discussed at weekly risk meeting
    - Plans to address staff shortages (recruitment and retention)
    - Implement midwife on call rota
    - Use of escalation policy
    - Commence separate staffing and list for elective caesarean sections (with a view to moving to main theatre when possible) to reduce delays to elective C/S

Serious incidents
There have been 9 serious incidents identified cross site in 2016:

- Neonatal deaths x 3. Consideration is given to every neonatal death to determine if an SI investigation is required. All are reported to the confidential enquiry MBRRACE
- Stillbirth x 2 (one from 2015 found on review of cases)
- Serious maternal clinical conditions x 2 (acute fatty liver and cardiac arrest at elective caesarean section)
- Maternal death x 2 cases. Mandatory reporting as SIs and reported to the confidential enquiry MBRRACE

All cases have an identified lead and investigation team member from the opposite site to provide objectivity to the reviews. Any learning identified from each case is followed up by the Directorate team.

Wider learning from serious incidents is planned by the Yorkshire and Humber clinical expert group in 2017.

Actions and mitigation of risk from serious incidents include to;

- review and update of guidelines including VTE in line with NICE guidelines
- improve documentation, including electronic fetal monitoring
- improve decision to delivery communication for assisted birth
- commence electronic fetal monitoring for women where the length of second stage cannot be determined on admission
- develop guidance on management of multiple emergency situations on Labour Ward
- increase awareness and management symptoms in high risk cases

Patient Experience and user involvement

The Maternity Services Liaison Committee (MSLC)

The Vale of York MSLC is maintained and chaired by the CCG, working in partnership with local maternity providers. The aim is to ensure that maternity services commissioners and the provider units hear and take account of the views of women and families using the service**.**
The group endeavour to be inclusive of diversity and ethnicity and include input from women / fathers who have used maternity services within the last 3 years.

A new service user group has formed at York called ‘mums voices’ which now feeds into the MSLC. This group are keen to work on recommendations from the National maternity review report ‘Better Births’ in particular in relation to personalised birth plan and the provision of postnatal care. This group have also started to provide service user input into patient information provided.

Changes following service user feedback;

- Recommencement of face to face parent education in Childrens Centres from January 2017 in York and Selby (already provided in Scarborough)
- Plans to review and refresh on line parent education in 2017
- Use of social media to provide information and updates for service users. Facebook page commenced ‘York and Scarborough Bumps 2 Babies’
- Recent services user group formed in 2016 (following an press visit and article in the York press)

Friends and Family Test
Maternity services continue to receive very positive FFT feedback with a response rate of 42% in November 2016. Of those who respond, 99% are extremely likely or likely to recommend the service. A quarterly report is produced and circulated to staff by the Matron, which includes a selection of comments, themes and an action plan.

Themes from FFT in 2016;

- Not good continuity of carer for some women
- Staffing levels at York site, impacting on care received.
- Ability of partner to stay on postnatal ward overnight
- Staff attitude and communication
- No provision of face to face parent education classes

An action plan has been developed to address the above themes and includes;

- To improve continuity of carer (also a 'Better Births' recommendation) minimum contracted hours have increased for community midwives to 22.5 hours. Length of rotational posts in community increased from 6 months to 1 year. Current review of size of community teams and caseloads.
- On call midwives for Labour Ward commenced in September 2016 to provide support in times of high activity and acuity.
- Recruitment and retention strategies; preceptorship packages, timely recruitment
- 'Chosen companions' to support new mothers overnight on postnatal wards both sites
- Recommence face to face parent education classes (January 2017)

Achievements:

- Good FFT feedback. Quarterly qualitative feedback report shared with staff and user representatives at the MSLC. Action plan developed from this.
- Improved engagement with service users
- Changes and developments to service made from service user feedback

Currently there is no MSLC at Scarborough site; however there are plans to explore opportunities to develop a user forum with Scarborough and Ryedale CCG.

Patient Safety

Saving Babies' Lives. ***A care bundle for reducing stillbirth***

The care bundles are designed to support providers, commissioners and professionals to take action to reduce stillbirths. It supports the delivery of safer maternity care, as described by the National Maternity Review, in Better Births.

In November 2015 the Secretary of State for Health announced a new ambition to reduce the rate of stillbirths by 50% in England by 2030, with a 20% reduction by 2020. 'Saving babies' Lives' will help maternity services meet this aspiration.

York submit data to the RCOG (Royal College of Obstetricians and Gynaecologists) Each baby Counts project and MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) and became an early implementer/pilot site of the stillbirth care bundles.

Number of stillbirths

Stillbirth number/rates	York	Scarborough	Trust
2014/15	14 4.1:1000	8 4.9:1000	22 4.4:1000 births
2015	7 2.0:1000	4 2.5:1000	11 2.2:1000 births
2016	9 2.6:1000	4 2.5:1000	13 2.6:1000 births
Y&H Regional average			4.4:1000 births (Q1 2016/17)

All stillbirth cases are reviewed using a recognised tool from the perinatal institute for case review and discussed at the weekly risk meetings and monthly perinatal mortality meetings. Peer site MDT review is undertaken of all stillbirth cases.
Serious incident investigations are triggered for all stillbirths where the baby was alive at the onset of labour or if any concern is found regarding care provided (in line with regional practise)
There are four elements of care that are recognized as evidence-based and/or best practice which we have implemented:

1. Reducing smoking in pregnancy

2. Risk assessment and surveillance for fetal growth restriction

3. Raising awareness of reduced fetal movement

4. Effective fetal monitoring during labour

Reducing smoking in pregnancy by carrying out Carbon Monoxide (CO) test at antenatal booking appointment to identify smokers (or those exposed to tobacco smoke) and referring to stop smoking service/specialist

There is strong evidence that reducing smoking in pregnancy reduces the likelihood of stillbirth. Actions taken;

- Implemented Carbon Monoxide testing for all women at booking and repeat for smokers at 36 weeks, working on electronic data to capture this information.
- Provide 'opt out' referral to smoking cessation services for all smokers
- Midwives all trained in very brief interventions- raised at every appointment
- 'Baby clear' pilot 'risk perception intervention' at Scarborough- hard hitting 1:1 appointment immediately after 12 week scan to arrange 'treatment' for smoking. This is delivered by a Midwife with extended training. Use of specific software to link the CO monitor to trigger discussion about harms caused to babies by smoking.

Risk assessment and surveillance of pregnancies for fetal growth restriction.
Antenatal detection of growth restricted babies is vital and has been shown to reduce stillbirth risk significantly as it gives the option to consider timely delivery of a baby at risk.
Actions implemented;

- Introduced Customized growth charts in all Trust areas
- Intensive training and assessments for staff
- Women referred in for scans following local guidance
- Auditing all cases of growth restricted babies not diagnosed in pregnancy
- Audit and monitoring of detection rates of growth restriction all Trust sites

Raising awareness amongst pregnant women of the importance of **detecting and reporting reduced fetal movement (RFM),** and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM.
Confidential enquiries into stillbirth have consistently described a relationship between episodes of reduced fetal movement (RFM) and stillbirth incidences.
Actions taken;

- All women are given a leaflet highlighting the importance of fetal movements between booking and 24 weeks of pregnancy. Movements are then discussed at every midwife appointment after 24 weeks. Women can self-refer to the maternity unit with any concern.
- A standard checklist is being developed to manage the care of women who report reduced movements.

Effective fetal monitoring during labour. Actions taken;

- All staff who are involved in labour care attend annual mandatory training face to face training with case discussions and competency assessment.
- All staff must complete an e-learning package annually.
- A 'Fresh Eyes ' buddy system is in place (every hour for women who are being continuously monitored a second registered professional must make an assessment of the monitoring and classify it using NICE guidance. This is documented in maternity records using a standard sticker)
- Weekly case discussions in place on both sites for staff to attend.

Perinatal mental health

Suicide remains a leading cause of maternal death in pregnancy and up to 12 months following birth (Confidential Enquiry into Maternal Death 2016)

NHS England has set plans to provide more support for pregnant women and new mums suffering mental illness. £40m is to be allocated to 20 areas of the country to fund new specialist community mental health services for mums in the immediate run up to and after birth, and help reach 30,000 more women a year by 2021. A further £20m will be allocated next year.

Maternity services contributed to a CCG bid for funding in 2016 however this was not successful. Maternity services will be involved in a planned North Yorkshire and York Perinatal mental health sub-group to help prepare for the second wave of funding; this will also be linked into the local Perinatal mental health network.

Perinatal mental health training for midwives is planned as part of the maternity mandatory training 2017.

Environment

Bereavement facilities Scarborough site
The bereavement suite was completed and opened in April 2016 following the successful Scarborough snowdrop appeal to raise money for this valuable facility. A Scarborough SANDS group has formed following this appeal for support, they held their first bereavement service for families in December 2016.

Plans have been submitted to capital planning to develop the bereavement facilities at York site maternity, supported by York SANDS charity.

New furniture was purchased by York SANDS for the 'quiet room' in Antenatal Day services where women can be in a private area away from the main clinic rooms when receiving bad news.

Achievements:

- Improvement in Maternity entrance; decoration and new flooring providing a more welcoming entrance.
- Opening of the bereavement suite at Scarborough

Supervision of Midwives

Local Supervising Authority Midwifery Officer (LSAMO) annual audit 9 November 2016

Verbal feedback provided on the day was very positive; it was recognised the Supervisors of Midwives team are effective in their role and have worked hard to address issues highlighted in last year's audit. The final report is awaited.

The legislative processes are moving forward to remove supervision of midwives from statute. We await the findings from the Department of Health consultation on the proposed changes to midwifery legislation. Indication from the Department of Health is that the timeline remains on track for this planned change to occur on the 31st March 2017.

There is concern nationally regarding the impact of the removal of the NMC Midwives Rules and Standards once statute is removed.

NHS England has released initial information around a new model of midwifery supervision 'EQUIP' which is being piloted in 6 sites; Airedale and Calderdale and Huddersfield are sites in Yorkshire and The Humber region. This model is based on restorative supervision and will support midwives to provide high quality care supporting choice, education and safety aspects of the vision set out in the National Maternity Review report, Better Births.

Supervisors of Midwives have been involved in ensuring that the new process of Revalidation with the NMC is completed by midwives.

LSA investigations into midwifery practice

There were 11 investigations in midwifery practice over the last year. Themes from these investigations were; escalation of concerns, record keeping, confidentiality breach and not following guidance. Six Midwives were recommended to have local action plans which included development plans with their named supervisor of midwives.

Achievements:

- Supervisors of Midwives continue to work as a coherent and consistent team demonstrating commitment and achievement in their role supporting midwives delivering the core function of the statutory framework.
- Supervisory support provided to midwives to successfully revalidate with the NMC
- Supervisors of Midwives have taken part in external LSA audits and investigations.

Risks and plans to mitigate risks

- Supervisor of midwife role will cease on 1 April 2017. There is a plan to develop a new model following feedback from the pilot sites and a decision by NHS England. Senior midwives will provide support, advice and guidance to midwives whilst awaiting this.
- Supervisor on call rota will cease on 31 March 2016. We to commence a 'senior midwife' on call from 1 April 2017 to provide support and advice for staff and women.

The National Maternity review 'Better Births' 2016

The NHS England commissioned review – led by independent experts and chaired by Baroness Julia Cumberlege – sets out wide-ranging proposals designed to make care safer and give women greater control and more choices.

The report finds that despite the increases in the number of births and the increasing complexity of cases, the quality and outcomes of maternity services have improved significantly over the last decade.
Prevention and public health have an important role to play; smoking is still the single biggest identifiable risk factor for poor birth outcomes. Obesity among women of reproductive age is increasingly linked to risk of complications during pregnancy and health problems of the child.

The framework highlights seven key priorities to drive improvement and ensure women and babies receive excellent care wherever they live. To make care more personal and family friendly, the report says that the following is needed:

- **Personalised care**, centred on the woman, her baby and her family.
- **Continuity of carer**, to ensure safer care based on a relationship of mutual trust and respect in line with the woman's decisions.
- **Better postnatal and perinatal mental health care**, to address the historic underfunding and provision in these two vital areas, which can have a significant impact on the life chances and wellbeing of the woman, baby and family.
- **A payment system** that fairly and more precisely compensates providers for delivering different types of care to all women, while supporting commissioners to commission for personalisation, safety and choice.
- **Safer care,** with professionals working together across boundaries to ensure rapid referral, and access to the right care in the right place.
- **Multi-professional working**, breaking down barriers between midwives, obstetricians and other professionals to deliver safe and personalised care for women and their babies.
- **Working across boundaries** to provide and commission maternity services to support personalisation, safety and choice, with access to specialist care whenever needed.

Maternity services have considered each recommendation and submitted a benchmark and action plan to the Yorkshire and Humber Clinical network.
Progress of the recommendations nationally, regionally and locally will be seen in 2017.

Service development and achievements

The following developments have been implanted to improve health and wellbeing, pathways of care, patient experience and reduce risk;

Enhanced recovery and increase in day 1 discharge following elective caesarean section at York and Scarborough sites has been a success.

Clinical protocols
Anaesthetic clinical protocols for maternity are agreed for use cross site improving the safety and efficiency of services and for medical staff and trainees working cross site.

Smoking in pregnancy
Reducing smoking in pregnancy remains a priority for Maternity services, joint work with Scarborough and Rydale CCG and Smoke free life North Yorkshire is continuing. There is a focus on Scarborough site as rates are significantly higher than in the York area. Bridlington in the East Riding CCG is also a high prevalence area where further work is needed.

Smoking at time of delivery at Scarborough site is 19.8% and 10.7% York site.

The national ambition is to reduce smoking at time of delivery to 11%

From January 2016 a pilot of 'Baby Clear' risk perception intervention has been taking place for women who live in Scarborough itself.
This is an initiative which has been very successful in the North East of England. It involves a specially trained Midwife seeing women at the time of their 12 week scan if they are smokers. The Midwife congratulates the women on their pregnancy and explains the concerns about the impact of smoking on the baby, explaining the increased risk of complications in pregnancy, small babies, stillbirth and subsequent infant death in the first year.
Computer software, mannequins and a CO monitor is used to demonstrate to the woman potential harm to the baby. Following this they are immediately offered 'treatment' for their smoking with a fast track referral to smoking cessation.

This initially ran every two weeks but will run weekly until the end of the financial year. It is too soon to see if it is affecting the smoking at delivery rates.

In 2017 smoking cessation brief intervention training is being delivered to all Midwives as part of Mandatory training. CO monitoring continues to be carried out at booking and 36 weeks for all pregnant women and we have continue to develop IT data collection systems around smoking figures.

This work is part of the national Stillbirth reduction care bundles, The lead Midwives for this project have presented their work at a regional forum and received very positive feedback.

UNICEF Baby Friendly Initiative (BFI)
Maternity services are fully accredited to BFI standards (achieved in January 2015). Reassessment is planned in March 2017.

The standards are to promote, protect and support breast feeding and bonding with baby and is the first ever national intervention to have a positive effect on breastfeeding rates in the UK.
Breastfeeding protects babies against a wide range of serious illnesses including gastroenteritis and respiratory infections in infancy as well as asthma, cardiovascular disease and diabetes in later life. It is also known that breastfeeding reduces the mother's risk of some cancers.

Both sites have seen an increase in initiation rates over the last few years.

Achievements:

- Improved referral process for breastfeeding support for babies readmitted under 28 days to the Children's Ward and training for paediatric staff.

Future plans:

- To commence a breastfeeding support clinic in 2017, two mornings a week from two different Children's Centres. A specially trained Maternity Support Worker will run these clinics with support from the infant feeding co-ordinator. The aim is to; support mothers and assess babies feeding with an identified tongue tie (the aim is to reduce the number of inappropriate referrals to the Tongue Tie Clinic as well as providing much needed additional support) and assess and support babies with a large weight loss either directly from the community midwives or the Children's wards.
- Development of Maternity Support Workers to run face to face parent education sessions on 'Building a happy baby' (patenting, bonding, importance of stimulation and relationship building and infant feeding)

Volunteer breastfeeding peer supporters continue supporting women in our community and in Hospital at Scarborough site.

Changes to hyperemesis pathway
Hyperemesis day case management commenced in December 2015 in Maternity (changed from Gynae) resulting in a reduction in admissions and positive patient experience.

Extended skills

- Midwives have untaken training to perform fetal presentation scans in York triage unit
- A midwife is trained to perform External Cephalic Version (for breech presentation) (following successful completion of a university training module and support from O&G Consultants).
- A Scarborough midwife has trained to perform growth scans for babies suspected of being small for gestational age. A second midwife commences training in 2017.
- Maternity support workers (MSW) have been trained to run antenatal education on infant feeding and parenting skills (due to commence in 2017)
- MSWs are to be trained to carry out Newborn blood spot tests in 2017
- An MSW has been trained to run breast feeding support clinics for babies with a tongue tie in the community

Celebrating our service

Trust Celebration of achievement awards
Maternity services were shortlisted for a patient safety award in 2016 for the work undertaken to reduce stillbirths.

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Royal College of Midwives 2017 awards. The Head of Midwifery and RCM health and safety representative have been shortlisted for their commitment to the 'Caring for you charter' and implementation of a local action plan to improve health, safety and wellbeing at work so that staff are able to provide high quality maternity care for women and their families.

RCM evidenced based midwifery journal award. The screening team and community midwives were shortlisted for this award for excellence in maternity care for the 'Spot on' work carried out to reduce unnecessary repeats blood tests in new born.

Antenatal and newborn screening

Antenatal & Newborn Screening Annual Report 2015-2016 was submitted in September 2016 to the Public Health England (PHE) Quality Assurance (QA) Team and the local Antenatal & Newborn Screening & Immunisation Team.

The aim of the report is to provide an assessment of the quality of the delivery of the six NHS Antenatal and Newborn screening (ANNB) programmes against the NHS Screening Programme requirements. This enables the service to be benchmarked for future service planning and quality improvement initiatives.

In 2015-2016 there were a total of 5870 women booked for antenatal care with York Teaching Hospitals NHS Foundation Trust; of these there were 5405 births.

The ethnicity of women accessing maternity services within the trust are; white UK (86.1%), Polish (3.2%) and other ethnic groups (10.7%)

The ANNB screening programmes within the trust work with numerous external services and stakeholders. The external laboratories include Leeds, Sheffield, Bristol and specialist haematology services in Oxford. The screening programmes professionals include the services of audiology, Child Health Records Department (CHRD) and the maternity services. The trust screening programmes work in close collaboration with NHS England Screening and Immunisation Team.

Summary of key findings:

- In March 2015 the screening service was reviewed by the PHE QA team. A full report was submitted to the trust with 27 recommendations. To date 17 of the 27 recommendations have been completed, with the remaining 10 at various stages of completion. A positive factor resulting from the visit is that it has raised the profile of the ANNB screening service within the trust. It has enabled all the screening service professionals to unite together and work collaboratively as a team to ensure the delivery of a high quality ANNB screening service for our service users. The Local Screening Co-ordinator (LCO) has a pivotal role in maintaining the provision of the ANNB Screening service.
- The report highlighted the continued collaborative work across the trust to integrate the ANNB Screening service to ensure equality of care and improved service delivery of the Screening programmes. This was reflected in a service user questionnaire of the services.
- It was evident that the service is constantly progressing and developing in line with new national recommendations and standards of each of the screening programmes. Predominately the Newborn Blood Spot programme was a key programme that has dramatically improved the service quality and provision to our service users. With the implementation of new national compliance standards within the screening laboratories in April 2015. The trust screening team positively embraced the opportunity to markedly improve the current service provision by a programme of teaching and education packages to maternity staff who deliver the programme. The delivery of this service improvement was evident in the key performance indicators and reduction in the ‘avoidable’ repeat rate.

Key Performance Indicators (KPI's):
Highlighted in the PHE QA report a recommendation to delivery all KPI's (as some have been nil submission due to the inability to match the cohort on the IT system)

- The KPI's that the trust was unable to submit were placed on the directorate risk register in March 2015. Close collaboration has taken place with IT and Data Analyst Team to resolve the issues and the trust have been able to submit the KPI's for ID1 for Quarter 1 (1st April -30th June 2015). Work continued to enable the submission of the other nil submissions for ST1 & ST3 (Submitted 1st June 2016)
- ID1- HIV coverage. The first submission was enabled for this KPI and has shown continued improvement from 93.2% to 95.7%
- ID2 – Hepatitis B referral to hepatologist within 6 weeks. Continued improvement throughout the year from 94.3 to 97.30%. Improved multidisciplinary communication has enabled this service improvement.
- FA1 – Completion of Downs forms. Delivery of proactive action plans and review across the trust has seen a consistent improvement in this KPI from 94.3% to 97.3%. The data is supplied from the Sheffield laboratory.
- ST1 – Conclusive result for sickle cell & thalassaemia. Nil submission. First submission June 2016 following close working with the trust IT department and ANNB Screening Co-ordinator.
- ST2 – Gestation at time of sickle cell & thalassaemia screening. Nil submission until June 2016.
- ST3 – Completed Family origin questionnaire. This KPI has been maintained at between 98.4% - 98.9%
- NB2 – Avoidable repeats for Newborn Blood Spot. With the introduction of the new national standards and an anticipated rise in 'avoidable' repeats with the approach applied by the screening team to this the KPI reduced from 4.1% (old standards) to 1.9% with the new standards. This data is supplied by the Leeds laboratory.
- NP1 – Newborn infant examination within 72 hours of birth. The first submission for this KPI was submitted in June 2015. The KPI has ranged from 82% to 88.7%. This data is collated from the national failsafe system.
- NP2 – Timely assessment of hip dysplasia. First submission was in June 2015. This data is collated from the national failsafe system. The KPI's range between 24.1% - 51.6%. Action planning has been implemented to improve this KPI.
- NH1- Coverage of hearing screening. This KPI is combined between York/Scarborough & Harrogate Newborn Hearing Screening Programme at 99.1%
- NH2 – Timely referral to audiology services. This KPI is combined across the trust with Harrogate audiology is at 82.5% with the standard being 90%. Action planning has been taken to improve the KPI.

Recommendations:

- To continue with compliance and achievement on the 10 outstanding QA recommendations in close collaboration with the ANNB Screening & Immunisation Team. An action plan is in place to facilitate this.
- Recognition by the trust to formalise and fully review the Newborn Infant Physical Examination (NIPE) Programme in regard to programme Co-ordinator and administrate assistance. This in turn will address some of the issues regarding improvement of the KPI's and the development of a robust failsafe to follow up missed screens and results.
- Action plan in place with the IT department and the Screening Co-ordinator to enable efficient data collection and submission of robust matched cohort data for future submission of the new annual Fetal Anomaly Screening Programme (FASP) and the Infection Diseases of Pregnancy Screening (IDPS) dataset.

Achievements:

- Continued collaborative working across the trust to integrate ANNB Screening service provision. It is recognised the excellent working relationships between staff across the Screening programmes.
- The trust was a pilot are for cardiac screening by pulse oximetry on babies, this has proved successful and the trust has continued this as standard practice following completion of the pilot study.
- Submission of the remaining KPI's previously not submitted.
- Reduction in the 'avoidable' repeats for the Newborn Blood Spot Screening Programme in line with the new national standards.

Research

Maternity services continue to support research studies.

The Research Maternity team have met or exceeded all their targets for the following studies in 2016;

- Minding the Baby. Comparison study using routine midwifery care versus NSPCC guided intervention for first time parents under 25 years of age.
- MiNESS. Study into causes of stillbirth looking at demographic and lifestyle information
- Respite. A comparison study using pethidine versus remifentanyl in labour.
- Baby & ME. Parenting app to use via smartphones using 'mind-mindfulness approach
- NaME . Neurodevelopment of Babies Born to Mothers with Epilepsy Study. Babies are followed up for 2 years following birth.

The Maternity unit has embraced research as we recognise its importance in improving the care we offer women in the future. We have an active portfolio which we hope to add to in the coming months. The following studies are open;

- **PRiDE** , which is focusing on micronutrients in Pregnancy as a risk factor for Diabetes and the effects on mother and baby, our Target is 150 by end June 2017

- **C-Stich**, multi-centred randomised controlled trial of 900 women who are at risk of insufficient cervix and scheduled to be treated by cervical cerclage. The women are either randomised to a monofilament suture material compared with a braided suture.

- **GOT-IT Trial,** a multi-centred randomised controlled Drug trial involving GTN spray verses a placebo for the management of Retained Placenta. The study has been endorsed by NICE and the Cochrane Group as non-surgical options for Retained Products are limited, new and effective treatments would dramatically reduce the number of women requiring MROP in theatre, reduce the number of mums & babies who are separated following birth, reduce morbidity and increase satisfaction rates.

- **PITCHES,** is a multi-centred masked controlled randomised drug trial to evaluate Ursodeoxycholic acid verses a placebo in women with Obstetric Cholestasis in Pregnancy. The study will examine the effectiveness of the drug UDCA in reducing perinatal adverse outcomes.

Plans for future research studies include:

- **January 2017**

PRE-EMPT, is a multi-centred randomised drug trial which will evaluate the clinical effectiveness and cost effectiveness of long acting reversible contraceptives compared with the combined oral contraceptive pill in preventing the recurrence of endometriosis.

- **March 2017**

VESPA, there are several arms to this study it will focus on the women attending EPAU and the effectiveness of the Early Pregnancy Unit.

- **Large for dates trial (perinatal institute)**

Achievement: We continue to support a wide range of research projects in relation to Maternity services and neonates

Conclusion

A lot of progress has been made in 2016 in order to improve and mitigate risk in maternity services including;

- a reduction of stillbirths
- a reduction of third and fourth degree tears
- an increase in recent service user feedback and engagement
- completion of a bereavement suite at Scarborough
- the development of a hyperemesis pathway and enhanced recovery to improve efficiency and patient experience
- achieving significant progress in delivering the antenatal and newborn screening service
- commencing a midwife on call rota to support the Labour Ward at York
- developing strategies from staff feedback to improve staff experience
- supporting research studies
- developing and extending skills of midwives and maternity support workers

Whilst we celebrate our achievements we recognise there are challenges and work continues with the aim to continually improve and deliver high quality, safe and effective services across sites.

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Workforce & Organisational Development Committee (WFODC) – 15 November 2016 – YH Post Grad Centre, Classroom 4

Attendance: Dianne Willcocks (Chair) Linda Provins Libby Raper Polly McMeekin Brian Golding
Mike Proctor Lydia Harris Tracy Astley (minutes)

Apologies: Sue Symington

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
1.	**Last Meeting Notes 13th September 2016**		The minutes were approved as a true record of the meeting.		
2.	**Matters arising and Action Log**		<u>Psychological Wellbeing</u> PM advised that the Trust's Health & Wellbeing project is being run in conjunction with support from NHS England. For the first time in many years mental health is no longer the main reason for sickness absence. Musculoskeletal is now the highest reason for sickness. This shows that the health and wellbeing project is having an impact with regard to the practical things the Trust is doing. The feedback from staff survey, currently underway, will also give a good indication of the support staff feel they have received. LH advised that her directorate is linked into this project and she has already had a meeting and will be involved in this going forward. **ACTION:** DW requested report for next meeting.		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
3	**Learning & Research – priorities going forward**		LH gave a presentation on the Learning & Research project and the challenges/opportunities ahead. There followed a Q&A session. PM asked if it is mainly clinicians who generally initiate a project. LH advised that anyone can initiate a project such as AHPs, dieticians, etc. PM suggested the expectation to participate in research should be strengthened through the job planning process. LH advised that in order to raise R&D profile the Trust needs to step up to the next level in order to attract people to come in and grow and lead an academic unit as they will receive the credit. She suggested that there might be a role for charitable funds to encourage research activity. DW asked for a Research Strategy. LH advised that she did not want to write this until she had been in post for at least six months in order to familiarise herself with current practices. It was agreed that LH bring the Research Strategy to the WFODC meeting when it is ready with a view to forwarding it to Board.	The committee commended to the Board the renewed engagement around research and supported further strengthening through a new research strategy.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
4	**Systems Leadership Programme**		MP gave overview of paper 3. He advised that this programme was an important contributor to the development of integrated working on the VoY patch and that the seniority of participants from diverse organizations was very encouraging. He agreed to update WFODC at a future meeting once the programme has progressed further. MP confirmed for LR that representatives from Public Health are involved.	The committee was assured that the Systems Leadership Programme is moving forward.	
5	**Update on Professional issues: internal nursing bank and use of agency staff**		PM gave overview of paper 4. She advised that a workshop had taken place on the York site, with another planned in Scarborough/ Bridlington, to determine what standard competencies are required. With the impending implementation of EPMA, bank workers are being given unique login passwords after initial IT training. A new induction check list for bank staff is being trialed which includes verifying identity. For the Trust's Pay Progression policy to apply bank workers are required to undertake their training and have an appraisal. This exercise will determine what training bank workers require but there will need to be extra capacity within Chief Nurse Team to ensure bank staff are appraised. LR asked why these issues were not picked up previously. PM answered that up until June last year the Trust used NHS Professionals to provide bank staff who did their own checks, etc. LR asked if this issue was recorded on the risk register. PM agreed to add this to the HR risk register.	The committee was assured of really positive developments and looked forward to seeing these come to fruition.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			ACTION: PM to put professional issues: internal nursing bank and use of agency staff, on HR risk register.		
6	**Workforce Metrics**		PM gave overview of paper 5 and highlighted some points that she wished to bring to the attention of the committee. • Graph 3 – turnover rates by head count and FTE is 7% lower than at this time last year. • Graph 6 – appraisal compliance rates have increased by 10% over the same period. A significant factor maybe the link to the introduction of the Pay Progression Policy and this corresponds to the reduced turnover figure. • Junior Doctors Contract – this will go live for 60 junior doctors on the 7th December. Those doctors have received all the relevant documentation. The BMA has encouraged junior doctors to write into the HR department that they are "working under duress" from the 7th December. Out of those 60 doctors, 12 are entitled to pay protection. • DRS system – the system calculates a salary depending on a junior doctors work placement. The system has been designed so staff can 'exception report'. By gathering information from other Trusts who have gone live with the junior doctors contract, 1 in 3 are exception reporting. This will be quite time consuming to Educational		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			Supervisors and for our Safer Working Guardian to oversee such a large number of exception reports. • Junior Doctor Forum – the inaugural meeting has been arranged for the 30th November. • Flu Uptake – current figure for front line staff is 51% against a CQUIN target of 75%. Deadline to reach target is 31st December. A final push is ongoing, with staff this week being contacted who have not had the vaccine at the hospital but may have obtained it elsewhere. This can still be counted in the Trust's figures. • The demand for bank staff has increased in line with establishment requirements, for example Graham Ward opening in Scarborough and the increase in York ED staffing to 11 RNs on each shift. • Online pay slips – these are being trialed at the moment with bank staff. Staff Side are aware of this. • Winter pressures – incentives to work bank. Analysis from last year indicates Bank only workers worked on average 19 shifts over the Winter period. This year if they work 25 shifts (187.5 hours) then a 10% bonus will be given. For substantive staff who want to do a few extra shifts they will be paid a 15% uplift on their basic bank rate.		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
7.	**Medical Agency Spend**		This year to date medical agency spend has reduced slightly from last year but demand has still been consistently high. The reduction is mainly due to robust negotiations with agencies to drive down rates. Spend is related to 50% medical and 50% nursing. Within Medical Agency Spend just under 50% equates to filling consultant posts, with 50% middle grades and trainee posts. Emergency Medicine is the speciality with the highest spend at £1.5m. The Trust is reporting weekly to NHS Improvement on agency spend and is following their good practice with regard to breaches. From the breaches being reported, the majority are related to using framework agencies but above the cap (circa 130 per week). This month (Nov) NHS England has given the Trust more information on what other Trusts are doing. They have stepped up the monitoring, now requiring CEO authorisation for spending higher than £120 per hour. The Trust is monitoring this every week with a spreadsheet being sent to the CEO. Some of the Trust's highest spend is due to patient safety. We have run some successful recruitment campaigns and the Trust is working really hard and flexibly with directorates to ensure staff are in post as quickly as possible. LR requested that on graph 1 a trend be added to it.		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			ACTION: PM to add trend to graph 1 in Medical Agency Spend paper. DW asked why there were a few negatives in table 1. PM replied that they have identified where agencies were overcharging the Trust, and they are recouping this back.		
8.	**Apprenticeship Update**		MP informed the committee that BG will become the executive lead on apprenticeships moving forward. MP gave overview of paper 7. Attention is focused on the £1.3/£1.4m levy next year. The national changes represent a huge change for how the organization recruits, trains and retains staff. It is anticipated that the majority of HCA's will train via an apprenticeship program in future. The volume of people will be focused on the lower bands. As a purchaser of training the Trust is in a far better position to influence training provision. MP assured the committee that the Trust is well ahead of the curve in comparison to other organisations, although there is much work still to be done LR asked if the Workforce was involved on the STP project. MP advised that they were to be involved in training needs analysis and the career structure around B1 – B4. He also advised that they are fronting a bid to become a Centre of Excellence which is hugely ambitious. DW asked if it is going to Board. MP informed that he will give a verbal update.	The committee commended this work that will position YTH to take advantage of new apprenticeship opportunities.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			MP advised that the Trust needs to maximize the potential skills of staff. The intention is that people can see and build their way through to realize their potential.		
9.	**Internal Audit Reports**		PM informed that every audit that has an outcome of 'limited assurance' will go to the WFODC. • Recruitment & Pre-employment checks Full centralised recruitment was implemented in January 2015. There have been teething problems. The limited assurance relates more to record keeping of interview notes and employment checks rather than the checks not having been conducted. Training had been temporarily suspended for around 18 months, which has now been reinstated in line with the new TRAC system. Trust policy is that recruitment for B7 upwards undergo an assessment centre, but audit had picked up that a few that had not gone through the process. Board are required to be notified of updates on a more regular basis. PM informed that one of the main drivers of centralised recruitment was governance, particularly on employment checks.		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			• Occupational Health - re-audit. With regard to effective governance arrangements of contract performance management, MOHAWK should be used for Occupational Health and the Trust needs to adopt MOHAWK with the level of service agreement. MOHAWK is put on hold. OH income target is £500k. It has been extremely difficult to generate income in excess of £250k/£300k. It has been difficult to recruit to admin in O.H. on the York site. DW asked if people can request a delay for a re-audit if circumstances are not conducive to provide a helpful audit. PM confirmed that re-audits need to be undertaken no later than 12-months after the initial audit.		
10.	**Recruiting People with Learning Difficulties**		The committee was informed that Karen Porter, from Project Choice, is spending the next 12 months on the York site setting up a program to start offering 12 week placements to people with learning/physical disabilities from September 2017.		
11.	**Risk Register and BAF action plans**		<u>BAF</u> The committee discussed the demarcation for the RAG rating. The committee considered reducing the risk relating to turnover to green **ACTION:** Linda Provins to lead on revising the BAF re KPIs.		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			Risk Register PM to put professional issues: internal nursing bank and use of agency staff, on HR risk register.		
12	**Review of WFOD Strategy – Excellent Place to Work**		Ratified.		
13.	**AOB**		DW asked if the Plank Challenge could be taken to the Health & Wellbeing Steering group for discussion. If this is to be explored further it was suggested Fundraising might helpfully be included. **ACTION:** PM to take it to the next Health & Wellbeing Steering Group.		
14.	**Next Meeting**		The next meeting is arranged for 18th January 2017, 11.00-13.00, YH Meeting Room 1, Park House		

Action Points: Workforce & Organisational Development

Committee Date of Meeting - 15 November 2016

Month	Action	Responsible Officer	Due date	Completed
November	Committee requested an update at next meeting on psychological wellbeing in relation to the Health & Wellbeing project initiatives taking place.	PM	January 2017	
November	Add professional issues: internal nursing bank and use of agency staff, on HR risk register.	PM	immediately	
November	Add trend to graph 1 in Medical Agency Spend paper.	PM	immediately	
November	Revise BAF re KPIs.	LP	immediately	
November	Discuss the Plank Challenge at next Health & Wellbeing Steering Group.	PM	January 2017	

York Teaching Hospital NHS
NHS Foundation Trust

Workforce & Organisational Development Committee (WFODC) – 18th January 2016 – YH Meeting Room 1, Park House

Attendance: Dianne Willcocks (Chair) (DW) Linda Provins (LP) Libby Raper (LR) Polly McMeekin (PM) Brian Golding (BG)
Mike Proctor (MP) Glenn Miller (GM) Lyeanda Berry (LB) Elaine Middleton (EM) Tracy Astley (mins) (TA)

Apologies: Sue Symington

0	The meeting began with an overview of workforce experiences during the Christmas period: PM – There has been a sickness spike with high numbers of medical locums and nursing bank staff calling in sick at the last minute which impacts on safety levels being frayed somewhat. There have been a couple of flu outbreaks as well. Despite a successful flu vaccination campaign these flu outbreaks have been in areas where not all staff have had a flu vaccine. Many agency staff had not been vaccinated and would not work in these areas. Next year the intention is to offer flu vaccine to agency staff as well. DW asked if there were any variations between SGH and YH. PM advised that SGH had always had a good uptake on bank staff (60%-70%), maybe because bank team have been traditionally based at SGH and have a good relationship with staff. The agency fill rate is always higher on the York site. Demand for temporary nursing spiked as is usual in winter. Long term bookings are in place with agencies for continuity with consideration of additional LT bookings. GM – cancellation of operations has been very variable. Where patients can be diverted to day units these have carried on. . The bed managers assist where possible. The main problem is the delay in starting at 9.00am because if patients are not allocated beds until late on then clinicians are pressured for time. In addition, staff have been tabled to other areas such as ED and feel uncomfortable with this and need to be directed. To avoid this some ask for leave rather than be put elsewhere. BG – absenteeism was the biggest problem with increased sickness levels. He is working closely with Andy Betts who is trialing an initiative at SGH where trained staff can be flexible developed for new E&F roles as demand requires ie a domestic who can undertake porter duties as required. It has been very successful at SGH and the intention is to introduce it at YH.

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
1.	**Last Meeting Notes 15th November 2016**		The minutes were approved as a true record of the meeting and ratified.		
2.	**Matters arising and Action Log**		Action log ratified. PM gave update on the plank challenge. At the recent Health & Wellbeing meeting it was suggested that it became part of an event. Discussions are ongoing.		
3	**Job Planning and Job Planning Principles**		GM outlined the revised Job Planning document and principles which closed loopholes and strengthened controls around SPA time. Main points were: • SPA time needs to be evidenced so Clinical Directors can have discussions with individuals about how they are spending their time. Any 'padding' in job plans to make up time can now be revisited. • Job Planning Executive Panels are arranged from now to end March to scrutinise all the job plans. GM will support CDs to create their job plans. • PAs can now be reduced to a quarter rather than being allocated in its entirety. • The Job Plans are going to be made available for others to look at on the intranet. PM advised that as part of Schedule 15 an individual needs to have had an appraisal and a job plan to be validated in order to satisfy the incremental pay progression. DW stated that the hospital is low on research work and asked if staff could be given encouragement to engage in research. GM replied that research is included in SPA time and job planning. However, it is initially up to the individual who is interested in research to build a project.business case.	Committee assured by revision to job planning	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			GM advised that the 2003 contract has never been enforced with regard to working in private practice. Staff would be less worried about losing their SPA time if they drop below 11 as they could still do private practice. LR was nervous about staff dropping below 11 SPAs and asked if it was not time to be firm about this. GM advised that there was a whole explicit section in the Job Planning Principles. In addition, all members of staff affected have been advised regarding Job Planning Principles via email plus a letter to their home address. GM suspected that they will not necessarily have more but less SPA time as a lot of individuals will want to do the amount required for revalidation and hence to evidence more DW asked if there was an evaluation plan. GM replied that the first outcome of this is that a member of staff is going through the disciplinary process because they have ignored the job planning principles. Importantly review is ongoing. **ACTION:** It was agreed that GM would supply an update report on Job Planning to the committee at the March meeting.		
4	**Community Workforce Project**		LB gave a PowerPoint presentation covering the key areas that she and Ginny Russell are working on in the community. Main points were:- • The way forward is to move away from the traditional way of working, ie. DN teams being badged to a doctors surgery, and instead to cover a geographical area.		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			• Age profile: 42% of staff are over 50 (93). Overall across all localities over 50% of Band 7 and 6 staff are eligible to retire either now or in the next 5 years followed by 40% of Band 5 staff. Overall 59% (131) of staff are over 45 - higher than the national average of NHS employees where 47% are over 45. Overall across all localities over 50% of Band 7 and 6 staff are eligible to retire now or in the next 5 years plus 40% of Band 5 staff. • There is potential to reskill RN workforce to meet changing demand to service. There is potential for structure within non-registered workforce band 2, 3, 4 – linking to the apprenticeship agenda. Moving forward:- • District Nurse Qualification: Further scoping needed • Practice Teacher role: Limited number of PTs, lack of interest in course – further scoping required • Prevention and Health Coaching: Need to up-skill staff in this area to support 'prevention' and 'community first' agenda. HEI offers available. • Geographical working and HUB model under development in York E / W and Scarborough to provide flexibility in capacity and skills mix. • DN Admin support role: Linking to admin review – scoping what admin support could bring to the workforce. • Emerging apprenticeship agenda – LB is working with Cathy Skilbeck on this. PowerPoint presentation available from TA on request. The group discussed mobile working and not having a base. MP noted the danger that staff would not engage as team and it would be difficult to check their practice and offer support	This is a significant long term project which merits full support both at trust level and via CCGs	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			PM advised retention is better in the community. DW asked if CCGs were aware of positive development within community. MP advised that through CQC community services came out well but some of the attitudes to community are traditional.		
5	**Psychological Wellbeing update**		EM gave an overview of the work she and her team had been doing with regard to mental health and wellbeing. Looking at the statistics over the years there has been an increase in time lost due MH issues. Main points were: • A mental health working group consists of HR, OH, Managers, Communications, etc. to develop a strategic framework that underpins support given. • Funding has been secured for the Schwartz rounds via Charity within the Trust. • A communications strategy has been developed including the printing of booklets and leaflets, and information on the intranet under Staff Benefits section. • There are 4 workshops available for line managers regarding having conversations with staff about MH • Headspace apps are available. EM discussed the stress audit which took place in York ED and ward 28. She is hoping to produce a dashboard that would help to target areas where a stress audit can take place and produce an action plan to support that area and then revisit in a year's time to explore impact. DW asked if there was a CBT waiting list. EM replied that essentially for those referred from O.H. there is not a waiting list. It is a rapid access. Also there is the WRAP service to work with staff on warning signs to look out for and develop a plan to agree with their manager.	Committee assured by interventions but look forward to receiving impact data.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			DW asked around the volume of staff using the service. EM replied that many of them are signposted on to relevant support but around 20% of staff are cases that need managing and linking with OH, HR, Managers, working together to create an improvement. **ACTION:** EM to produce a MH workstream update to the committee in six months, to include numbers where possible.		
6	**Nurse Rostering Project update**		PM gave an update of paper 3. From organizational level 'deep dives' there were 19 actions identified - 8 now complete and 10 in progress. A key action is to determine whether one roster model is more effective than the other. Accordingly, a de-centralised model is being trialed at YH and a centralised model at SGH. A recommendation will be made via the steering group by the end of March 2017. At the moment access to rosters is limited to matrons/ senior staff. However, it is the intention to roll out to other staff once trialing is complete. DW asked how robust the structure of approvals is. PM advised re substantial work between the Chief Nurse Team and the Rostering Team around safe staffing and flexible working arrangements. PM advised that Rebecca Hoskins had also met with members of O.H. to ensure that they are aware of the impact their recommendations are having as some staff may need to be moved due to staff rigidity with working patterns.	This important project continues to make good progress	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			LR enquired whether they were ready for an internal audit to be carried out. PM advised that this has been scheduled for Q1 during the new financial year.		
7	**Professional issues: Internal nursing bank and use of agency staff - update**		PM gave an update of paper 4. In total there are 550 staff (RNs and HCAs) registered on the nurse bank. Main points were:- • A scoping of practice is currently in development to identifiy the clinical and professional expectations for bank only and agency workers. • Ensure bank only workers can access a professional lead who supports their appraisal, CPD, pay progression and revalidation (as applicable). • Governance: The trial of an induction checklist is underway to provide a simple and easy way of identifying that correct workers are on duty and that they are presented in the appropriate manner. In addition, a project is underway to initially ensure that all substantive and bank only workers are using their unique IT login; usage is being audited. Once complete, training on EPMA will be offered to all bank workers to enable individual login -obviating the need for shared generic log ins. • Out of Hours provision: The audit of the impact of staffing out of hours is complete. Following one recommendation the bed management will be trained on Healthroster so they have a greater oversight of staffing numbers and therefore where best to redeploy them. Discussions continue as to what actions may be required.		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
8	**Workforce Metrics**		PM gave summary of paper 5. Sickness absence: she referred the committee to graph 2 Monthly Sickness Absence Rates which compares year on year. The trend of sickness absence in November had slightly reduced but the operational sickness absence spiked considerably in December with gastro issues and flu. 17% of absence was related to cold, cough, flu in November. LR enquired whether a break down is done by grades, directorate, etc. PM advised that a break down can be done by grades, wards, individuals, directorates so patterns can be pulled out to determine reasons and then work with various teams regarding intervention, ie. MH, OH etc Temporary Staffing: demand for temporary nursing staffing has increased by 26%. However, it does fluctuate with winter pressures. To meet the demand the Trust has offered incentives to bank staff again this year. Recruitment: centralised recruitment now in place for 12 months. Second phase was the introduction of TRAC, an applicant tracking system which manages all recruitment activity from vacancy authorization to start date. TRAC went live in October 2016 and from the two months data analysed, recruitment end to end has reduced significantly from an average of 100 working days to 56 working days. Junior Doctors Contract: since 7th December 61 doctors have transitioned on to the new contract. As of yesterday there have been 35 exception reports relating to working hours from 9 doctors. We are working closely with their CDs to establish reasons.		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			The Junior Doctors Forum is now up and running with the second meeting recently taking place – more positively than the first one with far greater attendance from the juniors. <u>Incremental Pay Progression Policy: s</u>ince implementation on 1st April 2016 there has been an average of 13.9% of staff not progressing through their incremental uplift. It is not possible to determine whether staff have just not applied or they are not eligible. No formal requests to review have been received. Negotiations with trade unions are ongoing to determine the success of the policy. As anticipated, benefits of doing this has seen an increase in appraisals to 75% and statutory and mandatory training compliance to 86% as shown in graph 7 page 8 of the report. The recording process of appraisals has been changed so that line managers and directorate management teams now have the ability to record and input appraisal activity at source directly into the Learning Hub which they find a lot easier. <u>Employee Relations Activity: </u>activity for November/ December 2016 has doubled. It has been identified that 62% relate to three directorates (Estates & Facilities, Out of Hospital Care, Elderly Medicine). <u>Flu Campaign 2016: t</u>here has been a significant increase in uptake from the previous campaign with uptake at 69% by 31st December and the Trust will receive 50% of allocated CQUIN funds. Although the campaign finished at the end of December offering flu vaccinations is continuing.		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			Non-Executive Director Recruitment: after a robust recruitment and selection process to replace Philip Ashton, Jenny McAleese has been successful and will commence in her new role in March 2017. Arts Strategy: Arts meeting arrange for tomorrow (19/1/17). The plan is to align the Arts and Music in hospitals with the Equality & Diversity agenda.		
9	**Apprenticeship Update**		BG/MP gave developmental overview. Main points:- • Need for governance around this. • Need to match apprenticeships with new job roles that are needed. • They are to meet some Principals of colleges to see what they already offer. • Conversations with directorates are taking place regarding apprenticeships and job roles. It is very much at the developmental stage but a report should be available within the next few weeks which can be circulated to the committee. **ACTION:** BG to produce report for March meeting giving base line data and progress to date.		
10	**STP Workforce Work Stream**		MP gave update. Main point was that progress is continuing with the Centre of Excellence bid. It has gone through to the final stage which involves giving a presentation in London when a date is confirmed.		

11	**Risk Register and BAF action plans**		BAF: Point 3.3 *We fail to retain our staff*. Now green. Point 3.1 *We fail to ensure that our organisation continues to develop and is an excellent place to work.* Need to add staff engagement and include staff achievements, star award, etc. **ACTION:** PM to capture staff engagement/ celebration and add to BAF point 3.1. Risk Register: PM confirmed that she had added the professional issues regarding temporary nursing.		
12	**Review of WFOD Strategy – Health and Wellbeing**		Ratified.		
13.	**AOB**		**ACTION:** Helpforce: PM to consider with Bev Geary/Helen Hey and give update at next meeting. PM informed that the Education Review Group has been re-established and asked if it would be helpful if she fed back on this. This was agreed.		
14.	**Next Meeting**		The next meeting is arranged for 22nd March 2017, 14.00-16.00, YH Meeting Room 1, Park House. (Please note this is subject to change)		

Action Points: Workforce & Organisational Development

Committee Date of Meeting – 18th January 2017

Month	Action	Responsible Officer	Due date	Completed
December	Supply a report on Job Planning update to the committee at the March meeting.	Glenn Miller	March meeting	
December	Produce a Mental Health workstream update to the committee in six months' time.	Elaine Middleton	Six months' time	
December	Produce report on Apprenticeship for March meeting giving base line data and progress to date.	BG	March meeting	
December	Capture staff engagement and add to BAF 3.1	PM	Immediately	
December	Helpforce: PM to consider with Bev Geary/Helen Hey and give update at next meeting.	PM	March meeting	
December	Update committee on regular basis regarding the Education Review Group.	PM	Ongoing	

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 January 2017

Workforce Report – January 2017

Action requested/recommendation

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

Summary

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

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

Outcomes 12, 13 & 14

Progress of report	Board of Directors
Risk	No risk

Resource implications	There are Human Resources implications identified throughout this report.
Owner	Patrick Crowley, Chief Executive
Author	Polly McMeekin, Deputy Director of Workforce
Date of paper	January 2017
Version number	Version 1

Board of Directors – 25 January 2017

Workforce Report – January 2017

1. Introduction and background

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

- The monthly sickness absence rate in November was 4.37% a slight reduction from 4.43% in October. Both the monthly absence rates for October and November have however shown an increase in line with seasonal sickness absence rates.
- Cumulative annual absence rates have remained static between 4.14% and 4.16% in the last six months.
- Demand for temporary nurse staffing continues to be high with requests totalling the equivalent of 390 FTE staff in December 2016.
- Appraisal compliance has continued to increase with a compliance rate of 75.34% in December 2016.
- As at the 31st December 69% of all frontline staff had received the flu vaccination.

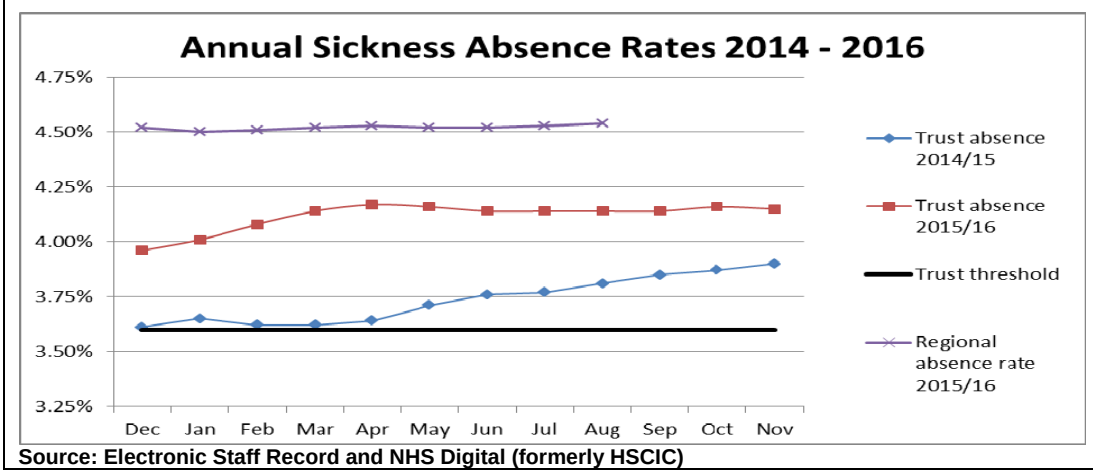
2.1 Sickness Absence

Sickness absence rates

The graph below compares the rolling 12 month absence rates to the Trust's locally agreed threshold and to the regional (Yorkshire and Humber) sickness absence rates. After rising in each month between April 2015 and April 2016, the Trust's cumulative annual absence rate reduced in May and June 2016 and then remained fairly static between 4.14% and 4.16% until the most recently available data (November 2016).

The Trust absence rate continues to compare favourably with sickness absence across the region. There is a delay in the publication of the regional data and currently only data up to August 2016 is available. In the year to August 2016, the regional annual absence rate was 4.54% compared to a Trust rate of 4.15%.

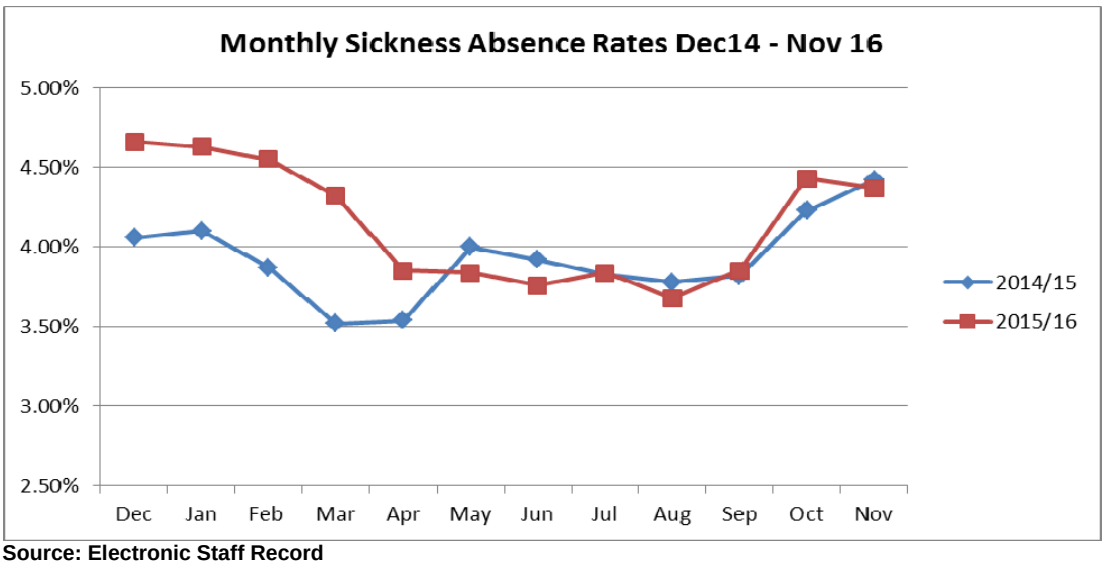
Graph 1 – Annual sickness absence rates



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

The graph below shows the monthly absence rates from December 2014 to November 2016. The monthly absence rate in November 2016 of 4.37% was a small reduction from the previous month's absence rate of 4.43%. However, the absence rates for both October and November have shown a steep incline mirroring a similar pattern in the same months of the previous year suggesting seasonal variation. The absence rate of 4.43% in October 2016 was also higher than in the same month of 2015 (4.23% in October 2015).

Graph 2 – Monthly sickness absence rates



Source: Electronic Staff Record

Sickness absence reasons

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

Top three reasons (days/FTE lost)	Top three reasons (episodes of absence)
MSK problems, inc. back problems – 20.22% of all absence days lost	Gastrointestinal – 20.50% of all absence episodes
Anxiety/stress/depression – 19.54% of all absence days lost	Cold, cough, flu – 17.08% of all absence episodes
Gastrointestinal – 9.77% of all absence days lost	MSK problems, inc. back problems – 11.48% of all absence episodes

In November there were 384 episodes of sickness due to 'cold, cough, flu'. There were an equally high number of episodes in October (393 episodes). The sickness reason of cold, cough, flu accounted for 17.08% of all absence episodes in November and 16.62% in October corroborating the seasonal increase in the overall monthly absence rates in October and November.

2.2 Temporary staffing

Temporary nurse staffing

Demand for temporary nurse staffing (Registered Nurses (RNs) and Health Care Assistants (HCAs)) in the last year has on average equated to around 371 Full Time Equivalent (FTE) staff per month. However, demand in the past six months has been much higher than this with demand in December increasing to 389.55 FTE. This was 26% higher than demand in the same month of the previous year (demand in December 2015 was 308.70 FTE).

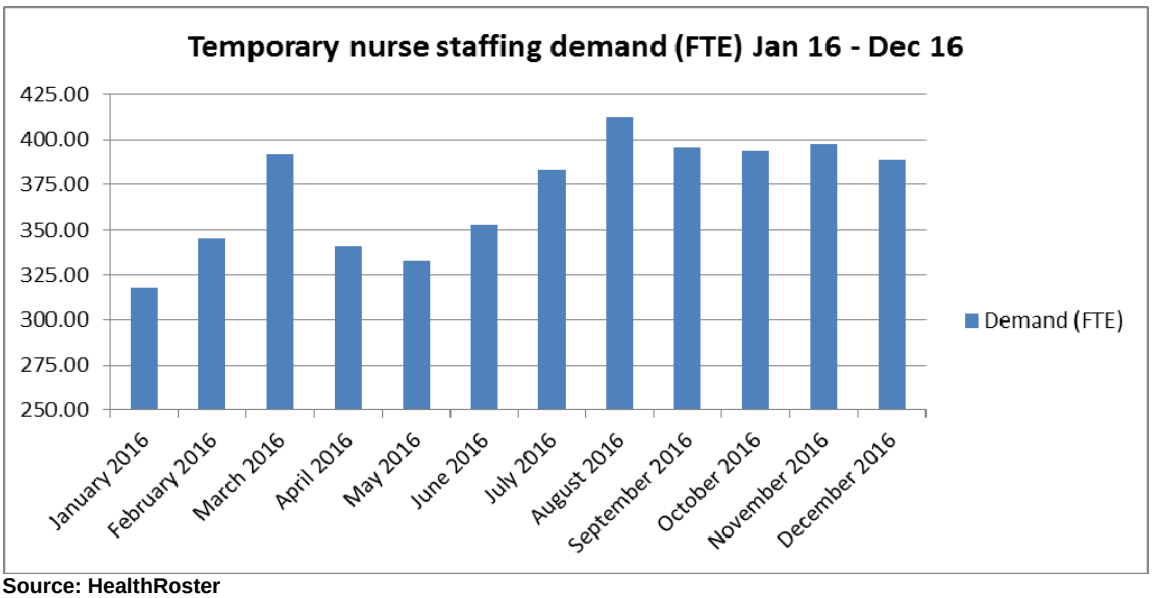
Demand for HCAs has outweighed that for RNs in the last two months with HCA demand exceeding

200 FTEs for the first time in both November and December (209.22 FTE and 206.50 FTE respectively). In December 2015 demand for HCAs was 130.48 FTE; this had risen by 58% to 206.50 FTE in December 2016. In contrast, demand for RNs was 178.22 FTE in December 2015 and has risen by 2.7% to 183.04 FTE in December 2016.

Although there is naturally a lull in demand over the Christmas period, demand for the rest of the month has still remained high. This has been, at least in part, due to an increase in capacity, with the Winter ward opening on 12 December. The week commencing 12 December saw the highest level of requests being made to the Nurse Bank team with just fewer than 2000 shifts being processed.

From the beginning of December until mid-May, agency block bookings of 18 RNs and 11 HCAs have been made to free up capacity and release staff in other areas around the Trust to provide cover for planned Winter escalation.

Graph 3 – Temporary nurse staffing demand



Source: HealthRoster

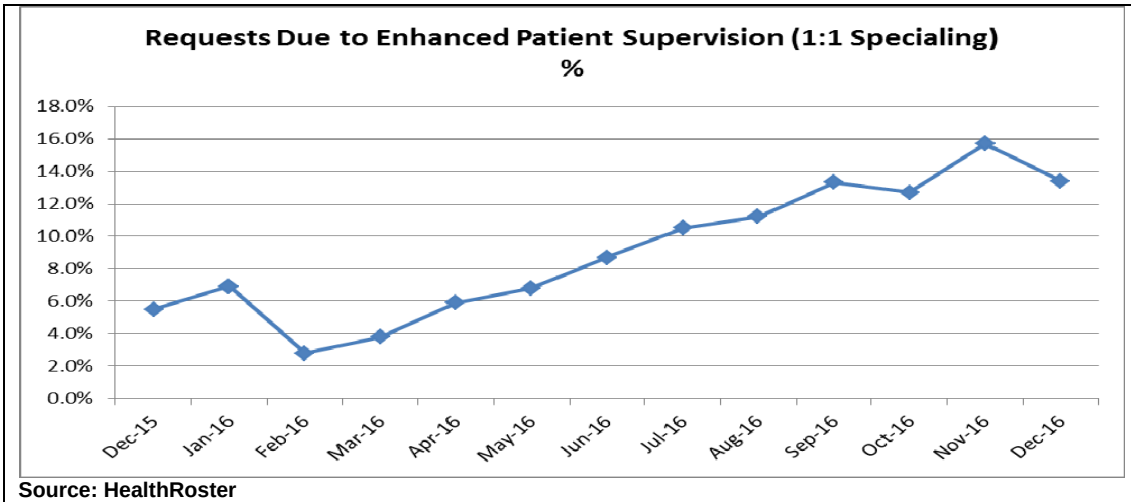
The most predominant reasons for making requests for temporary nurse staffing in December 2016 were:

- Vacancies – accounting for 51.6% of requests
- Sickness – accounting for 17.1% of requests
- Enhanced patient supervision (1:1 specialing) – accounting for 13.4% of requests

The proportion of shift requests due to the reason of sickness has shown an increase (making up 17.1% of requests in December, 17.5% in November, but 16.9% in October). By contrast, the proportion of shift requests made due to vacancies has fallen (from 56.8% of all requests in October to 52.2% in November and then 51.6% in December).

13.4% of requests were made with the reason of enhanced patient supervision in December 2016. This was a much higher proportion than in the same month of the previous year (5.5% of requests in December 2015). Requests made due to this reason has been increasing over the year as shown in Graph 4:

Graph 4 – Requests made due to Enhanced Patient Supervision

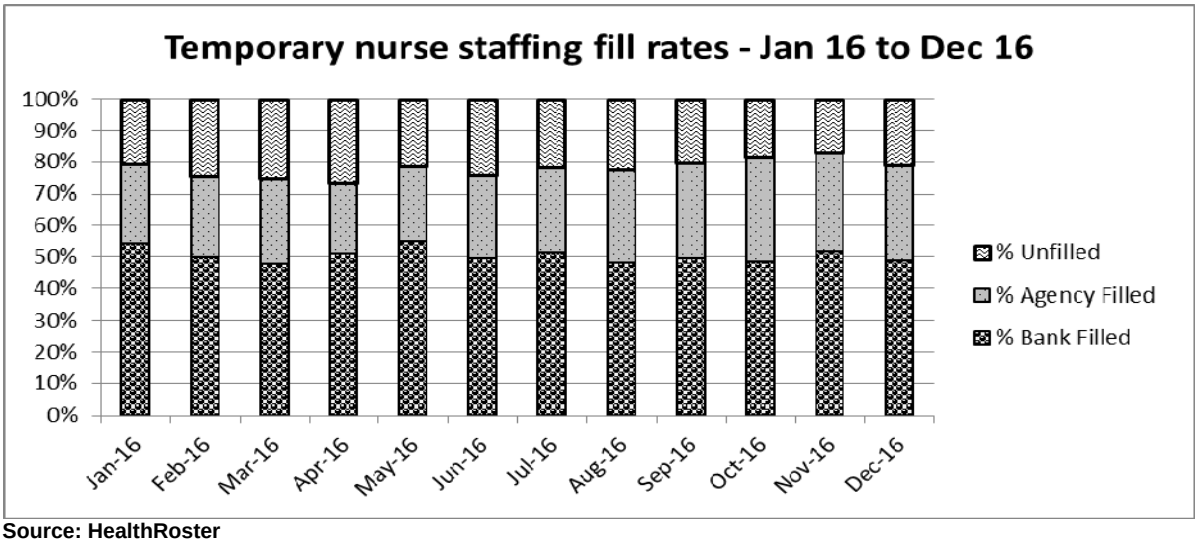


Source: HealthRoster

Graph 5 below shows the proportion of all shifts requested that were either filled by bank or agency or remained unfilled. Overall, bank fill rates continue to make up half of all requests but did reduce slightly in December compared to November (from 51.85% to 49.36%). Agency fill rates decreased from 31.13% in November to 29.84% in December.

Bank fill at the Scarborough site (59.25%) remains higher than at the York site (44.45%) whereas the agency fill rate at the York site (37.07%) remains higher than at the Scarborough site (15.28%). The agency fill rate at both sites had decreased from the previous month (in November 2016 the agency fill rate was 16.19% at Scarborough and 38.38% at York).

Graph 5 – Nursing Temporary Staffing Fill Rates



Source: HealthRoster

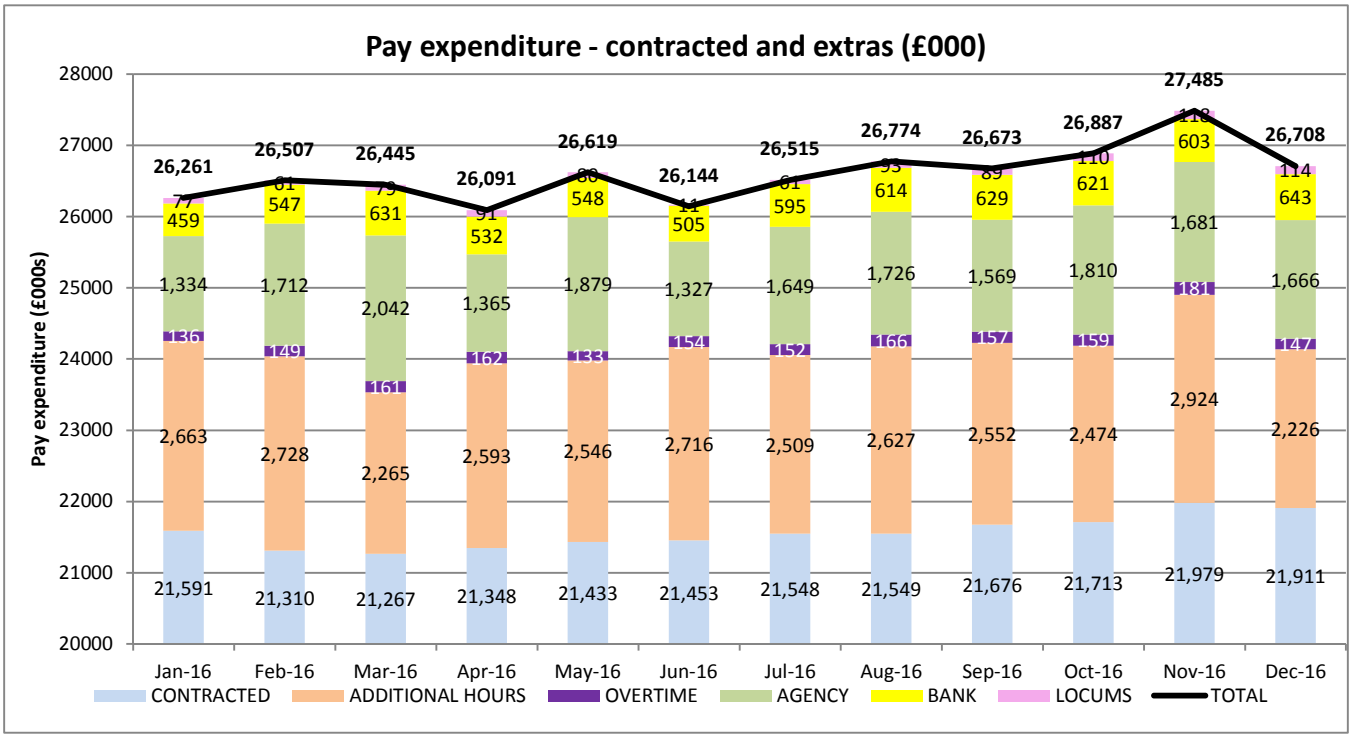
The Trust commenced offering incentives to staff undertaking work on the Bank over the winter period from 1 December 2016 to 31 March 2017.

Over this period, substantive staff are being paid a15% uplift on their basic bank rate which equates to an overall 20% uplift on the basic substantive pay rate (as basic bank rates are already 5% above the basic AfC rate).

Bank only staff are currently paid an enhanced rate of 10% above their basic bank rate in one block payment after they have worked 187.5 hours (equivalent to 25 standard shifts) which will be paid in arrears. This equates to an overall 15% uplift on the basic AfC pay rate. Bank only staff will subsequently have the opportunity to receive these payments after each additional block of 187.5 hours worked.

The winter incentives have however not yet shown an impact with the anticipated increase in the bank fill rate. Graph 6 below though does show that bank expenditure did increase in December compared to the previous month (whilst all other types of expenditure had reduced) and stands at its highest figure in the last 12 months.

Graph 6 – Pay Expenditure



2.3 Recruitment

Centralised recruitment has now been in place for 12 months. The final phase of the centralised recruitment transition was the implementation of the Trac recruitment system, an applicant tracking system, streamlining the administration process and acting as a platform to manage all recruitment activity from the initial vacancy authorisation to the final onboarding and induction. Trac was implemented at the start of October 2016.

Before centralised recruitment, the recruitment process was taking on average approximately 100 days end to end across the Trust. The implementation of the Trac system has enabled a more robust means of measuring the recruitment process and, as detailed in the table below, the average time to hire was 56.5 working days between October to December 2016.

	01/10/2016 to 06/12/2016
Average time to authorise vacancies (requisition by manager up to the point that full approval is granted) in working days:	8
Average time to hire (advert start date to candidate start date) in working days:	56.5
Employment check completion in working days:	14

Source: Trac Recruitment System

Data for the average time to hire and employment check completion will eventually be based on a 6 month cumulative report to allow for inclusion of applicant progress over a longer period.

2.4 Junior Doctor Contract

Since 7 December when a total of fifty-nine F1s and two F2s transferred on to the new terms and conditions, we have received a total of five exception reports from three Doctors – all related to safe working practices (hours and rest). To date (31 December 2016) we have not received any in relation to Education and Training issues.

Of the five exceptions, two were from General Surgery in York and three were from General Medicine in Scarborough.

None of the reported exceptions have necessitated a Guardian fine.

2.5 Incremental Pay Progression Policy

On 1st April 2016 the Trust introduced the Incremental Pay Progression Policy for staff on Agenda for Change terms and conditions of employment. The policy provides that annual incremental pay rises will no longer be automatic but dependent upon satisfactory performance, conduct, behaviours and meeting all essential training requirements for the role. All employees to whom the policy applies need to apply for their increment, demonstrating that they have achieved the required level of performance. This new requirement should shift the emphasis from entitlement to personal responsibility.

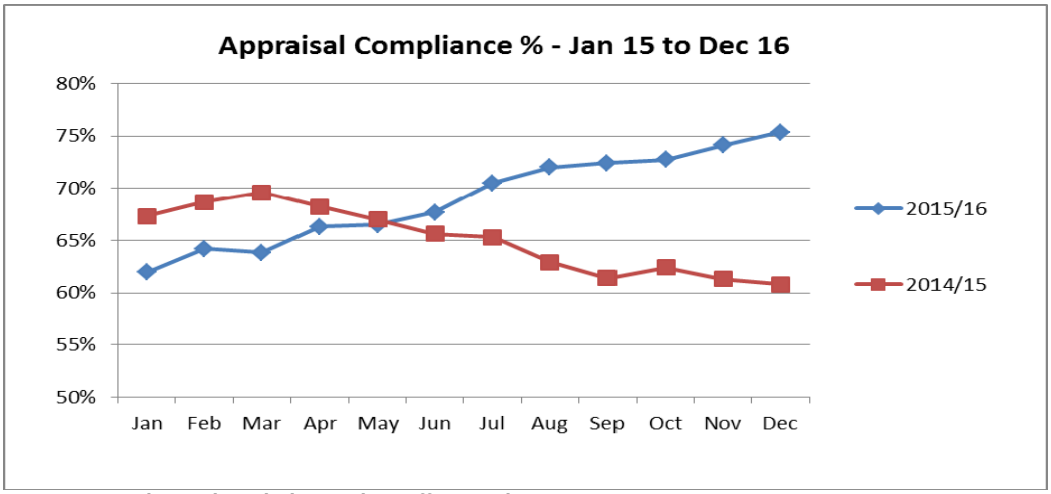
Since implementation there has been an average of 13.9% of staff not progressing through their incremental uplift. No requests for a Review have been received.

It was anticipated that this change in policy would contribute to improved compliance with statutory/mandatory training and appraisal rates. Since April the statutory and mandatory training compliance for the Trust has increased from 81% to 86% in December. Appraisal compliance stood at 66.3% in April and this has increased to 75.34%.

2.6 Appraisals

The graph below shows appraisal completion compliance from January 2015 to December 2016.

Graph 7 – Appraisal Compliance %



Source: Learning Hub and Electronic Staff Record

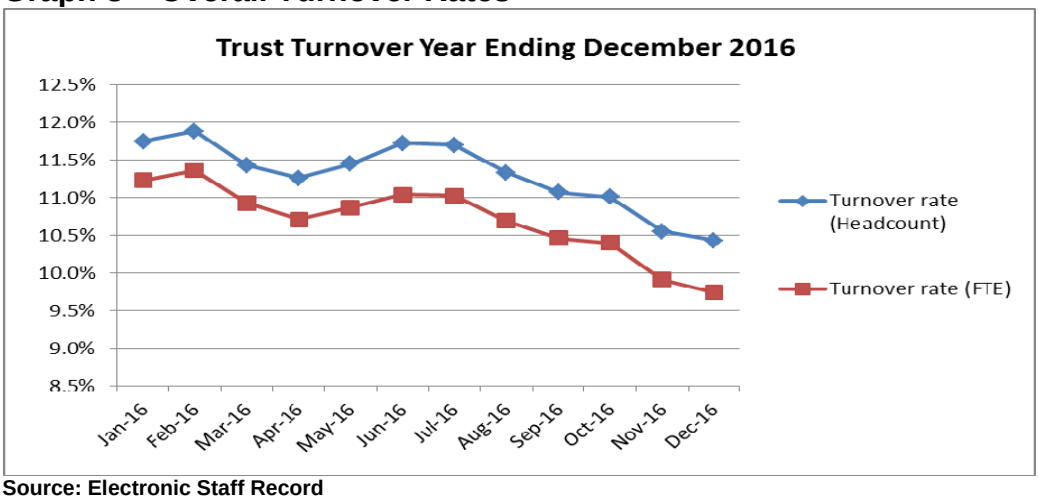
The overall Trust appraisal activity has continued to increase steadily over the last year with the overall Trust rate for December 2016 standing at its highest rate in the last three years at 75.34%. This increase in compliance will have been in part facilitated by the Trust's Incremental Pay Progression Policy as mentioned above and additionally by line managers and directorate

management teams now having the ability to record and input appraisal activity at source directly into the Learning Hub via the new e-appraisal functionality.

2.7 Turnover

Turnover in the year to the end of December 2016 was 10.43% based on headcount. Turnover calculated based on full time equivalent leavers for the same period was 9.74%. This is a reduction from 10.55% and 9.91% respectively in the year to the end of November 2016. The turnover rate in the year to the end of December 2016 represented 808 leavers from the organisation and is the lowest rate it has been in the last 12 months. This is the first time the turnover rate has been below 11% since September 2015.

Graph 8 – Overall Turnover Rates



Source: Electronic Staff Record

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

2.8 Employee Relations Activity

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

Employee Relations Activity	Sep 2016	Oct 2016	Nov 2016	Dec 2016
Number of Disciplinaries (including investigations)*	13	13	26	29
Number of Grievances	23	16	20	16
Number of Formal Performance Management Cases (Stage 2 and 3)*	3	0	2	3
Number of Employment Tribunal Cases*	0	0	1	1
Number of active Organisational Change cases in consultation (including TUPE)	18	12	10	8
Number of long term sick cases ongoing	176	178	152	164
Number of short term sick cases (Stage 2 and 3)	188	127	145	169

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

There has been an increase in disciplinary cases in the last quarter with 29 live cases in December.

The three busiest directorates in December contributing most of the cases were Estates & Facilities, Out of Hospital Care and Elderly Medicine (collectively making up 62% of all the live cases). By staff group, Nursing and Midwifery, HCAs and Estates & Ancillary staff contributed to most of the cases (with 10, 7 and 7 respectively out of the overall 29 live cases in December).

2.9 Flu Campaign 2016

The flu campaign commenced on 3 October 2016. Previous updates have outlined the operational detail of the campaign. The following information summarises achievement against the plan.

Statistics:

- Total number of Frontline Health Care Workers vaccinated = **4232**
- This equates to an overall uptake of = **69%**
- To achieve the CQUIN target and receive 100% of funds allocated we were required to vaccinate **4607** staff, ie.75% of frontline health care workers, the Trust shortfall being **375** staff overall.

Uptake by staff group:

- Doctors = **536** (**63%**)
- Qualified Nurses = **1353** (**58%**)
- All other professionally qualified clinical staff = 705 (**69%**)
- Support to clinical staff = 1638 (**85%**)

Outcome:

An achievement of 69% vaccine uptake suggests that the Trust will receive 50% of allocated funds since we've met the 65% - 74% milestone.

It is worth noting that whilst the target to vaccinate 75% of frontline health care workers was not achieved, the 2016 campaign has considerably improved upon the December 2015 figure where the Trust achieved an overall vaccine uptake of 46.5%.

Improvement is seemingly directly related to the significant change made to the delivery of the campaign. For example, the distribution of personal invitations to all defined frontline health care workers, the super clinic and peer vaccinator programme and the availability of a bespoke database to track those vaccinated enabling the Occupational Health Service to remind staff to attend for vaccine. Notwithstanding the determination to improve, diligence and effort of all those closely involved in the planning and delivery of the campaign.

2.10 Non-Executive Director Recruitment

With Philip Ashton approaching the completion of his full term as a Non-Executive Director at the Trust, the HR Team have led on the co-ordination of a campaign throughout November and December to recruit and select a replacement NED who is also able to Chair the Audit Committee going forward.

An extensive advertising campaign was completed for the position, with subsequent analysis showing that the Trust benefited from the attraction of candidates via websites such as LinkedIn, Indeed and the Trust's own web site. The campaign attracted 18 applications, which was reduced to eight via a long-listing process which eliminated applications from those who either lived outside of the Trust's catchment area or lacked the necessary financial qualifications/Board-level experience.

Of eight applications five were then chosen by representatives of the Nominations and Remunerations Committee to be invited for further assessment.

The assessment process involved attendance at an Assessment Centre where each candidate spent 20 minutes with three discussion groups comprising governors, Non-Executive Directors and HR, with each discussion accounting for 15% of the candidate's overall score. All five candidates then attended a 45-minute panel interview with members of the Nominations and Remunerations Committee, who selected the top-scoring candidate from the two-day selection process as their recommendation to the Council of Governors for appointment. Jenny McAleese's employment checks have successfully been completed and it is anticipated that she will commence in her new role in March 2017.

2.11 Rostering Best Practice

As part of the Department of Health's increased focus on workforce strategies and policy, the health secretary made a number of key announcements on workforce related measures in November 2016. One of which was a requirement that, by the end of 2017, all trusts must be meeting the best practice on rostering, as outlined in the NHS Improvement's Rostering Good Practice Guide.

This good practice guidance has been developed from the work developed through working with the Carter cohort to inform, and support staff with rostering responsibilities to better:

- Develop rosters in line with service activity;
- Maintain and operate rosters that meet patient, staff and organisational needs; and,
- Audit and challenge.

Whilst the Carter report recommends that all Trusts use an E-Rostering system due to the ease with which the resultant data can be analysed, the Good Practice Guidance applies to all staff using either electronic or manual rostering systems as the principles and the guidance will assist in ensuring common processes and maximum benefit from workforce efficiency. By following the guidance Trusts will be able to deliver the Carter recommendations by easily identifying areas of improvement within their current rostering practices.

For our Nursing workforce the majority of recommendations are process and practices that have already been implemented within the Trust as most of our nursing workforce are already being rostered via the Healthroster eRostering system. However, on the back of the Best Practice Guidance, the Nurse Rostering Steering Group has now also established a more formalised Roster Assurance Panel.

In line with the best practice guidance recommendations, the eRostering team are drafting a business case to expand the number of licences we have for the electronic rostering system to cover all staff and staff groups.

A review of the Rostering Policy is currently in progress and has been brought forward from the planned review date of August 2018. This was initially to address issues identified through the Nurse Rostering Project and to fit more in line with the recommendations of the Carter report. Additionally, the Rostering policy currently only applies to the Nursing and Midwifery workforce but this will now be expanded as part of the policy review to cover all staff groups in line with the government recommendations.

In order to monitor and review adherence to the policy for rostering a series of Key Performance Indicators (KPIs) should be reported monthly. The Carter Review (2016) identified many good examples of how dashboards were used by Trusts to monitor performance against KPIs. This

enables ward managers, matrons, senior staff and the Trust Board to review current levels of efficiency and quality. These KPI's include:

- Headroom and usage of annual leave, study leave, sickness, maternity leave and other leave;
- 6 week roster approval rates;
- Lost contracted hours not used per month;
- Additional shifts and reasons for booking;
- Working restrictions;
- Auto-roster percentage enabled;
- Number of bank requests to the total bank hours worked; and,
- Number of bank requests on weekend and night duties

The Trust's own KPIs are therefore being developed and established via the Nurse Rostering Steering Group.

2.12 Arts Strategy

<u>The Art and Design Operational Work Plan 2017 – 2019 for the delivery of the 2016 – 2019 Arts strategy</u>

The activities of the 3 year work plan address all eight main priorities, through the four key areas of work, outlined in the strategy document (Exhibiting and Commissioning art works for public spaces; Improving the Design of the Hospital Environment; Participation, Workshops and Residencies ; Music and Performance). However 'Supporting and fulfilling the Trust's ambitions Visions and Value' and 'Supporting the Trusts Equality and Diversity Objectives' are overarching themes of all planning.

The work plan and development methodology is being delivered across two broad phases to inform the work programme effectively:

Phase 1: Initial research and consultation for the Arts in Hospitals
Three main themes to be addressed came out of the needs analysis with internal and external stakeholders

- Internal development (Team / CPD)
- Proactive and planned approaches
- Collaborative development

Phase 2: Art and design priorities
Actions and targets addressing the themes from phase 1, highlighting the priorities and ensuring the objectives are clear, achievable and will deliver the strategy is set out in the 3 year plan. Briefly the Trust will start:

- Internal development (Team / CPD) – connect the arts team, CPD and an arts vision (as below)
- Proactive and planned approaches – budget, effective work plans, communication and evaluation
- Collaborative development embracing good working practice, community partnerships and national initiatives – working within our 4 Key Areas of work.

3. Conclusion

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

4. Recommendation	
The Board of Directors is asked to read the report and discuss.	
Author	**Polly McMeekin, Deputy Director of Workforce**
Owner	**Patrick Crowley, Chief Executive**
Date	**November 2016**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 January 2017

Freedom to Speak Up Report

Action requested/recommendation

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

Summary

This is the initial report of the Freedom to Speak Up Guardian which outlines the implementation of the role and the initial impact it has had within the organisation.

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

No reference to CQC outcomes.

Progress of report	Initial Report on Freedom to Speak Up
Risk	No Risk
Resource implications	Implications for the FTSU Guardian.

Owner:	Patrick Crowley, Chief Executive
Author:	Lisa Smith, Freedom to Speak Up Guardian
Date of paper	January 2017
Version number	V1

Board of Directors – 25 January 2017

Freedom to Speak Up Report

1. Introduction and background

The appointment of a National Guardian for speaking up freely and safely, and Freedom to Speak Up (FTSU) Guardians in NHS trusts were recommended by Sir Robert Francis, following his review and subsequent report into the failings in Mid-Staffordshire. In July 2015, the Secretary of State confirmed the steps needed to be taken to develop a culture of safety, and supported Sir Roberts's recommendations. The NHS contract 2016/17 specifies that NHS trusts should have nominated a Freedom to Speak Up Guardian by 1 October 2016.

The priorities of the National Guardian include establishing and supporting strong regional networks of FTSU guardians, highlighting NHS organisations who are successful in creating the right environment for staff to speak up safely and share this best practice across the NHS, independently review cases where NHS organisations may have failed to follow good practice and working with statutory bodies to take action where needed.

FTSU guardians have a key role in helping to raise the profile of raising concerns in their organisation and provide confidential advice and support to staff in relation to concerns they have about patient safety and/or the way their concern has been handled. Guardians do not get involved in investigations or complaints, but help to facilitate the raising concerns process where needed, ensuring organisational policies are followed correctly.

This is the first FTSU report to the Board and will outline the progress made in implementing the role since September 2016, the impact the role is making within the organisation and will include some recommendations.

2. Freedom to Speak up

Implementing the Role

The role has been well received and well supported within the organisation at the most senior levels. Engagement will all staff has its challenges, especially for an organisation employing over 8,500 staff, providing services across North Yorkshire. Being available and responsive to staff are key successes to the role, meaning the role is flexible and agile as opposed to being office based. Staff are always given a choice about where and when they wish to meet. It is important to maintain both the independence and confidentiality that goes with the role.

A new module has been established on the Datix system which allows the FTSU Guardian to record details of the concern confidentially and run reports as required. It is important to follow staff up who have raised concerns and so a 3 month 'well- being' check has been built into the system to ensure this happens where appropriate. This will include a brief questionnaire about their experience of raising a concern.

A communication/marketing strategy was launched in October; the role was introduced via Staff Matters and through the publication of flyers and posters which have been distributed throughout the organisation and are now included in the corporate induction packs. The FTSU Guardian has been attending JNCC and LNC, directorate, team and professional meetings at all trust sites as well as

ward walk-about's and the staff flu clinics. A presentation was given to the Audit Committee in December and some further work will be undertaken in the new year following an internal audit.

Updating the Whistle-Blowing Policy
NHS England has set minimum standards for whistle-blowing/raising concerns and the expectation of the National Guardian is that these are incorporated into trusts own local policies. As a result, an updated policy has been drafted and will be going through the usual organisational ratification during the early part of 2017.

Care has been taken not to undermine existing processes, but to complement and enhance them. We want everyone to feel that they can have a difficult conversation, if required, in order to speak up so that the best care can be provided for our patients. A key component of the policy is to be clear about how the organisation learns from concerns that have been raised and how those staff who have raised concerns will receive feedback. Staff have described the frustrations they have with Datix, which appears to be two-fold: firstly, there is a sense that the system is used to apportion blame and secondly that nothing happens or changes as a result of submitting a report. It may not always be appropriate to provide feedback when the process involves individual staff members, but where there is organisational learning to be had, or changes to systems and process required, it is important to communicate and share this. The FTSU Guardian is working closely with other departments such as governance, patient safety, HR, the learning and research (LaRC) team and the audit committee to explore this.

Networking
There is a requirement and expectation of the FTSU Guardian to attend national and regional events and training to promote standardized approaches to the role, to share and learn from peers and to set up a 'buddying' system. The FTSU Guardian has attended the national training programme and the launch of National Guardian with Dr H Hughes and Sir Robert Francis and has been instrumental in establishing a regional network for Yorkshire and Humber FTSU Guardians, the trust will be hosting the next regional meeting in February.

The Trust Guardian has been invited to be part of a new National Stakeholder Advisory Group, advising the National Office on whistleblowing cases for review and producing reports on recommendations for improvements.

The national office, in time, will also be requiring performance data from each FTSU guardian to publish nationally. The NHS staff survey results specifically around raising concerns will be used as a benchmark for improvement.

The FTSU Guardian has also been invited to speak at the annual NHS Audit Committee event for members from across the Yorkshire and the Humber region.

Concerns raised: The Story So Far September 1st – December 31st
Since starting in September, there have been a total of 22 individual concerns (speak ups') raised to the FTSU Guardian up to the end of December 2016. It is not surprising to note that not all of these would be regarded as 'whistle-blowers', some staff have made contact out of frustration with current procedures or lack of progress/communication and others have raised concerns that have not yet been raised elsewhere and therefore not had the opportunity to be discussed or addressed. These situations are not unexpected as the role is new and FTSU Guardians across the country are having similar experiences.

Of note, none of the individuals who have contacted the FTSU Guardian have done so anonymously – this is encouraging as it helps establish trust in the independence and confidentiality of the role, as well as providing the FTSU Guardian an opportunity to feedback to individuals and ensure no detriment is suffered as a result of raising a concern. The number of 'off site' meetings is also

significant, again, this is an experience shared by other FTSU Guardians nationally.

Intelligence gleaned from the regional network suggests this number is somewhat higher than that experienced by FSUP Guardians in other Trusts in the region. It is difficult to make comparisons as the number of staff differ and the length of the time each FTSU guardian has been in post differs from Trust to Trust, however, it would appear that an early indication of an average number of speak up contacts per month is between 2-4 depending on the size of the Trust.

A summary of the concerns raised in detailed below:

Month	No Of Contacts	Open	Closed	Anonymous	Off Site Meetings
September	1	1	1	0	0
October	9	4	5	0	7
November	8	6	2	0	2
December	4	2	3	0	TBA
TOTAL	**22**	**12**	**10**	**0**	**9**

Staff Group	Number
Domestic	4
Nursing	5
Midwifery	5
Medical	3
Management	3
Other	2

Trust Site	Numbers
York	16
Scarborough	4
Community	1
Bridlington	1
Malton	0
Selby	0

Themes	Numbers
Patient Safety	3
Attitudes & Behaviours	14
Staffing Levels	3
Health & Safety	1
Other	1

Outcomes

- Concerns that remain ‘open’ are those which are currently being investigated or reviewed. The individual who raised the concern is kept informed of progress on a regular basis. Concerns are only ‘closed’ when the process/procedures have been completed and the individual has been informed of the outcome.

- Outcomes of the concerns that have been closed have included a review of current management structures, a health and safety audit, changes to processes and formal HR procedures.

- Of note, one individual has since left the Trust, another is actively seeking employment elsewhere and has been hospitalised for exacerbation of a stress related chronic condition since raising a concern.

Next Steps

- Some joint work is being planned with the ODIL team to develop a 'raising concerns' training video to be used on all the leadership programmes to encourage being open, how to handle a concern and to understand the escalation policy.

- Work is also currently underway to develop and establish a trust- wide network of freedom to speak up champions through joint working with the existing team of 'fairness champions'. In January we are holding workshop to explore development of the role to promote an open culture of raising concerns across the Trust.

- Working with internal audit following the completion of the report to ensure any improvement actions are addressed.

- It is hoped in the spring that the FTSU will be able to attend the corporate induction days to introduce the role to all new employees.

3. Conclusion

Being free to speak up requires a significant culture change in the NHS, the FTSU Guardian role cannot achieve this single-handedly in the organisation, culture change comes from leadership at all levels in the organisation and living the trust values makes a huge contribution to this culture. Ensuring staff are aware of how to raise and handle concerns is everybody's responsibility.

4. Recommendation

The Board of Directors is asked to:

1. read and note the report and consider how often they would like to receive updates; and

2. consider how the organisation can develop a system of feedback/communication on lessons learnt from concerns raised or reported incidents.

Author	**Lisa Smith, Freedom to Speak Up Guardian**
Owner	**Patrick Crowley, Chief Executive.**
Date	**January 2017**

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 January 2017

Guardian of Safe Working Report - January 2017

Action requested/recommendation

The Board of Directors are asked to:

1. read and note this first report from the Guardian of Safe Working; and

2. encourage clinical directors, directorate managers and educational supervisors to be aware of their responsibilities within the new contract, in particular that payment for additional hours worked should be the exception rather than the rule.

Summary

This paper sets outs the background and context around the introduction of the Guardian of Safer Working as part of the 2016 Terms and Conditions for Junior Doctors and implementation of that role in the Trust.

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

Implications for equality and diversity

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

No reference to CQC outcomes.

Progress of report	Initial Report
Risk	Lack of engagement from affected staff. System failure.
Resource implications	Implications for clinical time from supervisors. Significant new administration functions.
Owner	Patrick Crowley, Chief Executive
Author	Lisa Smith, Guardian of Safe Working
Date of paper	January 2017
Version number	Version 1

Board of Directors – 25 January 2017

Guardian of Safe Working Report - January 2017

1. Introduction and background

This paper sets outs the background and context around the introduction of the Guardian of Safer Working as part of the 2016 Terms and Conditions for Junior Doctors and implementation of that role in the Trust.

The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours, during negotiations on the junior doctor contract agreement was reached on the introduction of a 'guardian of safe working hours' in organisations that employ or host NHS trainee doctors to oversee the process of ensuring safe working hours for junior doctors. The Guardian role was introduced with the responsibility of ensuring doctors are properly paid for all their work and by making sure doctors aren't working unsafe hours.

The role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours for the junior doctors employed by it. The work of the guardian will be subject to external scrutiny of doctors' working hours by the Care Quality Commission (CQC) and by the continued scrutiny of the quality of training by Health Education England (HEE). These measures should ensure the safety of doctors and therefore of patients.

The Guardian will:

- Champion safe working hours.
- Oversee safety related exception reports and monitor compliance.
- Escalate issues for action where not addressed locally.
- Require work schedule reviews to be undertaken where necessary
- Intervene to mitigate safety risks.
- Intervene where issues are not being resolved satisfactorily.
- Distribute monies received as a result of fines for safety breaches.
- Give assurance to the board that doctors are rostered and working safe hours.
- Identify to the board any areas where there are current difficulties maintaining safe working hours.
- Outline to the board any plans already in place to address these
- Highlight to the board any areas of persistent concern which may require a wider, system solution.

The Board will receive a quarterly report from the Guardian, which will include:

- Aggregated data on exception reports (including outcomes), broken down by categories such as specialty, department and grade.
- Details of fines levied against departments with safety issues.
- Data on rota gaps / staff vacancies/locum usage
- A qualitative narrative highlighting areas of good practice and / or persistent concern.

Other new features of the 2016 contract include:

Work scheduling –junior doctors and employers will be required to complete work schedules for the doctors in training. This will begin as a generic schedule setting out the hours of work, the working pattern, the service commitments and the training opportunities available during the post or placement.

Exception reporting – enabling doctors to raise exception reports where their work schedules do not reflect their work, and to ensure that a work schedule remains fit for purpose, This is beneficial to employers as it will give real-time information and be able to identify key issues as they arise. It also benefits doctors, as issues over safe working or missed educational opportunities can be raised and addressed early on in a placement, resulting in safer working and a better educational experience.

Requirement for junior doctor forums to be set up - principally these forums will advise the Guardian of safe working who will oversee the processes in the new contract designed to protect junior doctors from being overworked. The Guardian and Director of Medical Education in each Trust and relevant organisation shall jointly enable a nomination/election process to establish a Junior Doctors Forum (or fora) to advise them and make appropriate arrangements to enable the elected representatives time off for their activities & duties in connection with their role. Election onto the forum will be for the period of rotation and replacements must be sought for any vacancies.

2. Guardian of Safe Working Report

Implementing the Role

This is one of the only organisations that have appointed a non-medic to the role of Guardian. This has been well received by the junior doctors who believe this gives the required independence. The Guardian has been working closely with colleagues from medical staffing and rostering, post graduate medical education staff, human resources and finance to establish the role in the Trust and build relationships.

In December 59 junior doctors in the Trust transferred onto the contract. By the end of 2017 all junior doctors will be on the new contract. The table below shows the number of trainee posts available and filled by Health Education Yorkshire and the Humber. Some of the vacancies have been filled by the Trust.

	Scarborough		York	
Grade	Posts	Filled by trainees	Posts	Filled by trainees
F1	27	26	33	33
F2	17	15	33	32
GPST R	16	12	24	18
CT	27	17	36	28
ST	34	25	96	89
Total	121	95	222	200

The picture will change over the coming year until all the junior doctors have transitioned onto the new contract. The table below gives a summary of the total number of junior doctor posts across the Trust.

Site	No of posts December 2016	No of posts February 2017	No of posts April 2017	No of posts August 2017	No of posts Sept 2017	No of posts October 2017	Total
York	33	27	25	114	5	9	**213**
SGH	27	11	9	63	0	2	**112**
Total	**60**	**38**	**34**	**177**	**5**	**11**	**325**

Challenges

Engagement

Engagement with the junior doctor workforce has been difficult due to the fact that the majority of them associate the guardian role with the new contract, to which many are still opposed. Since September there have been a significant amount of engagement events for junior doctors, including: 17 hours of 'drop in' across both sites, which in total attracted only 6 doctors, attendance at junior doctors induction day, and attendance at junior doctors training sessions. In addition there have been a number on one to one meetings between the Guardian and the junior doctor BMA representative. Offers were made to attend the doctors Mess which were declined, a flip chart was made available in the Mess for doctors to write questions about the new contract on but was returned blank.

Engagement with the Educational Supervisors (ES) has also been challenging as the national team were unable to provide any training or standard information for ES until late December. Post Graduate staff and the Guardian held 5 training sessions for ES throughout November and also attended clinical governance meetings at both hospitals.

Software System

The Trust uses a nationally procured system for medical staff rotas called the Doctors Rostering System 4, which is the system now used for exception reporting. There have been significant problems and delays in getting the system live and we were unable to test this out until the day before the first doctors transferred onto the new contract. Each junior doctor on the new contract has been given log in details and been registered on the system in order to submit an exception report as necessary. The Educational Supervisors have also been registered and set up on the system. This process has to happen with each rotation. All exception reports, once seen and signed off by the supervisor go to a central inbox monitored by the Guardian, the Director of Medical Education (DME) and the Administrator.

The DRS4 does not 'speak' to payroll and as a result all requests for additional payment for hours worked have to be administered manually.

Workload

Due to the complexity of this 'virtual' team and the amount of administration associated with introducing and administering the new contract, a fixed term contract has been offered to an administrator to support the process.

The new contract does have workload implications for both educational and clinical supervisors

when a trainee submits an exception report. The amount of time will depend on the number of exception reports submitted and it is too early to make a judgement about this currently.

Junior Doctors Forum

The DME and the Guardian have established the Junior Doctor Forum; there is one forum across both hospital sites. The inaugural meeting was held at the end of November in line with the T&Cs. Due to the challenges faced around engaging with the junior doctor workforce the first meeting had only five junior doctors in attendance, however, this is comparable to the experience of other trusts, some of whom are even struggling to get a forum established.

Terms of reference and membership were discussed at this meeting and an agreement to meet every 6 weeks and keep it under review. Every effort has been made to widen the junior doctor membership of the Forum to encourage a more diverse representation across the trust.

Exception Reports and Fines.

The whole point of the exception reporting system is to allow employers to address issues and concerns as they arise, in real time, and to keep doctors' working hours, both rostered and actual, within safe working limits. If the system of work scheduling and exception reporting is working correctly, in anything other than truly exceptional circumstances, the levying of a fine indicates that the system has failed or that someone – the supervisor, Guardian or the individual doctor concerned – has failed to discharge his or her responsibilities appropriately.

Any levying of a fine should therefore be followed by an investigation in to why it was necessary and remedial action to ensure that it does not happen again. The most important thing to remember is that fines should rarely, if ever be applied at all.

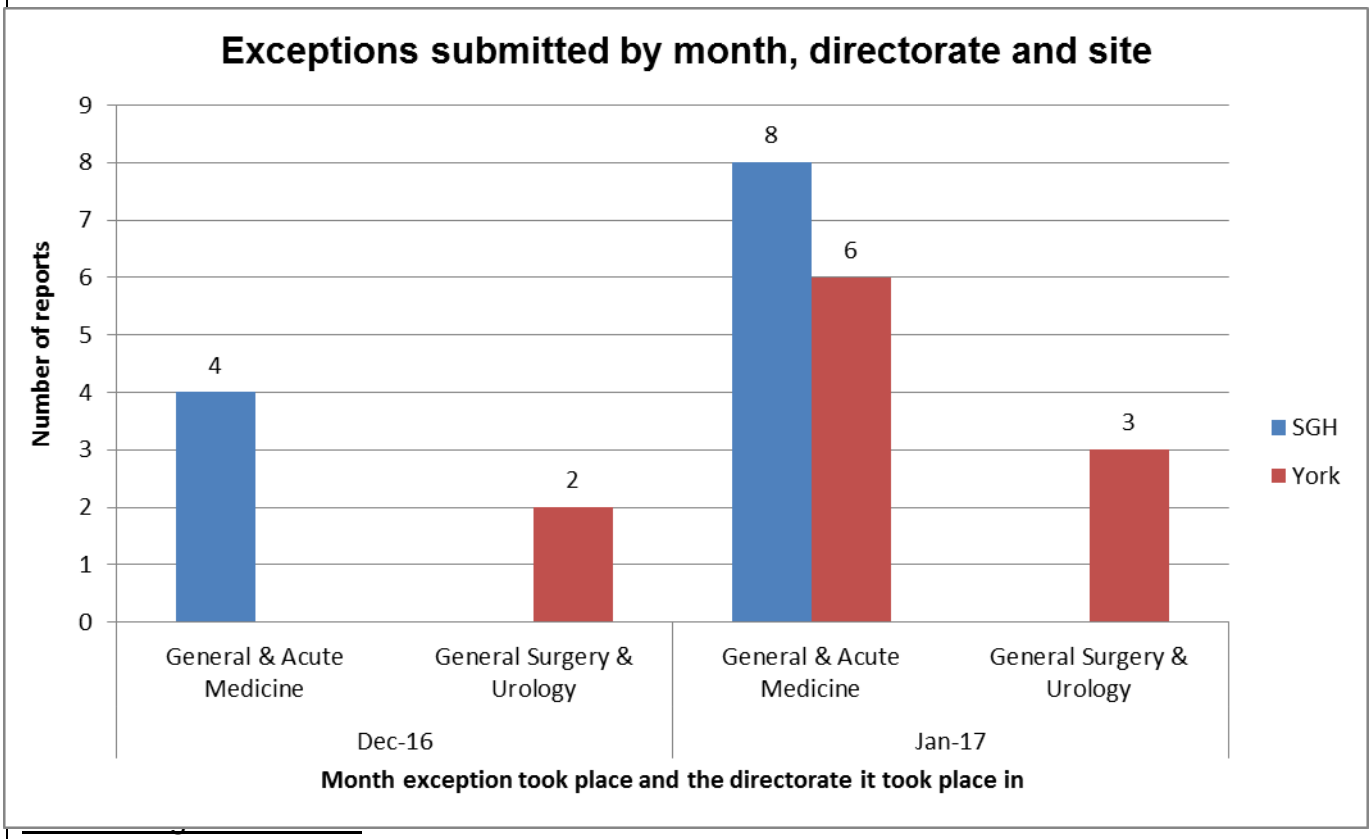
From 7th December to 13th January we have received 23 exception reports. The 23 reports came from 6 doctors, 7 in the whole of December and 16 within the first 13 days of January:

- None resulted in guardian fines
- 8 have resulted in payment to the Dr for additional hours worked
- 1 required no action as it was the Drs choice to stay late rather than a patient safety need
- 12 are currently being reviewed (within timescales)
- 2 are currently being reviewed (outside of timescales)

There have been some early outcomes associated with these reports including; identifying some individuals who need to be better supported and others which have resulted in quite practical solutions such as additional IT and access to phlebotomy on wards. However, concerns by junior doctors have been expressed as comments are being made on the ward about why exception reports are being raised and what outcomes they are generating along with speculation about who has raised them, and this only serves to promote a 'blame culture' and discourage junior doctors from reporting.

The new contract contains safeguards to protect the safety of our junior doctors and patients and ensures doctors are accessing required education. In the event of a junior doctor submitting an exception report, this must be reviewed by the appropriate supervisor and the actions agreed to prevent it re-occurring. The priority must always be to give the doctor time back in lieu to ensure safety is not breached, therefore payment for additional hours worked should always be discussed and agreed with the appropriate budget holder and should be the exception rather than the rule.

Month	Reports	Exception type	Exception sub type	Site	Dept	Grade	Outcome	Fine
Dec 16	2	Hours & rest	Late finish	York	General Surgery & Urology	FY1	2x payment agreed	N/A
Dec 16	1	Hours & rest	Late finish	York	General & Acute Medicine	FY1	1xunder review (within timescales)	N/A
Dec 16	4	Hours & rest	Late finish 4x unable to achieve Breaks	SGH	General & Acute Medicine	FY1	2xunder review (outside timescales) 2x payment agreed	N/A
Jan 17	3	Hours & rest	Late finish	York	General Surgery & Urology	FY1	3x payment agreed	N/A
Jan 17	5	Hours & rest	Late finish 2x unable to achieve breaks	York	General & Acute Medicine	FY1	5xunder review (within timescales)	N/A
Jan 17	8	Hours & rest	Late finish 3x unable to achieve breaks	SGH	General & Acute Medicine	FY1	7xunder review (outside timescales) 1x payment agreed	N/A
TOTAL	**23**	**(7 in December 16 In January)**						



1 x vacant post General medicine (Dec – April)/ Psychiatry (April – August)

A Trust Grade Doctor had been recruited to occupy the General Medicine element of this post,

however gave back word. We have had an Agency Locum covering the full rota pattern for this post from 7th December – 3rd January. The Department have asked the Rota Team to source Agency cover at F1 level for this post, however No CV's have been forthcoming. This post may be filled January – April with an Agency Doctor at a level higher than F1 if alternative cover cannot be sought. At present we will cover the OOH's element of this post only.

The Psychiatry element of this post does not need to be covered as it is not a York Trust post.

York

We have 2 x vacant F1 posts for the December rotation, the rotations for both posts have been reviewed and agreed the following we have recruited 1 Trust Grade to cover the Medical and Elderly rotation of these two posts from December - April (Dec – April and April – August). As such the Trust Grade will cover for 8 months.

The Surgical rotation of these posts is being covered by filling the OOH's duties only, with a combination of Bank and Agency locums

The Anaesthetic rotation remains unfilled as the F1and is deemed super nummerary.

Networking

The Guardian has attended national training and is a member of the regional forum of safer working guardians as well as having email contact with a number of other Guardians in the region to share updates etc. Intelligence form this network suggests that the level of exception reporting has been very similar across Trusts within the region.

There is a view that junior doctors are reluctant to report excess hours, for fear of damaging their relationship with their training supervisor - even possibly affecting their jobs in the future, hence the culture of no blame being of utmost importance.

Next Steps

1. To encourage wider junior doctor engagement in the Forum by introducing the Guardian role and the principles behind the Forum by attendance at each junior doctor induction/training events.

2. Communication strategy early in New Year to encourage wider understanding of the impact of the new contract for all staff and attendance at directorate meetings.

3. Conclusion

Overall, the Guardian role represents an opportunity for a cultural move towards a value based approach to trainees as opposed to the blame culture often encountered in the past, however the challenge remains engagement with a workforce that are skeptical about the benefits of the new contract.

4. Recommendation

The Board of Directors are asked to:

1. read and note this first report from the Guardian of Safe Working; and

2. encourage clinical directors, directorate managers and educational supervisors to be aware of their responsibilities within the new contract, in particular that payment for additional hours worked should be the exception rather than the rule.	
Author	**Lisa Smith, Guardian of Safe Working**
Owner	**Patrick Crowley, Chief Executive**
Date	**January 2017**

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

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

Apologies: Gordon Cooney, Graham Lamb

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

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

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

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

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			Cancer - JW stated that the Trust had met 5 out of the 7 cancer targets for quarter 2. The 2 targets failed were the 14 day fast track and pressures were predominately in relation to skin which dermatology were working towards getting enough capacity to get back on track and 62 day waits. The Trust is still within the tolerance of 1% for the STP funding for 62 day waits so will not be penalised for September. The Trust will need to resubmit trajectories for getting back on track. JW stated that cancer was a significant challenge, but this was also a national picture. **18 weeks** - JW stated that theatres had done well with recruitment and that this had led to a reduction in the number of list losses, however, there were still some staff shortfalls. 40 of the 100 elective cancellations were due to beds and that this week non-urgent operations were being cancelled. The plan was to make better use of day cases and theatres to reduce the backlog along with extra external capacity. She noted that the national position was similar and that it was vital that the Bridlington work went ahead. JW highlighted that work was in progress to extend theatre sessions and get the workforce recruited to ensure greater capacity. **Finance –** AB stated that the Trust achieved a £3.5m surplus against a planned surplus of £3m. He noted the loss of half of the surplus buffer in October and this was due to loosing £396k from the sustainability funding due to ECS, RTT and Cancer targets not being achieved. For October ECT and RTT both lost £140k each and Cancer lost £50k for September and October. However, AB hoped that this could be recouped by the end of the year due to the plans in place. AB stated that all the indicators are that this picture will continue for a number of months with the exception of cancer, but the Trust would still achieve the £10m surplus at the end of the year.	The Committee noted the risks around the control total and agency spend.	AB to update Board on the risks around agency spend and achievement of the control total

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

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

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

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

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

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

York Teaching Hospital NHS
NHS Foundation Trust

Finance and Performance Committee – 17 January 2017 – Boardroom, York Hospital

Attendance: Mike Keaney (Chairman), Mike Sweet, Steven Kitching, Graham Lamb, Lynda Provins, Juliet Walters, Lynette Smith, Sue Rushbrook, Brian Golding

Apologies: Gordon Cooney, Andy Bertram

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
1.	**Last Meeting Notes 18 October 2016**	The agenda covered the following AFW and CRR items AFW DoF COO CRR DoF 1-4, 8 & 9 COO 2, 3 & 6	The minutes of the meeting held on the 22 November 2016 were agreed. JW provided a number of minor revisions for the minutes.		
2.	**Matters arising**		The following matters arising were discussed: **Matters Arising – Agency Spend Risks** – JW stated that a locum has started and 5 day cover is now being provided in the Frailty Unit. **Emergency Care Standard** – page 6, 2nd paragraph – JW stated that the CCG had agreed funding to provide a small community response team with a case load of 8 patients, but this required expanding and discussions will take place with the CCG regarding more funding at the A & E Delivery Board. **Finance** – page 8, penultimate paragraph – GL stated that conversations were still taking place around the Local Price Modification, which had been submitted to NHSI. Although NHSI has indicated that this is unlikely to be successful, further discussions had still to take place with NHSI regarding alternatives including a possible revision to allocated Control Totals for 2017/18 and 2018/19. **Poorly Performing Directorates Review** - page 10, first paragraph – SK responded to MS that the 14 high risk schemes		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			had been reduced. **Tenders** – page13 – It was confirmed that the East Riding Community Services contract had been awarded. The Trust will be part of a subcontract to this with City Healthcare Partnership. **Tenders** – page 13 - Cytology Appeal – this item was discussed and a verbal update will be provided to the Board.		AB to provide the Board with an update on the Cytology Tender
3	**TAP – Key Priorities:** **Emergency Care Standard Delivery** **Finance Control Total Delivery**		**Operational Performance** **ECS** - JW briefed the Committee that in relation to the ECS, 81.01% had been achieved for December and current performance in January was at 78.93% up to the 15th January. She highlighted the national context and that the work being done now was to look at how effective the winter plan had been and what actions were needed to get the Trust back on track. JW stated that she had provided daily updates to staff as it was important staff were kept fully aware of what is happening and to galvanise support for the actions required. She stressed that the hospitals feel calm and well managed. JW highlighted the peaks in activity and that patients were attending with a lot higher acuity and she commended the work put in by staff. JW stated that the ED front door model had been very successful, but that this had been exacerbated by the biggest increase in non-elective admissions seen by the Trust. JW stated that bed occupancy had been very high and it had peaked at 99% in Scarborough which had not been experienced before. This had also been combined with increased acuity of patients, increased staff sickness in both the medical and nursing workforce and increased levels of flu across both hospitals which had required cohorting being put in place to prevent the spread of infection. Currently there are a number of bays closed and one ward at York with flu and one	The Committee received assurance that the Trust was providing safe levels of care. However it was concerned about the levels of activity and risks faced which need escalating to the Board	JW to provide the Board with an update on the challenges experienced over the Christmas period and work being done to recover the position and the risks involved

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			bay at Scarborough. JW stated that there had been reduced GP provision from the 24 December to 2 January and this had led to surges in attendance and footfall into both EDs. The biggest increase was seen at York at 21.3% (+ 435 patients) in comparison to the same period last year. MK stated that figures for December did not look any worse to those of the previous months, but JW stated that it was more about the acuity and more complex patients who required longer stays. SR stated that this period had been worse than the period in December 2014/January 2015 when the Trust had previously initiated a majax. 27th December had seen the biggest spike in the number of attendances together with the raised acuity. SR noted that it was only due to the new assessment models which had been put into place that allowed greater management of the situation. She stated that the acuity could be seen from the number of patients which had been admitted to ICU directly from ED and the decisions required as to which patients were placed in resus. SR stated that normally after a spike there is a dip which gives the organisation a chance to recover, but the dip was only partial before it spiked again. JW stated that due to the position regionally and nationally the Trust had had supportive dialogue with colleagues from other Trusts, but were unable to divert. LS stated that the challenges were likely to continue into February. She noted that the winter plan was working and having an effect, but the level of admissions had been unprecedented. BG stated that the chart on page 16 clearly showed the steadily		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			increasing acute admissions and that the Trust was fighting a constant increase in patients so despite all the work being done things appeared to be standing still. MK stated that there appeared to be some considerable improvements in the position at Scarborough. JW stated that this was due to the service developments relating to the new acute medical model and that unplanned escalation areas had been opened. JW stated that the numbers are starting to steady and the Trust is managing more effectively and so the work to close the unplanned escalation areas was in progress together with targeting non-admitted breaches and discussions about how to get routine electives back in. MK asked how the Bridlington unplanned escalation area had been staffed and JW responded that this had been through a mixture of existing staff and bank and agency. SR recognised the phenomenal amount of work done by staff especially since there had been increased sickness as well. She noted that the word 'heroic' had been used as staff had faced a relentless succession of very sick patients. LS stated that there had been a high focus on patient safety with a number of walk rounds being carried out to ensure safety was paramount. JW stated that there had been a significant number of 12 hour breaches. SR stated that clinicians had responded by coming down into ED and using the NEWS scores so that they retained an awareness of the acuity of patients coming into ED. JW stated that credit also had to be given to the out of hospital		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			care teams who had kept expanding to help with demand. MK stated that if the raw data was looked at, the population was increasing and admissions going up and that it was likely that this position would continue. MK highlighted that despite the pressures experienced, staff had also facilitated an organ donation over the Christmas period which was amazing. JW stated that the Trust were currently constantly on OPEL 3 with system calls taking place throughout. LS stated that the aim was to stabilise throughout January and work the trajectories back up, however, this would remain a significant risk. MK stated that even with all the work done over the last two years the Trust appears to be standing still due to the increase in admissions. He asked if any further significant changes were planned. JW stated that a lot of the work still needs to fully embed, but that going forwards it was absolutely about the whole system approach and doing things differently to ensure the reliance is not solely on hospital provision. She noted discussions are starting to explore working tighter as a whole system and she stated that it was about ensuring there was provision in the community. She stated that there would be a full debrief at the A & E Delivery Board. SR stated that the national picture could not be ignored and that no one had expected it to be as busy as it had been. She stressed that some things were out with the Trust's control like the increase in social care funding that was required. JW highlighted that a number of patients were awaiting packages of care and could not be discharged until they were in place. MS asked whether the position could be recovered by the end of March and it was noted that the monthly position may be		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			possible, but not the cumulative. **RTT** – LS stated that there had been a reduction in routine appointments and an increased number of cancellations. The Trust had achieved 89.29% which was a downward trend against the national target of 90.5%. The reason for this was the significant backlog in admitted and non-admitted. Work is being carried out to maximise waiting list initiatives and outsourcing together with ensuring existing plans are being embedded. She noted the issues with maxillofacial, but also highlighted that funding had been secured from NHSE for 200 cases to be outsourced which was being operationally worked through. In relation to non-admitted, LS stated that there was some decline in performance especially in Dermatology and Rheumatology which were struggling with staff vacancies, however, work on training GPs is being progressed. LS stated that the recovery plan is being updated to understand capacity and demand. LS stated that the projection currently is to achieve the quarter 4 position through outsourcing and looking at different pathways, but this is very ambitious and therefore high risk. LS stated that theatre productivity has started to improve due to staffing, but that this has also been hit by the non-elective demands. A number of open days have been held to boost staffing and the position will continue to improve, but the full impact will not be seen until staff are all in place in September. **Cancer** – LS stated that there had been a decline in performance in quarter 3 and work is being done to get back on track. The Trust is underperforming in 4 areas, but in relation to the 31 day fast track it should be noted that this is due to low		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			numbers. However, she stated that the picture is starting to improve, but work will continue on breach allocation and there are still issues with tertiary capacity. Work is being done to embed some of the pathways to increase the amount of time left at the end of the pathway, but currently the Trust is struggling with capacity on CTs and MRIs. **Diagnostics** – LS stated that she had included diagnostics as this was close to the edge and was to do with staff recruitment and training. **CQUIN Delivery** LS stated that the quarterly position had been provided in the pack. She noted that there continued to be problems with sepsis, but nothing new or that the Board were not already sighted on. MS asked about the red areas and SR stated that sepsis was a national concern and one Trust in the region has said that they cannot achieve it. She noted that the ability to identify those patients requiring screening and to then screen them was taking place. The challenge was to provide treatment within an hour to those identified as needing it. The work had also created issues for the CCGs with regards to increasing the payments required and therefore considerable time had been used to explain the process and justify the amount being claimed. GL stated that this is an area that is on the verge of being taken to arbitration this year, however, the impact is likely to be less next year following a change in the HRG. MK asked JW to update the Board on the position and requested that risk registers are looked at in terms of risks that		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			have now come to fruition. JW and LS will amend the risk register for the next meeting. MS asked that the date of amendment is put onto each new risk register entry to make it easier to see changes. **Finance Report** GL stated that at the end of quarter 3 the Trust was reporting an I & E surplus of £4.6m, which had improved from £4.1m the previous month. The places the Trust £0.9m behind plan for the year to date, which stood at a £5.5m surplus. The key feature is the STF for quarter 3. GL is reasonably confident that the 70% financial STF funding will be achieved, but that performance funding for Q3 of £963k is not expected to be achieved. GL stated that based on how much performance would need to recover in Q4 it is unlikely that the Trust will receive the STF for performance for that quarter either, which will bring the total lost STF for the year to £1.5m. GL stated that NHSI are strongly encouraging the Trust to enter appeals process designed to recognise where there are exceptional circumstances, such as increased referrals and admissions, that contributed to the Trust failing to meet its performance targets. If the appeal is successful then it is possible to still be paid the lost performance element of the STF. GL indicated that a number of Trusts used this process in quarter 2 and were successful. MK stated for clarity that one scenario was that the appeal was successful and the Trust would recoup the £1.5m thereby achieving the full £13.6m and the second scenario was that the £1.5m would be lost and that this may affect achievement of the 70% finance element. GL stated that achievement of the finance element was not dependant on achieving the	The Committee acknowledged the risks around the STF position but received assurance that an appeal would be made.	AB to provide the Board with an update on the risks to the financial position especially in relation to the STF position

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			performance element, although ultimately failure to secure the performance element may place pressure on the Trust in meeting its Control Total. GL stated that there was optimism that the Trust had a sufficiently robust case to make a successful appeal, and that delivery of the control by the end of the year was still being forecast. MK asked about agency spend which he noted was projected to be £3m over the cap and wondered if this had been factored in. GL stated that it had been factored into the reported position, and confirmed that the Trust is forecast to be £3m to £3.5m above the cap at the year end. Currently, the Use of Resources rating for the Trust was a score of 2 (1 = best and 4 = worst), against a plan of 1. The agency spend was contributing to the current score In relation to cash, GL expressed some concern as the Trust is currently £11m behind plan, but explained that this was due to non-payment of overtrades by commissioners especially regarding the challenges now subject to arbitration around sepsis, ambulatory care and rehabilitation bed days. He noted that this would be raised this afternoon in a meeting with VoY CCG. GL stated that there may be more impact on the cash position due to the Trust being behind with elective work, although this would be partly mitigated by increased emergency income. There was £44m in the bank, although SK highlighted that as the Trust was being paid in tenths by commissioners, this would reduce over the final 2 months of the year. GL provided an update on the 2016/17 contract position and noted that all parties were being required by NHSE and NHSI to resolve outstanding issues through an arbitration process.		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			There were three main areas being contested; sepsis, ambulatory care and rehabilitation bed days. The Trust and CCGs would enter into arbitration and information was due in by noon today with the outcome expected within the next week or two. In respect of the contracts for 2017-18 and 2018-19, the outcome of arbitration on ambulatory care and rehabilitation bed days would also have an impact on those contract values. The base line position has been agreed, but this does not include any QIPP schemes from the CCGs. Under the Heads of Terms the Trust has agreed to work closely with the CCGs and help them deliver their QIPP schemes, and to work with them to develop mitigating actions when activity triggers are reached in the contract. MS stated that this sounded positive. **Efficiency Report (inc. Carter Progress)** – SK stated that the month 9 position showed an achievement of £20.6m against a full year target of £26.4m with £4.2m being achieved since the last report. This is 78% of the target although this position is £600k behind plan. He noted that no challenge has been received from NHSI regarding the behind profile position. SK noted a £2m planning gap when the high risk schemes are taken out, but he stated that he was not too concerned as areas of underspend usually provided a boost in quarter 4. However, he did note that this was an area to improve on and that if next year's target was added in, this provided a £17m 4 year planning gap which is a risk. A recurrent figure of 63% has been achieved which is the best ever, but there are still gaps and the Trust needs to achieve a recurrent total of £15m to ensure that nothing further is added to the £22.8m target for next year.	The Committee were assured that the CIP target will be achieved by the year end.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			In respect of the Carter work, SK stated that the back office return has been amended and resubmitted, the 2015-16 reference costs have been refreshed and revalidated and information on pathology looks positive and will be going to the next Carter Steering Group. SK acknowledged Carter requests had currently gone quiet, but this was due to them getting staff in place. MS stated that the table on page 85 did not make sense in relation to the variances and SK agreed to look at this. MK stated that he still felt comfortable with the position, but it was acknowledged that if the challenge gets too great, then staff will become worn down especially since 4% CIP had been in place for 6 to 7 years now.		
5.	**Operational Plan 2017-2019 Update**		GL noted that the plan seen by the Board in December had been submitted to NHSI before Christmas, although with NHSIs agreement this had been classed as draft 2 and not the final version. Discussions with NHSI were still to take place regarding the control totals and the local price modification agreement. Following the outcome of the discussions another plan would be presented to the Board.		
6.	**Capital Programme Update**		BG stated that the 16/17 plan will be underspent by more than the 15% monitor tolerance, however, he explained that this was due to a number of factors. Page 47 of the report highlighted the two projects (VIU and Endoscopy) which have been approved but not yet received loan funding as the ITFF have currently stated that they have no money to lend. He also noted delays with the fire alarm scheme at Scarborough, purchase of radiology equipment and minor slippage on the backlog maintenance programme. The currently forecast outturn position for the fy16/17 is £17m against a planned	The Committee were assured by the information received on the capital programme	BG to provide the Board with an overview of the Capital Plan

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			position of £22m. The committee then considered the plans for fy 17/18. BG explained the sources of funding which were summarised in the table on page 53, including routine depreciation, charitable funds, strategic funds and loan funding. In respect of the loan applications BG stated that he and AB have started to approach non NHS organisations, and are confident that alternative funding strategies will be available if the Foundation Trust financing unit cannot provide funds. GL stated that he was aware of discussions starting to take place with City of York Council and North Yorkshire and York County Council to see if they are interested in lending to the Trust. MS asked when the funding/loan issue would be discussed with the Board and BG stated that he anticipated being able to put this before the Board by the end of the financial year. BG also noted that the Trust has approximately £9m left of the strategic funding for Scarborough which was forthcoming at the time of the acquisition. The consensus is that this should be spent by the end of the year or it may be at risk. Therefore plans have been created to accelerate spending on the Scarborough site, but this will mean that the £9m will not be available for the proposed redevelopment of ED at Scarborough, which will in turn need a separate funding strategy. BG provided an overview of the available funding for 2017/18 together with details of the schemes that are part of the planned capital expenditure. BG stated that the balance of the strategic capital funding for Scarborough would be used for a number of schemes including		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			refurbishment of the lifts, the firm alarm, the body storage facility, conversation of theatre 4 for vascular work and some of the building works for the new CT scanner. He noted that it was proposed to spend the remaining funds this calendar year. MS asked whether it was always intended that the vascular works would spread into 2018-19, to which BG replied that this had always been the plan as there was detailed design work which still needed doing. BG highlighted that there are still master plan projects which do not have a funding source. One of these is the work at Bridlington which will be brought back to the Board for discussion in the near future with a 'do nothing' cost. BG also highlighted a risk related to the need for continued oversight and control. This was about how the department managed projects within the resources available to ensure that the Trust is not overcommitted.		
8.	**Risk Registers**		It was agreed that the risk registers will be reviewed before the next meeting to ensure they reflect any risks which have materialised and any further changes. MS asked that dates are added when entries are amended to enable members to see recent additions. **Action: Risk Registers to be updated**		
9.	**Any other business**		No other business was discussed.		
10.	**Next Meeting**		The next meeting is arranged for the 14 February 2017 in the Boardroom, York Hospital		

Finance & Performance Committee – Action Log – January 2017

No.	Month	Action	Responsible Officer	Due date	Completed
1	Jan 2017	Risk registers to be updated for the next meeting	Chief Operating Officer – Finance Director	Feb 2017	

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 January 2017

Finance Report

Action requested/recommendation

The Committee 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 December 2016.

At the end of December the Trust is reporting an Income and Expenditure (I&E) surplus of £4.6m against a planned surplus of £5.5m for the period. The Income & Expenditure position places the Trust behind of its Operational plan.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	Finance & Performance Committee
Risk	There are financial risk implications identified in the report.
Resource implications	There are financial resource implications identified in the report.
Owner	Andrew Bertram, Finance Director
Author	Graham Lamb, Deputy Finance Director
Date of paper	January 2017
Version number	Version 1

Briefing Note for the Finance & Performance Committee Meeting 17 January 2017
Briefing Note for the Board of Directors Meeting 25 January 2017

Subject: December 2016 (Quarter 3) Financial Position

From: Andrew Bertram, Finance Director

Summary Reported Position for December 2016

The Trust's I&E account shows a quarter 3 surplus of £4.6m against a planned surplus of £5.5m. The Trust is therefore currently reported as £0.9m behind plan. Of note is the failure of ECS, 18-weeks and cancer performance standards with an adverse impact on our sustainability funding of £0.9m. Sustainability funding is now shown on the face of the I&E account. Whilst we have not maintained our positive variance against plan, considering the pressure the organisation is currently under it is encouraging that the Q3 control total has been delivered, this being assessed before taking into account sustainability funding.

The month 9 CIP position is also encouraging with £20.6m of our £26.4m target (78%) removed from budget. Of note is some £12.9m has been removed recurrently. This continues to be the highest recurrent delivery proportion the Trust has ever delivered. Work continues to close the planning gap for the year, currently at £2m.

Cash levels are behind plan with the main variance relating to unpaid commissioner overtrade bills. Discussions are continuing to ensure appropriate payment.

Sustainability Funding

The Board are aware that the business rules associated with the sustainability funding have been published and the Trust has received its Q1 and Q2 payment.

As a reminder a payment of 70% is made for meeting the financial control total and a payment of 30% is made for meeting the required performance standards.

The current reported I&E position assumes payment of 70% of the Q3 sustainability funding for delivery of the control total but we have adjusted down the in-quarter sustainability funding by £963k recognising the reported failures against the ECS trajectory, 18-weeks and cancer 62-day targets.

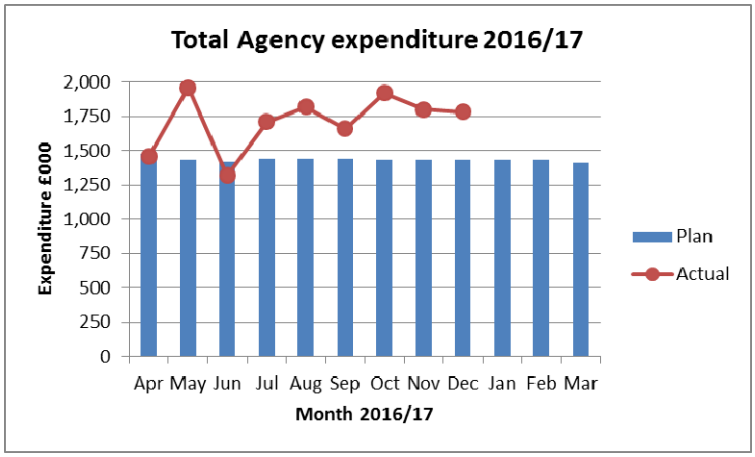
There is an appeal process under which the Trust can request that mitigating circumstances such as increases in referrals, increases in emergency admissions and increases in system-wide delays in discharge are taken into account in assessing eligibility for receipt of sustainability funding. The Trust is currently preparing an appeal submission. Pending the outcome of the appeal we have removed the 30% performance related sustainability funding from our year to date reported I&E position but we have assumed a successful appeal in our forecast outturn for the full financial year. We have taken advice from NHSI in this regard.

Enhanced Agency Expenditure Analysis

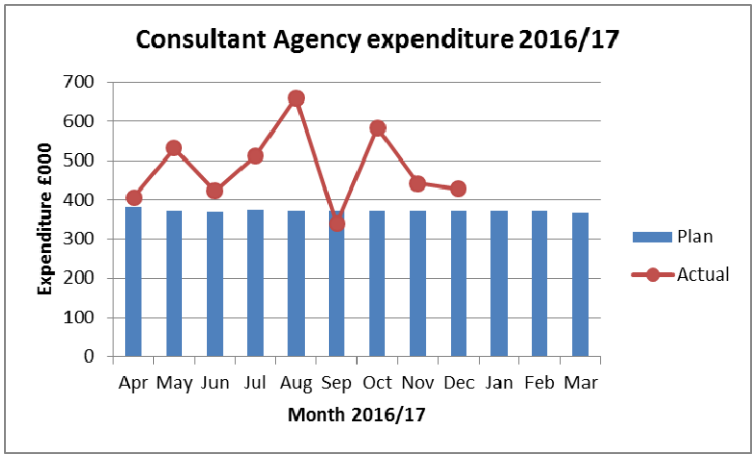
As discussed previously at the Board we have developed our agency staff cost reporting to ensure full visibility against the Trust's overall improvement trajectory. The Board are aware that NHSI has set the Trust an upper cap limit of £17.2m for its 2016/17 agency expenditure. As a reminder the agency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

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

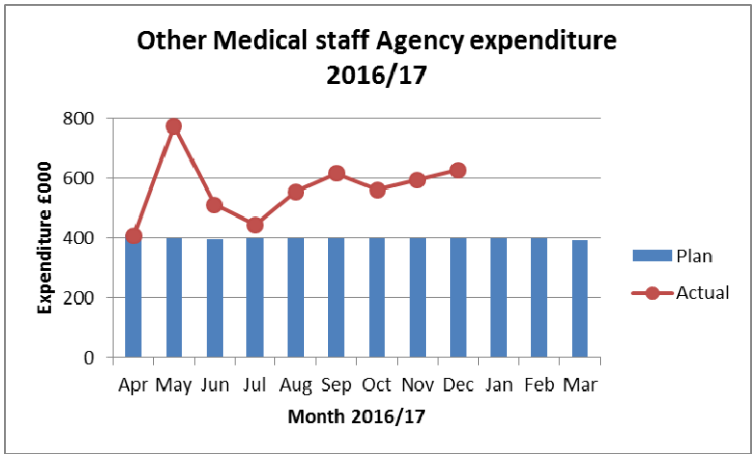
Expenditure is above trajectory but remains significantly below the pro-rata position based on the 2015/16 spend. Corrective action continues to be necessary.



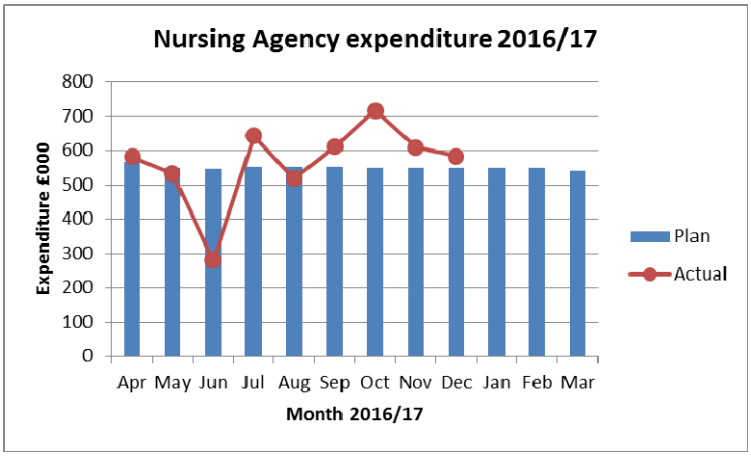
This first chart shows the monthly overall agency target; set at approximately £1.4m per month. Spend has stayed high in recent months at around £1.8m. The forecast outturn now stands at £20.6m (20% cap breach).



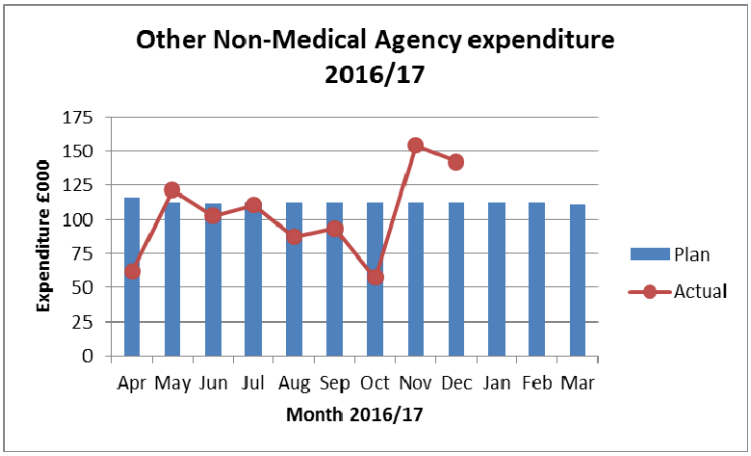
Consultant medical staff agency expenditure has been a significant pressure area. October spend was high but recent months have been closer to indicative target.



Other medical staff (junior staff) agency expenditure also continues to be a main pressure area. For 5 months we have spent significantly above cap and we are now forecasting a 42% breach against the indicative cap rate by the year end.



Nursing staff agency expenditure remains under overall control with the forecast outturn matching almost exactly the indicative cap.



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

2016/17 Contract Issues

Disappointingly we have not been able to bring the outstanding areas of contract dispute to any form of reconciliation. This is now impacting on both our ability and the CCG's ability to forecast outturn positions and to agree a final contract starting baseline for 2017/18.

We have been in discussion with NHSI and NHSE over this position. Any concession on the part of the Trust is likely to compromise delivery of our control total and therefore our Q4 sustainability funding and the CCG is in such a deficit position that it has no choice but to pursue all avenues to restrict its liabilities. We have agreed to a binding "expert determination" process that will be jointly undertaken by both NHSE and NHSI in the next couple of weeks. The Board will be kept informed as to how this process progresses.

2017/18 and 2018/19 Contract Issues

We have avoided arbitration will all commissioners and have agreed baseline contract positions for the New Year. These are largely in line with outturn positions for 2016/17, notwithstanding the above disputes.

We have agreed heads of terms that will sit alongside the contract, the key principles of which are:

- The baseline will be adjusted for any relevant outcome of the 2016/17 challenge process.

- CCGs have significant QIPP intentions which they must pursue to lower their current contract spend levels. These have, in the main, not been adjusted for in the baseline. We have committed to working with the CCGs to jointly deliver the QIPP and as the schemes are constructed and confidence in delivery is gained we have agreed to the principle of reducing the contract baseline through formal contract variation.
- Activity level triggers will be agreed for key contract lines, especially where QIPP schemes have been, or will be, implemented. Should these triggers be exceeded then we have committed to provide rapid senior clinical and corporate input to work alongside CCG GPs and corporate teams to discuss and agree mitigating action.

Issues of CCG affordability are going to be a significant element to the 2017/18 and 2018/19 financial years. It is imperative that we align ourselves to work alongside the CCGs in a concerted effort to manage the finances of the health community. This work will not involve the Trust taking blind financial risks but is going to require much greater collaboration and joint ownership of activity reduction schemes.

York Teaching Hospital NHS
NHS Foundation Trust

Finance Performance Report

January 2017

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

Finance Report
Chapter Index

Summary Income and Expenditure Position
Month 9 - The Period 1st April 2016 to 31st December 2016

York Teaching Hospital NHS
NHS Foundation Trust

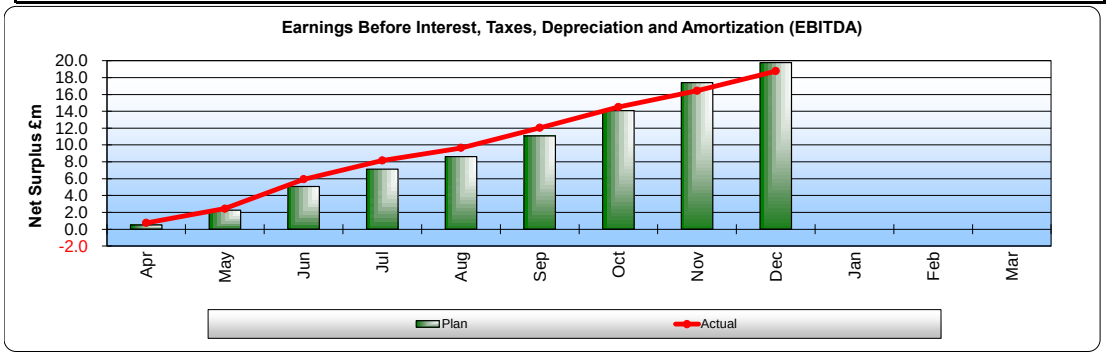
Summary Position:

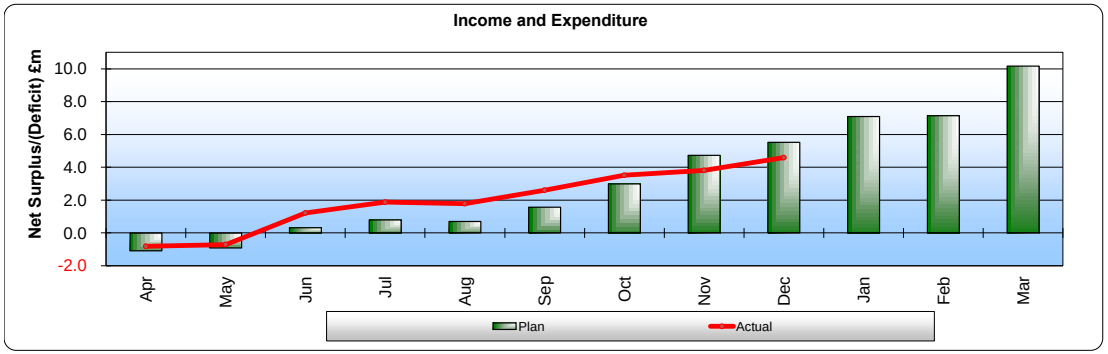
* The Trust is reporting an I&E surplus of £4.6m, placing it £0.9m behind the operational plan.

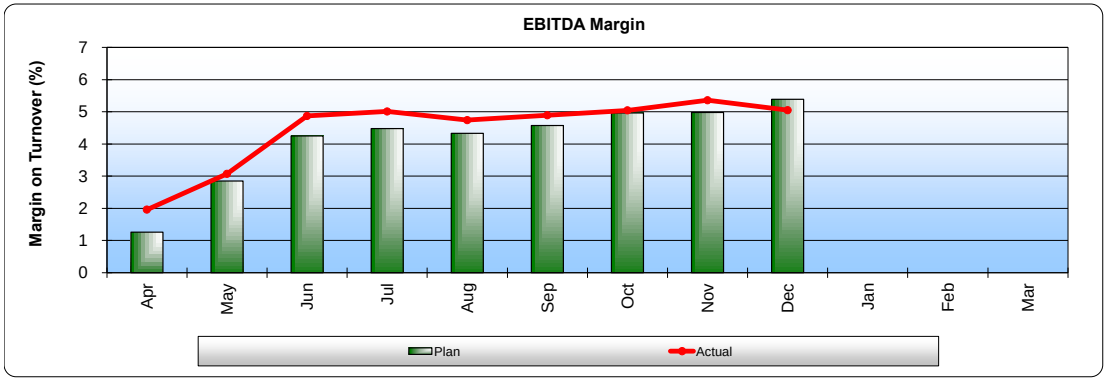
* Income is £5.4m ahead of plan, with clinical income being £3.3m ahead of plan and non-clinical income being £2.1m ahead of plan.

* Operational expenditure is ahead of plan by £6.4m, with further explanation given on the 'Expenditure' sheet.

* The Trust's 'Earnings before Interest, Depreciation and Amortisation' (EBITDA) is £18.8m (5.05%) compared to plan of £19.8m (5.39%), and is reflective of the reported net I&E performance.







	Annual Plan	Plan for Year to Date	Actual for Year to Date	Variance for Year to Date	Forecast Outturn	Annual Plan Variance
	£000	£000	£000	£000	£000	£000
NHS Clinical Income						
Elective Income	27,304	20,583	19,536	-1,047	27,304	0
Planned same day (Day cases)	39,443	29,470	28,948	-522	39,443	0
Non-Elective Income	111,616	84,074	82,187	-1,887	111,616	0
Outpatients	65,578	48,654	49,097	443	65,578	0
A&E	13,800	10,367	10,730	363	13,800	0
Community	30,235	22,630	22,902	272	30,235	0
Other	138,004	102,958	108,601	5,643	138,004	0
	425,980	**318,736**	**322,001**	**3,265**	**425,980**	**0**
Non-NHS Clinical Income						
Private Patient Income	1,005	754	702	-52	1,005	0
Other Non-protected Clinical Income	1,827	1,370	1,489	118	1,827	0
	2,832	**2,124**	**2,190**	**66**	**2,832**	**0**
Other Income						
Education & Training	15,049	11,287	11,120	-166	15,049	0
Research & Development	3,167	2,376	2,661	286	3,167	0
Donations & Grants received (Assets)	0	0	0	0	0	0
Donations & Grants received (cash to buy Assets)	739	554	590	36	739	0
Other Income	18,299	13,661	16,518	2,856	18,299	0
Transition support	10,045	7,534	7,534	0	10,045	0
STF	13,600	10,200	9,237	-963	13,600	0
	60,899	**45,612**	**47,660**	**2,049**	**60,899**	**0**
Total Income	**489,711**	**366,472**	**371,852**	**5,380**	**489,711**	**0**
Expenditure						
Pay costs	-321,563	-239,188	-239,731	-543	-321,563	0
Drug costs	-50,845	-38,101	-41,284	-3,183	-50,845	0
Clinical Supplies & Services	-45,905	-34,337	-34,155	182	-45,905	0
Other costs (excluding Depreciation)	-47,701	-35,721	-37,800	-2,079	-47,701	0
Restructuring Costs	0	0	-109	-109	0	0
CIP	5,786	646	0	-646	5,786	0
Total Expenditure	**-460,228**	**-346,701**	**-353,079**	**-6,378**	**-460,228**	**0**
Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA)	**29,483**	**19,771**	**18,773**	**-998**	**29,483**	**0**
Profit/ Loss on Asset Disposals	0	0	-2	-2	0	0
Fixed Asset Impairments	-300	0	0	0	-300	0
Depreciation - purchased/constructed assets	-11,658	-8,743	-8,743	0	-11,658	0
Depreciation - donated/granted assets	-342	-257	-257	0	-342	0
Interest Receivable/ Payable	100	75	120	45	100	0
Interest Expense on Overdrafts and WCF	0	0	0	0	0	0
Interest Expense on Bridging loans	0	0	0	0	0	0
Interest Expense on Non-commercial borrowings	0	0	0	0	0	0
Interest Expense on Commercial borrowings	-487	-352	-316	36	-487	0
Interest Expense on Finance leases (non-PFI)	0	0	0	0	0	0
Other Finance costs	0	0	-16	-16	0	0
PDC Dividend	-6,627	-4,970	-4,970	0	-6,627	0
Taxation Payable	0	0	0	0	0	0
NET SURPLUS/ DEFICIT	**10,169**	**5,524**	**4,588**	**-935**	**10,169**	**0**

Contract Performance

Month 9 - The Period 1st April 2016 to 31st December 2016

York Teaching Hospital NHS
NHS Foundation Trust

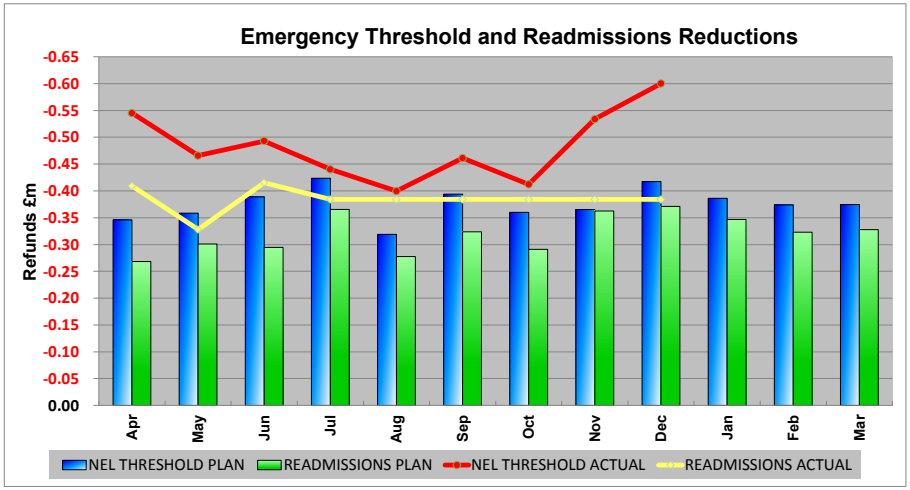
Contract	Annual Contract Value	Contract Year to Date	Actual Year to Date	Variance
	£000	£000	£000	£000
Vale of York CCG	206,033	153,666	160,406	6,740
Scarborough & Ryedale CCG	78,061	58,214	62,062	3,848
East Riding CCG	42,000	31,583	31,762	179
Other Contracted CCGs	17,332	13,017	13,093	76
NHSE - Specialised Commissioning	37,475	28,163	30,067	1,904
NHSE - Public Health	14,190	10,640	11,237	597
Local Authorities	4,740	3,581	3,542	-39
Total NHS Contract Clinical Income	**399,831**	**298,864**	**312,169**	**13,305**

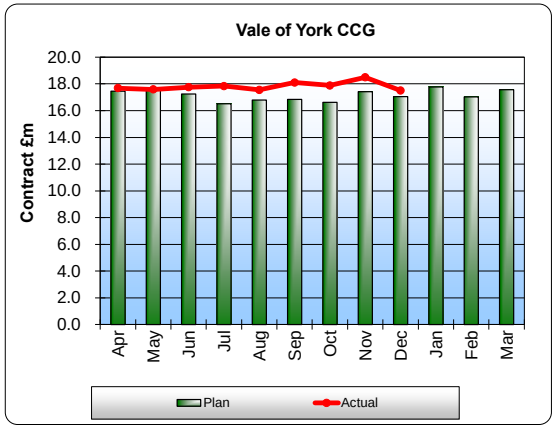
Plan	Annual Plan	Plan Year to Date	Actual Year to Date	Variance Year to Date
	£000	£000	£000	£000
Non-Contract Activity	15,511	11,668	10,712	-956
Risk Income	10,638	8,204	0	-8,204
Total Other NHS Clinical Income	**26,149**	**19,872**	**10,712**	**-9,160**

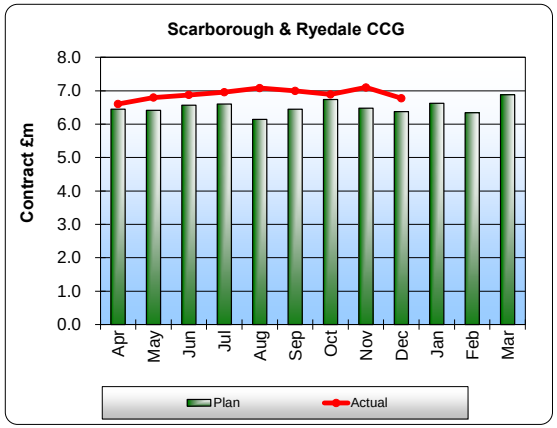
Specialist registrar income moved to other income non clinical	-999
Winter resilience monies in addition to contract	119

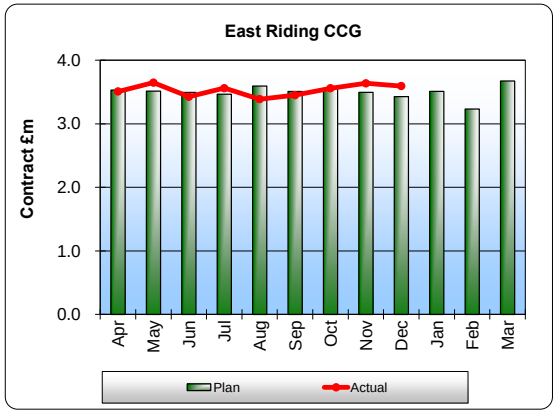
Total NHS Clinical Income	**425,980**	**318,736**	**322,001**	**3,265**

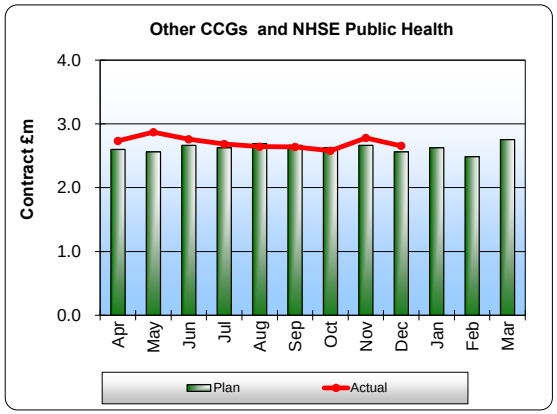
Activity data for December is partially coded (44.8%) and November is 90% coded. There is therefore some element of income estimate involved for the uncoded portion of activity.

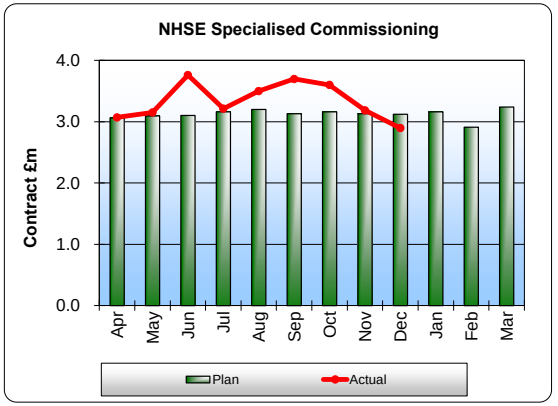


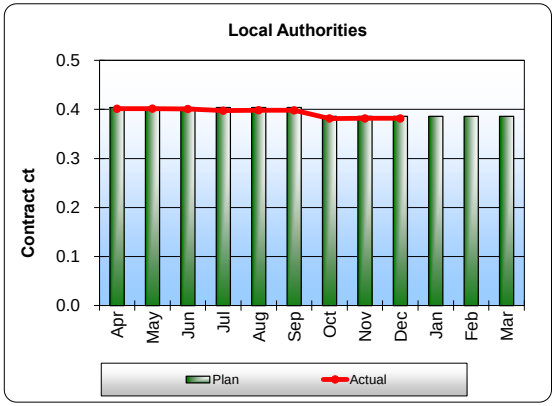












Expenditure Analysis
Month 9 - The Period 1st April 2016 to 31st December 2016

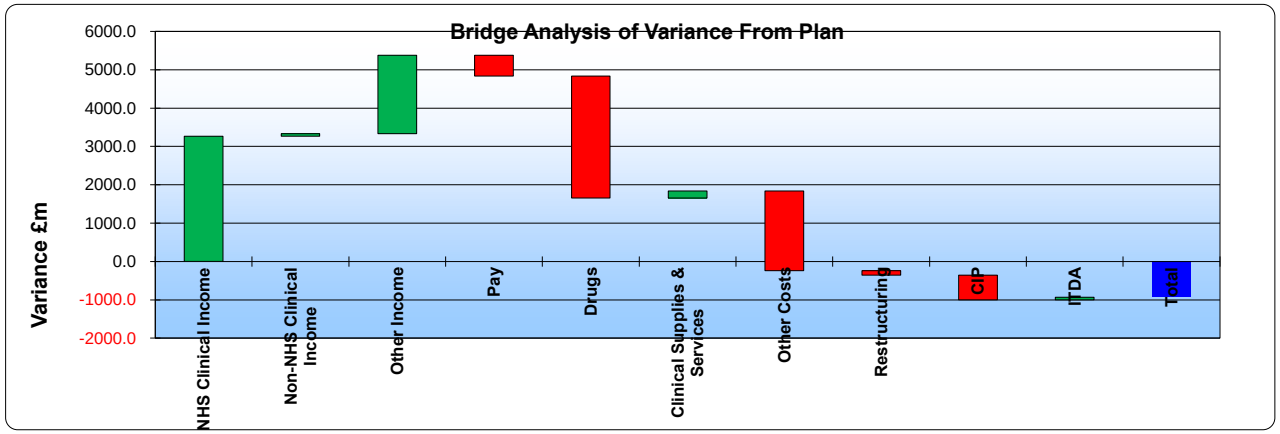
York Teaching Hospital NHS
NHS Foundation Trust

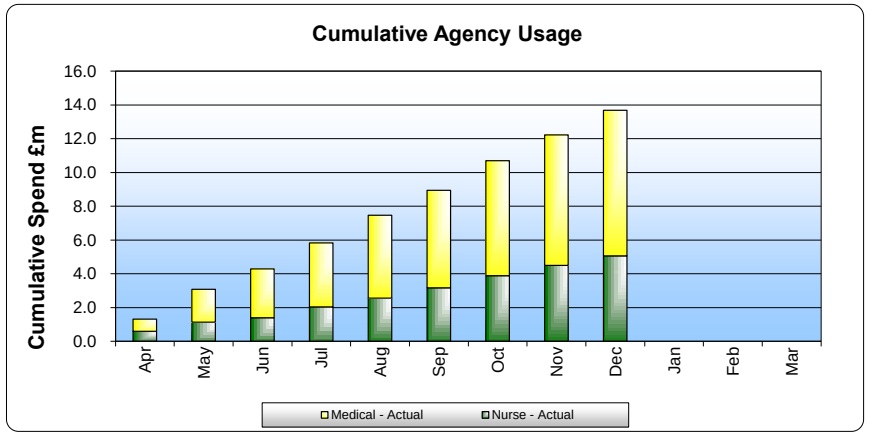
Key Messages:

There is an adverse expenditure variance of £6.4m at the end of December 2016. This comprises:

* Pay budgets are £0.5m adverse, linked to agency expenditure for Junior Doctors.
* Drugs budgets are £3.2m adverse, mainly due to pass through costs for drugs excluded from tariff.
* CIP achievement is £0.6m behind plan.
* Other budgets are £2.1m adverse.

Staff Group	Annual	Year to Date								Previous	Comments
	Plan	Plan	Contract	Overtime	WLI	Bank	Agency	Total	Variance	Variance	
Consultants	58,366	43,436	37,847	0	1,137	0	3,765	42,749	687	561	
Medical and Dental	29,907	22,399	19,903	0	184	0	4,853	24,940	-2,541	-1,813	
Nursing	95,472	71,599	58,923	413	332	5,109	5,058	69,834	1,765	2,213	
Healthcare Scientists	10,970	8,089	6,850	171	161	0	159	7,341	748	689	
Scientific, Therapeutic and technical	14,961	11,101	10,477	56	1	2	204	10,740	361	594	
Allied Health Professionals	25,160	18,821	16,871	63	216	7	183	17,340	1,481	1,249	
HCAs and Support Staff	44,702	33,418	30,131	527	99	59	163	30,979	2,439	1,735	
Chairman and Non Executives	163	122	122	0	0	0	0	122	0	-1	
Exec Board and Senior managers	12,252	9,145	10,145	4	0	0	0	10,149	-1,004	-780	
Admin & Clerical	37,039	27,645	24,917	206	84	114	216	25,537	2,108	1,748	
Agency Premium Provision	5,597	4,194	0	0	0	0	0	0	4,194	3,258	
Vacancy Factor	-13,025	-10,780	0	0	0	0	0	0	-10,780	-8,745	
TOTAL	**321,563**	**239,188**	**216,186**	**1,438**	**2,214**	**5,291**	**14,602**	**239,731**	**-542**	**708**	



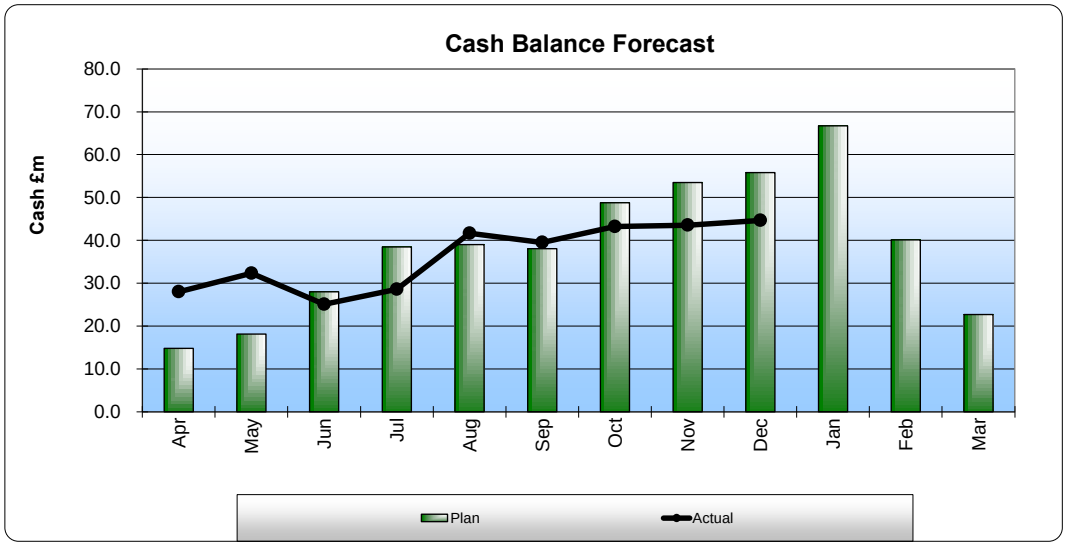


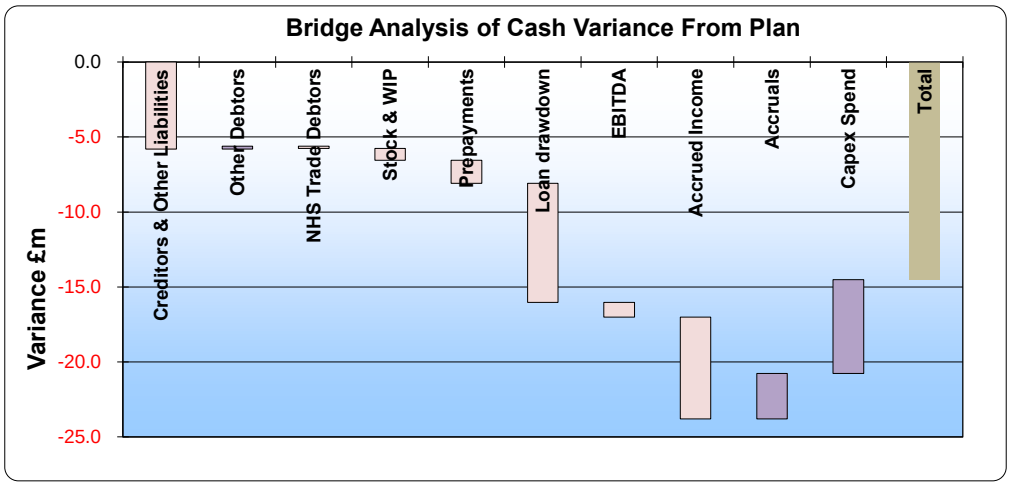
Cash Flow Management
Month 9 - The Period 1st April 2016 to 31st December 2016

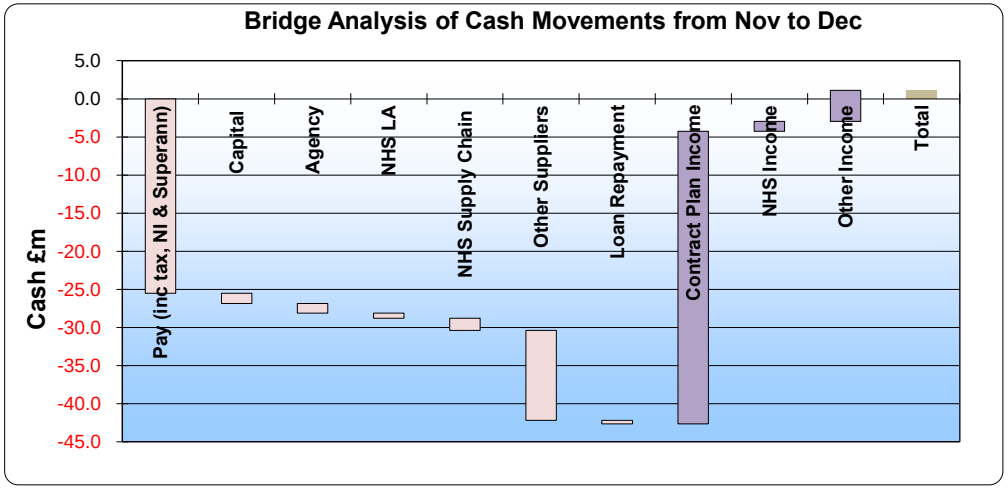
York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

* The cash position at the end of December was £44.7m, which is behind plan. The £1m outstanding S&T funding from last month was received in December.
* The key factors influencing cash are:
- Negative impact due to increased expenditure incurred with the level of overtrade activity (Approx £8.5m at Q2, Q3 figure to be confirmed).
- Postive impact due to unwinding of debtors ahead of plan.
- Positive impact due to delays in the Capital Programme.







Cash Flow Management
Month 9 - The Period 1st April 2016 to 31st December 2016

York Teaching Hospital NHS
NHS Foundation Trust

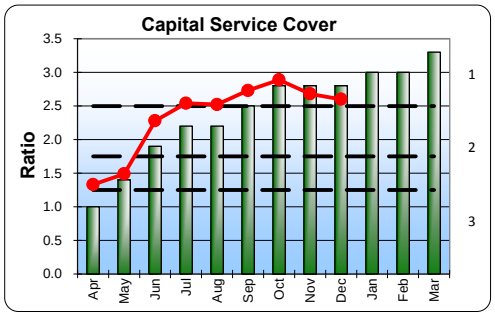
Key Messages:

* The receivables balance at the end of December was £8.6m, which is below plan.
* The payables balance at the end of December was £6.2m, which is below plan.
* The Financial Sustainability Risk Rating (FSRR), which is assessed as a score of 4 in October, and is reflective of the I&E position.

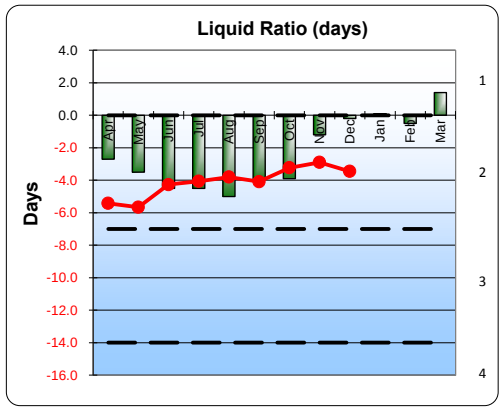
Significant Aged Debtors (+6mths)

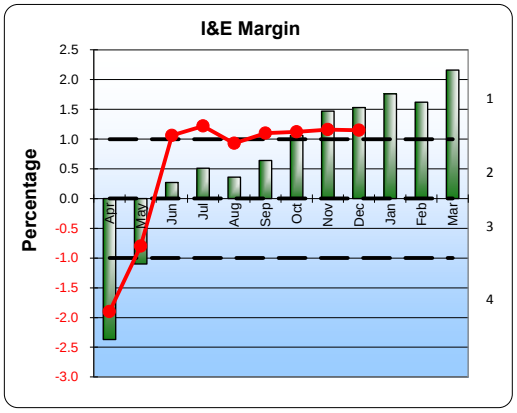
Leeds & York Partnership NHS FT	**£375K**
Harrogate & District NHS FT	**£229K**
NHS Property Services	**£228K**

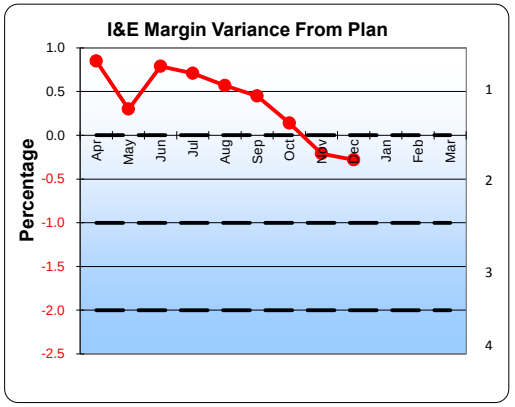
	Under 3 mths	3-6 mths	6-12 mths	12 mths +	Total
	£m	£m	£m	£m	£m
Payables	3.87	0.85	0.71	0.74	6.17
Receivables	5.99	0.79	1.15	0.67	8.60

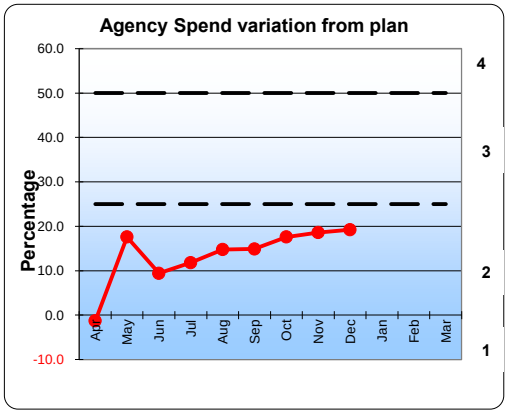


	Plan for Year	Plan for Year-to-date	Actual Year-to-date	Forecast for Year
Liquidity (20%)	1	2	2	1
Capital Service Cover (20%)	1	1	1	1
I&E Margin (20%)	1	1	1	1
I&E Margin Variance From Plan (20%)	1	1	2	1
Agency variation from Plan (20%)	1	1	2	2
Overall Use of Resources Rating	**1**	**1**	**2**	**1**









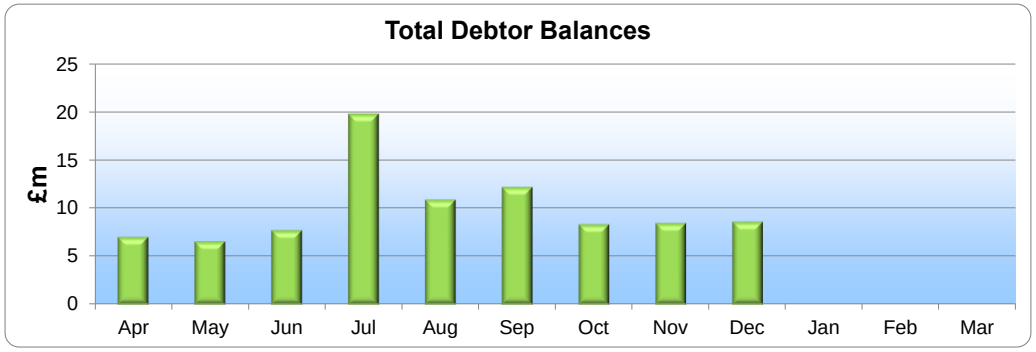
Debtor Analysis

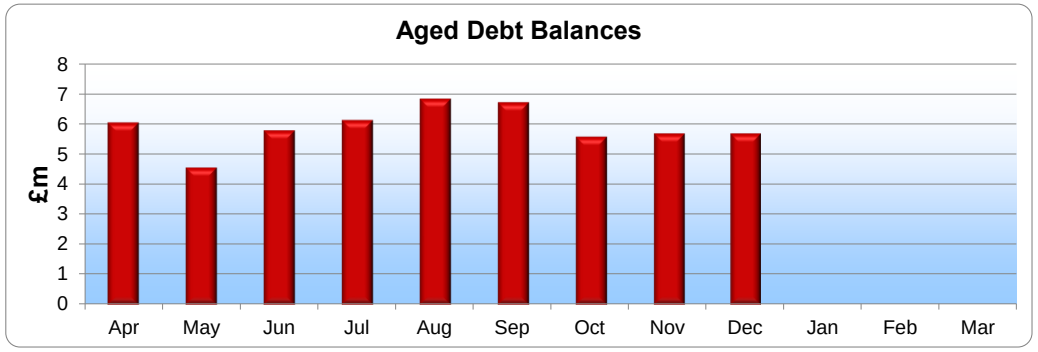
Month 9 - The Period 1st April 2016 to 31st December 2016

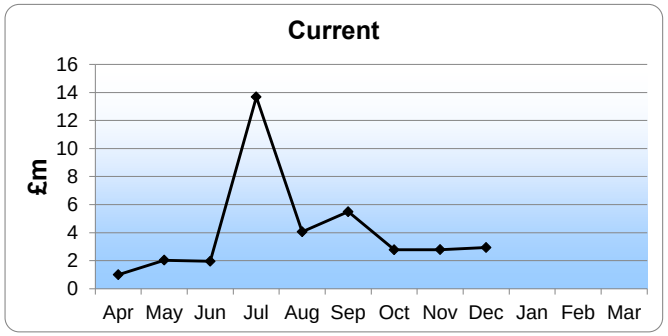
York Teaching Hospital NHS
NHS Foundation Trust

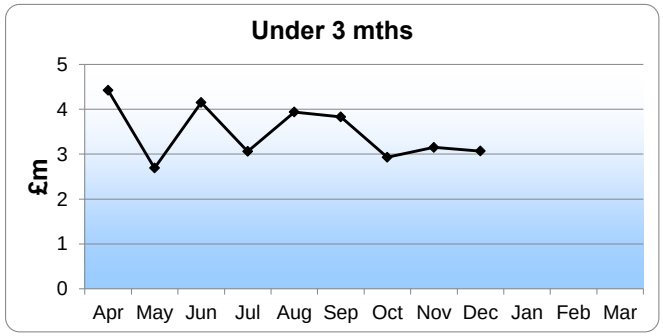
Key Messages:

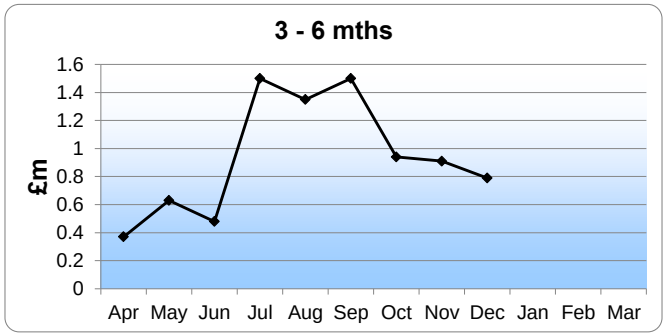
* At the end of December, the total debtor balance was £8.6m, with £2.9m relating to 'current' invoices not due.
* Aged Debt was £5.7m, however £3.1m of this is under 3 months old.
* The debtor position has stablised over the last 3 months and the YTD monthly average aged debt has improved on the average from last financial year.

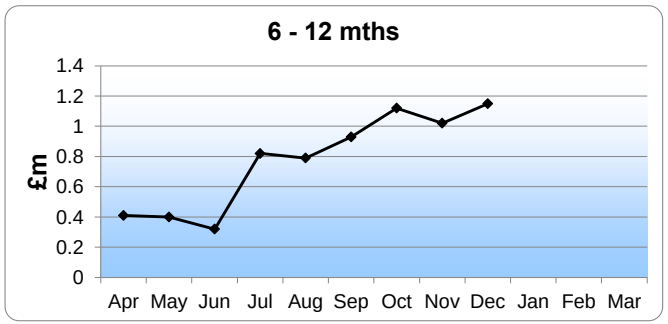


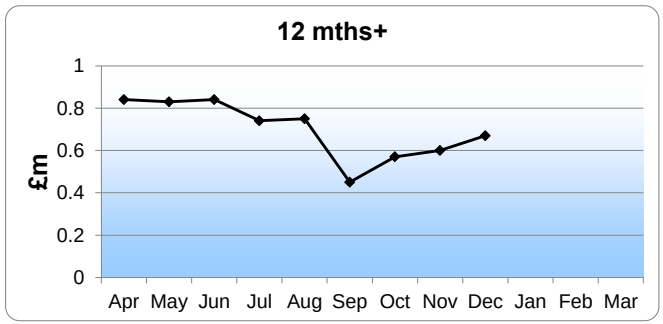












Capital Programme
Month 9 - The Period 1st April 2016 to 31st December 2016

York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

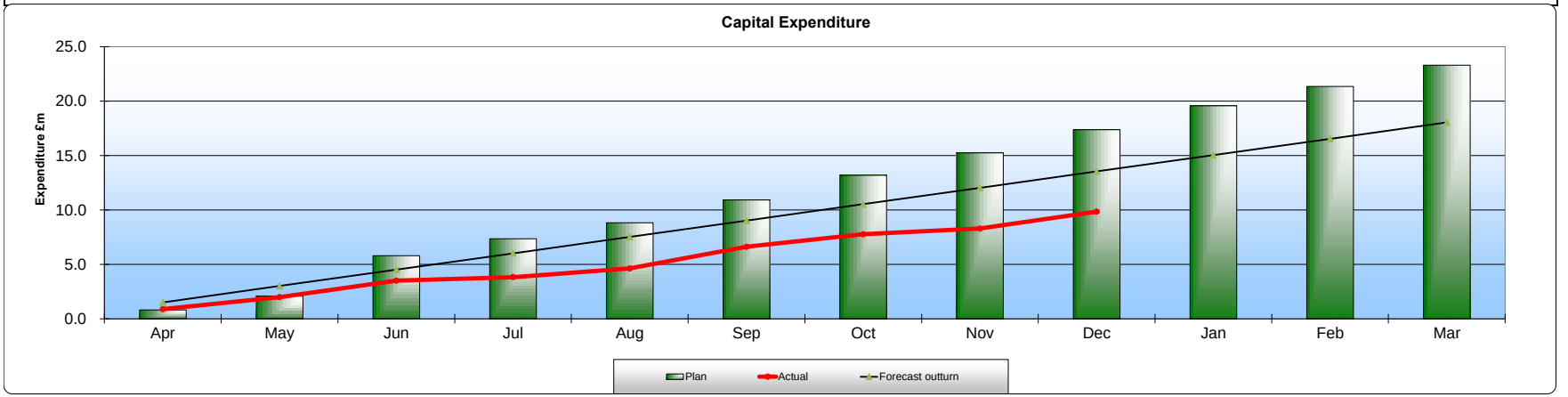
* Total in year spend to 31 December 2016 is £9.85m this is £7.54m behind plan at the end of December. The Trust outturn position has reduced to £18.06m which is shown in the forecast outturn line in the graph.

* There is still no news regarding the release of the ITFF loan for the Endoscopy and VIU schemes. This has impacted on the Trust Capital outturn position.

* The Radiology schemes have now been programmed over the remainder of this year and next financial year this again impacts on the Capital outturn position.

* The Radiology lift replacement scheme in SGH is due to start in January , the replacement Estates portacabins and the replacement of the alarm system schemes are due to start in February.

* The SGH Ambulance hand over (OPAL) scheme completed in December along with the work on Ward 14 and the Surgical Assesment Unit.



Scheme	Approved in-year Expenditure	Year-to-date Expenditure	Forecast Outturn Expenditure	Variance	Comments
	£000	£000	£000	£000	
Urology Facilities Malton	1,600	1,757	1,600	0	
Purchase of Tanpit Lodge Easingwold	1,000	1,000	1,000	0	
Theatre 10 to cardiac/vascular	1,100	487	1,000	100	
Radiology Replacement	5,730	48	2,275	3,455	Slipped to 2017/18
Radiology Lift Replacement SGH	640	51	293	347	Slipped to 2017/18
Fire Alarm System SGH	640	141	445	195	Slipped to 2017/18
Other Capital Schemes	2,719	2,007	3,546	-827	York Admin Block plus Breast imaging PACS
SGH Estates Backlog Maintenance	750	655	1,210	-460	Roof repairs-Malton & Scarborough
York Estates Backlog Maintenance - York	750	250	750	0	
Surgical Assesment Unit/ Ward 14	-	170	590	-590	
Medical Equipment	450	279	450	0	
IT Capital Programme	1,600	1,062	1,600	0	
Capital Programme Management	1,350	1,160	1,350	0	
Star Appeal	243	30	191	52	
SGH replacement of estates portakabins	732	37	755	-23	
Endoscopy Development	3,500	715	1,000	2,500	Waiting for loan approval
Contingency	500	-	-	500	
TOTAL CAPITAL PROGRAMME	**23,304**	**9,849**	**18,055**	**5,249**	A level of capital creditors is included in the total spend figure.

This Years Capital Programme Funding is made up of:-	Approved in-year Funding	Year-to-date Funding	Forecast Outturn	Variance	Comments
	£	£	£	£	
Depreciation	12,000	8,254	12,000	-	
Loan Funding b/fwd	-	-	-	-	
Loan Funding	7,950	715	3,000	4,950	
Charitable Funding	787	302	758	29	
Strategic Capital Funding	2,567	578	2,297	270	
TOTAL FUNDING	**23,304**	**9,849**	**18,055**	**5,249**	

Efficiency Programme

Month 9 - The Period 1st April 2016 to 31st December 2016

York Teaching Hospital NHS
NHS Foundation Trust

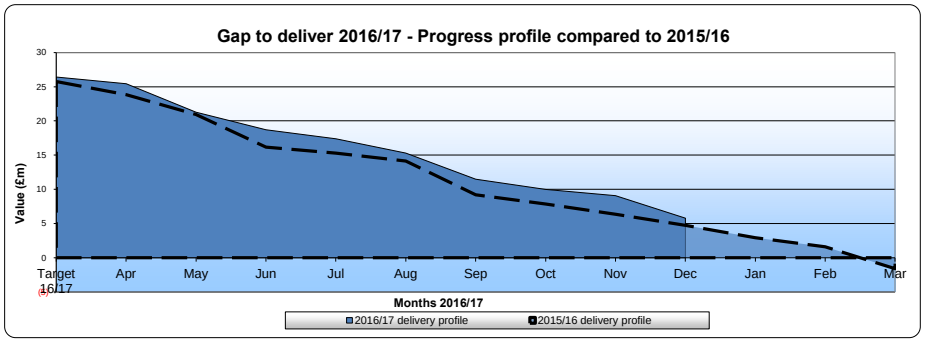
Key Messages:

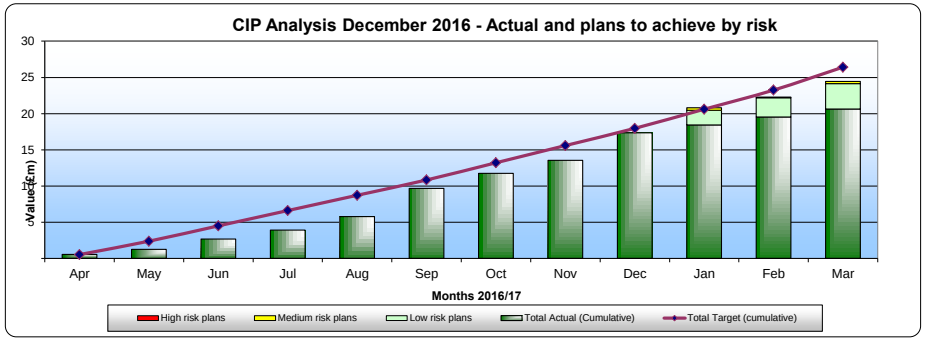
* Delivery - £20.6m has been delivered against the Trust annual target of £26.4m, giving a shortfall of (£5.8m)
* Part year NHSI variance - The part year NHSI variance is (£0.6m).
* In year planning - The 2016/17 planning gap is currently (£2.0m), High Risk Plans have now been excluded from the planning position.
* Four year planning - The four year planning gap is (£10.2m).
* Recurrent delivery - Recurrent delivery is £12.9m, which is 49% of the 2016/17 CIP target.

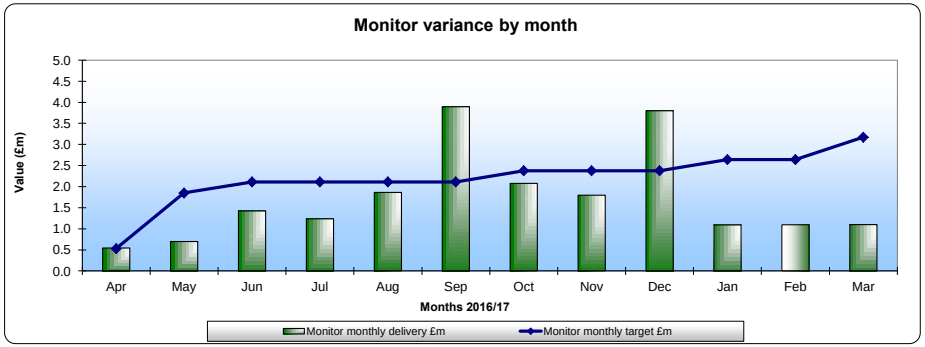
Executive Summary - November 2016	
	Total £m
TARGET	
In year target	26.4
DELIVERY	
In year delivery	20.6
In year delivery (shortfall)/Surplus	-5.8
Part year delivery (shortfall)/surplus - NHSI variance	-0.6
PLANNING	
In year planning surplus/(gap)	-2.0
FINANCIAL RISK SCORE	
Overall trust financial risk score	(2 - RED/AMBER)

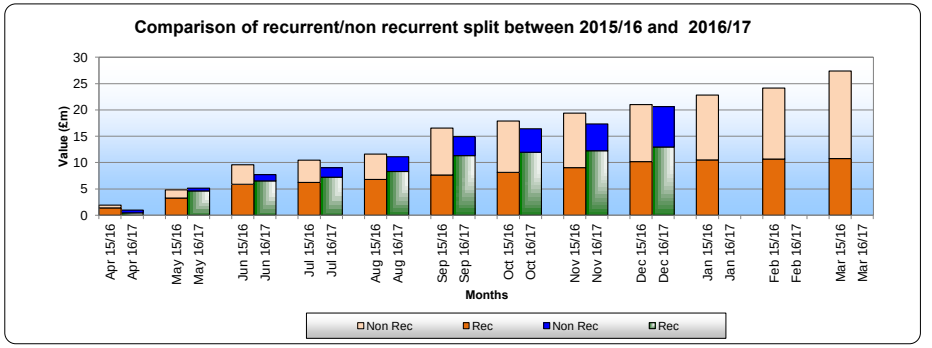
4 Year Efficiency Plan - December 2016					
Year	2016/17	2017/18	2018/19	2019/20	**Total**
	£m	£m	£m	£m	**£m**
Base Target	26.4	15.5	15.5	15.5	**73.0**
Plans	24.4	19.4	10.9	8.1	**62.9**
Variance	-2.0	3.9	-4.6	-7.4	**-10.2**
%	**93%**	**125%**	**70%**	**52%**	**86%**

Risk Ratings			
Financial			
Score	November	December	Trend
1	10	8	↓
2	3	4	↑
3	5	6	↑
4	4	5	↑
5	5	4	↓
Governance			
Score	November	November	Trend
Red	0	0	→
Green	26	26	→





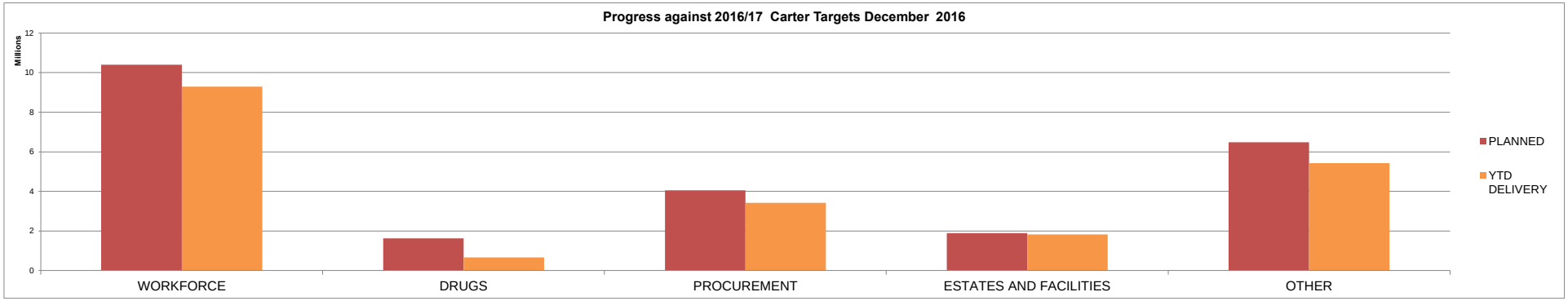




Key Messages:

Work ongoing with Carter Leads
The Model Hospital Benchmarking Tool has been updated with 2015/16 Reference Cost Data - validation in progress.

EFFICIENCY PROGRAM - CARTER WORKSTREAM PERFORMANCE NOVEMBER 2016						
CATEGORY	**WORKFORCE**	**DRUGS**	**PROCUREMENT**	**ESTATES AND FACILITIES**	**OTHER**	**TOTAL**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
2016/17 OVERALL TARGET						26,416
PLANNED	10,397	1,629	4,049	1,887	6,479	24,441
YTD TARGET						17,963
YTD DELIVERY	9,287	670	3,417	1,829	5,428	20,631
YTD VARIANCE	-2,249	-1,152	1,441	222	4,406	2,667
4 YEAR TARGET						0
4 YEAR PLANS	18,892	7,560	7,086	5,200	24,128	62,866
4 YEAR VARIANCE						0



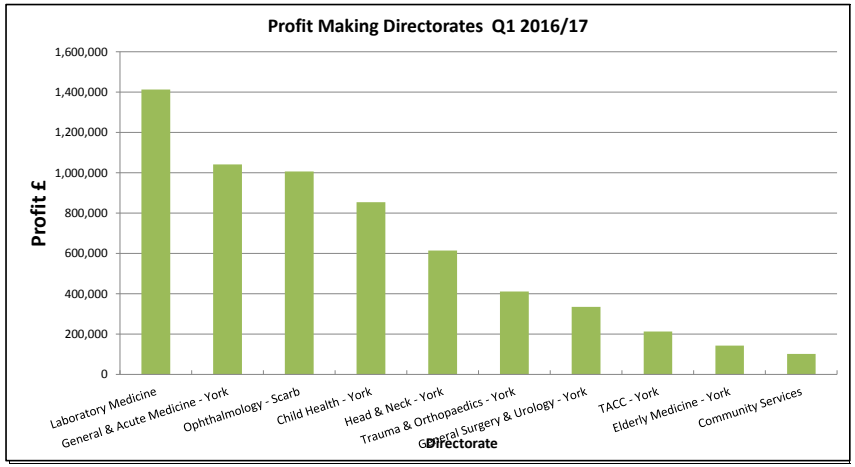
WORKFORCE	DRUGS
1. Draft Internal Dashboard set up and is being reviewed by the Workforce Lead. 2. Work ongoing with Improvement Director and Deputy Director of Workforce lead to identify and refine key schemes. 3. Back office Costs Data Collection has been validated and final submission sent on 6 January 2017. The Model Hospital will be updated by NHSI to reflect this submission.	1. Draft Internal Dashboard set up and is being reviewed by the Pharmacy Lead. 2. NHSI updated Model Hospital Portal with National Pharmacy Dashboard August 16.
PROCUREMENT	**ESTATES AND FACILITIES**
1. Procurement Steering Group set up and monthly meetings are being held to drive the programme forward. 2. Internal Dashboard set up and in use and reported in to the Carter Steering Group. 3. Workshop held with Procurement and a follow-up held in September with schemes being identified and updated on a monthly basis.	1. Work progressing on Internal Dashboard. 2. National Dashboard now live on Model Hospital and being reviewed.

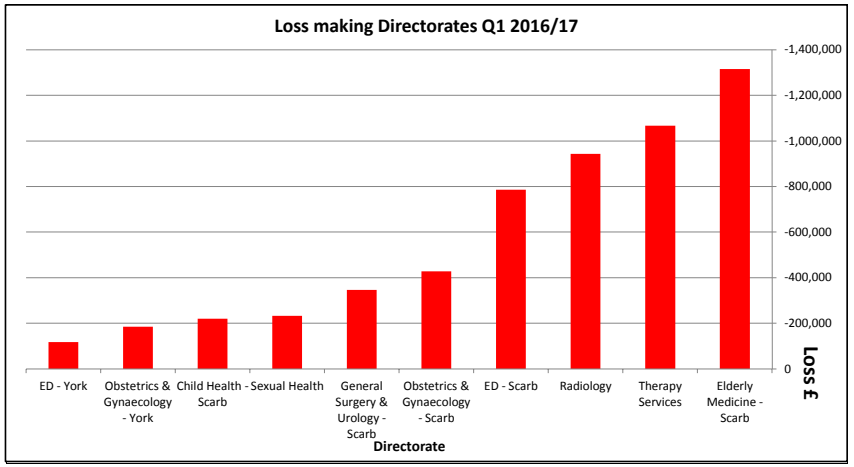
Service Line Reporting
Month 9 - The Period 1st April 2016 to 31st December 2016

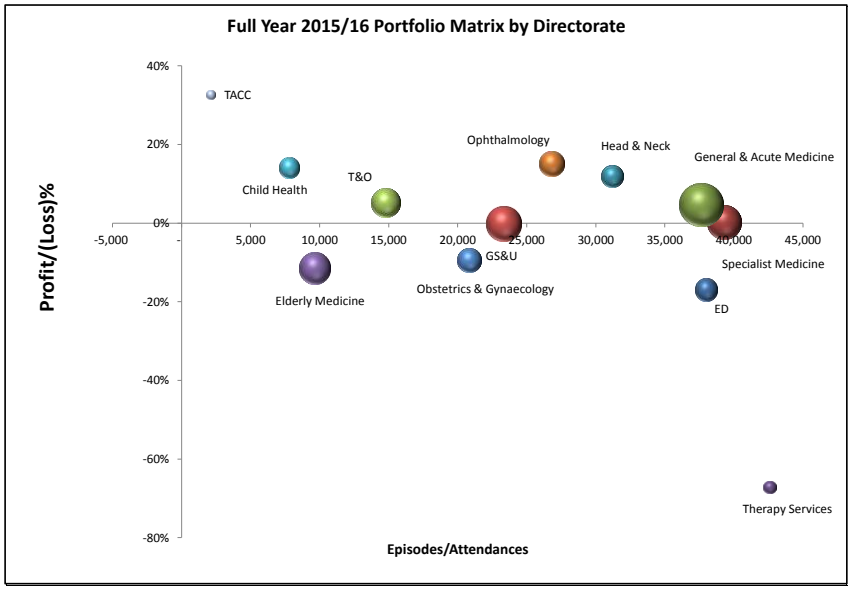
York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

* Current data is based on Q1 2016/17
* It is expected that Q2 2016/17 will be completed towards the middle of January 2017
* New Qlikview user guides are being developed to help users log in and navigate round the system







DATA PERIOD	Q1 2016/17
CURRENT WORK	* Q2 2016/17 SLR reports are now the key focus for the team *Three new Qlikview user guides have been published to help users log in and navigate round the system. More user guides covering different areas of Qlikview will be relased over the coming months * Work with Directorate teams is currently on-going to improve the quality of consultant PA allocations used within the SLR system for each quarterly reporting period * The SLR team are continuing to work with Directorate teams to improve the quality of outpatient staffing group costs within SLR
FUTURE WORK	* Work on the Q3 2016/17 SLR data will commence once the Q2 data is published * Future work around junior doctor PA allocations will improve the quality of the SLR data and also inform the annual mandatory Education & Training cost collection exercise * Planning for the NHSI Costing Transformation Programme will soon begin to ensure that we are prepared for future mandatory reporting requirements

FINANCIAL BENEFITS TAKEN SINCE SYSTEM INTRODUCTION	**£2.78m**

J2

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 January 2017

Efficiency Programme Update – December 2016

Action requested/recommendation

The Board is asked to note the December 2016 position.

Executive Summary

This report provides a detailed overview of progress to date regarding delivery of the Trust's Efficiency Programme. The 2016/17 target is £26.4m and delivery, as at December 2016 is £20.6m.

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

Implications for equality and diversity

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

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

Reference to CQC regulations

There are no references to CQC regulations

Progress of report Finance & Performance Committee

Risk	The Efficiency Programme presents a significant financial risk to the organisation.
Resource implications	The aim of this work stream is to ensure the most effective use of the Trust resources.
Owner	Andrew Bertram, Finance Director
Author	Steven Kitching, Head of Corporate Finance & Resource Management
Date of paper	January 2017
Version number	Version 1

York Teaching Hospital NHS
NHS Foundation Trust

Briefing note for the Finance & Performance Committee Meeting
17 January 2017 and Board of Directors Meeting 25 January 2017

Subject: December 2016 - Efficiency and Carter update

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

Summary reported position for December 2016

Current position – highlights

Delivery - Overall delivery is £20.6m in December 2016 which is (78%) of the £26.4m annual target. This position compares to a delivery position of £21m (85%) in December 2015.

Part year delivery is (£0.6m) behind the profiled plan submitted to NHSI.

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

In year planning – There is an in year planning gap of (£2m) at December 2016, the comparative position in December 2015 was a gap of £1.5m.

Four year planning – The four year planning gap is (£10.2m). The position in December 2015 was a gap of (£15.1m).

Recurrent vs. Non recurrent – Of the £20.6m delivery, £12.9m (63%) has been delivered recurrently. Recurrent delivery is £2.7m ahead of the same position in December 2015. The work continues to identify recurrent schemes.

Quality Impact Assessments (QIA) – Of the 14 schemes that have been rated as high risk following the self-assessment process 5 are considered to be High Risk of which 2 are reputational risk; 5 schemes require clarification and 4 schemes have been re-assessed as Low Risk. These schemes are to be reviewed at the February Carter Steering Group.

Overview

The December 2016 position is encouraging with recurrent delivery at £12.9m (49%) of the annual target while the in-year planning gap remains at £2m.

Carter

The NHSI Corporate Services Template (back office functions) has been validated and re-submitted.

The Pharmacy and Medicines Dashboard on the Model hospital has been refreshed and we are currently validating the data contained.

The Model Hospital has now been refreshed with 2015/16 data and we are currently validating this.

Risk

The key risks in the programme:

- There is an overall planning gap of (£2m) in year and a (£10.2m) 4 year planning gap.
- Recurrent delivery to date is £12.9m of the overall target (£26.4m) and this remains a key focus.
- There are 10 schemes which have been rated as high risk following the self-assessment process.

RISK SCORES - DECEMBER 2016 -APPENDIX 1

DIRECTORATE	FINANCE						GOVERNANCE	
	R	RA	A	AG	G	Trend	R	G
COMMUNITY	1	2	3	4	5	→	○	●
RADIOLOGY	1	2	3	4	5	→	○	●
EMERGENCY MEDICINE	1	2	3	4	5	→	○	●
WOMENS HEALTH	1	2	3	4	5	→	○	●
TACC	1	2	3	4	5	→	○	●
SEXUAL HEALTH	1	2	3	4	5	→	○	●
SPECIALIST MEDICINE	1	2	3	4	5	→	○	●
AHP & PSYCHOLOGICAL MEDICINE DIRECTORATE	1	2	3	4	5	→	○	●
GS&U	1	2	3	4	5	→	○	●
MEDICINE FOR THE ELDERLY	1	2	3	4	5	↑	○	●
CHILD HEALTH	1	2	3	4	5	→	○	●
GEN MED SCARBOROUGH	1	2	3	4	5	→	○	●
GEN MED YORK	1	2	3	4	5	→	○	●
OPHTHALMOLOGY	1	2	3	4	5	↓	○	●
HEAD AND NECK	1	2	3	4	5	↑	○	●
LAB MED	1	2	3	4	5	→	○	●
PHARMACY	1	2	3	4	5	→	○	●
ORTHOPAEDICS	1	2	3	4	5	→	○	●
CORPORATE								
MEDICAL GOVERNANCE	1	2	3	4	5	↑	○	●
ESTATES AND FACILITIES	1	2	3	4	5	↑	○	●
CHIEF NURSE TEAM DIRECTORATE	1	2	3	4	5	→	○	●
SNS	1	2	3	4	5	↓	○	●
FINANCE	1	2	3	4	5	→	○	●
OPS MANAGEMENT YORK	1	2	3	4	5	→	○	●
CHAIRMAN & CHIEF EXECUTIVES OFFICE	1	2	3	4	5	→	○	●
HR	1	2	3	4	5	→	○	●
LEARNING ORGANISATIONAL DEVELOPMENT & RESEARCH	1	2	3	4	5	→	○	●
TRUST SCORE	1	2	3	4	5	→		

RISK SCORES - DECEMBER 2016 - APPENDIX 2

DIRECTORATE	Yr1 Target (£000)	4Yr Target (£000)	Yr 1 Plan v Target		Yr 1 Delivery v Target		Y1 Recurrent Delivery v target		4 Yr Plan v Target		Risk Score	
			%	Score	%	Score	%	Score	%	Score	Total Score	Monitor Rating
COMMUNITY	1,099	2,281	38%	1	26%	1	20%	1	63%	1	4	1
RADIOLOGY	1,693	3,295	39%	1	28%	1	18%	1	33%	1	4	1
EMERGENCY MEDICINE	522	1,930	31%	1	31%	1	31%	1	77%	1	4	1
WOMENS HEALTH	1,683	3,430	43%	1	33%	1	32%	1	57%	1	4	1
TACC	2,248	6,274	56%	1	50%	1	27%	1	72%	1	4	1
SEXUAL HEALTH	635	1,329	58%	1	51%	1	0%	1	88%	1	4	1
SPECIALIST MEDICINE	3,172	7,189	64%	1	49%	1	45%	3	53%	1	6	1
AHP & PSYCHOLOGICAL MEDICINE DIRECTORATE	1,280	3,462	56%	1	54%	2	48%	3	45%	1	7	1
GS&U	1,964	5,109	99%	2	84%	5	40%	2	82%	1	10	2
MEDICINE FOR THE ELDERLY	1,513	3,774	108%	3	90%	5	57%	4	88%	1	13	3
CHILD HEALTH	1,072	2,374	92%	2	75%	4	58%	5	103%	3	14	3
GEN MED SCARBOROUGH	871	2,311	104%	3	82%	4	62%	5	95%	2	14	3
GEN MED YORK	1,846	5,686	101%	3	83%	5	52%	4	106%	3	15	3
OPHTHALMOLOGY	763	2,795	101%	3	90%	5	75%	5	106%	3	16	4
HEAD AND NECK	850	2,050	106%	3	91%	5	59%	5	116%	4	17	4
LAB MED	794	2,881	189%	5	188%	5	108%	5	101%	3	18	4
PHARMACY	374	1,065	145%	5	118%	5	87%	5	114%	4	19	5
ORTHOPAEDICS	1,228	3,521	209%	5	196%	5	99%	5	143%	5	20	5
CORPORATE												
MEDICAL GOVERNANCE	195	533	87%	1	87%	5	5%	1	32%	1	8	2
ESTATES AND FACILITIES	2,701	7,099	70%	1	67%	3	60%	5	80%	1	10	2
CHIEF NURSE TEAM DIRECTORATE	389	730	108%	3	84%	5	33%	1	64%	1	10	2
SNS	750	1,772	104%	3	96%	5	83%	5	100%	2	15	3
FINANCE	417	1,203	138%	5	138%	5	55%	4	48%	1	15	3
OPS MANAGEMENT YORK	205	568	124%	5	105%	5	85%	5	62%	1	16	4
CHAIRMAN & CHIEF EXECUTIVES OFFICE	74	186	234%	5	234%	5	105%	5	93%	2	17	4
HR	376	1,007	128%	5	128%	5	86%	5	126%	5	20	5
LEARNING ORGANISATIONAL DEVELOPMENT & RESEAR	217	627	177%	5	159%	5	70%	5	133%	5	20	5
TRUST SCORE	**28,929**	**74,481**	**93%**	**2**	**78%**	**4**	**49%**	**3**	**87%**	**1**	**10**	**2**

J3

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

York Teaching Hospital NHS
NHS Foundation Trust

Public Performance Report

January 2016

Our ultimate objective

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

Access Targets: 18 Weeks

Indicator	Consequence of Breach (Monthly)	Threshold	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Oct	Nov	Dec
Incomplete Pathway: Percentage of patients on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	Not applicable for 2016/17 - part of NHS England Sustainability and Transformation Fund (STF)	**92%**	93.0%	92.5%	90.8%	89.3%	90.9%	90.0%	89.3%
Zero tolerance RTT waits over 52 weeks for incomplete pathways	Not applicable for 2016/17 - part of NHS England Sustainability and Transformation Fund (STF)	**0**	0	0	0	0	0	0	0
Admitted Pathway: Percentage of admitted patients starting treatment within a maximum of 18 weeks from Referral	Not applicable	**Not applicable**	74.2%	70.6%	68.6%	67.8%	64.5%	67.6%	71.7%
Non Admitted Pathway: Percentage of non-admitted patients starting treatment within a maximum of 18 weeks from Referral	Not applicable	**Not applicable**	95.3%	95.5%	94.4%	93.3%	93.2%	93.2%	93.7%

Access Targets: Cancer

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

Indicator	Consequence of Breach	Threshold	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Sep	Oct	Nov
14 Day Fast Track	Not applicable	**93%**	93.5%	92.8%	89.9%	n/a	92.7%	86.2%	89.8%
14 Day Breast Symptomatic	Not applicable	**93%**	95.1%	95.6%	93.3%	n/a	95.8%	97.6%	97.8%
31 Day 1st Treatment	Not applicable	**96%**	98.6%	99.4%	99.0%	n/a	98.0%	98.2%	97.1%
31 Day Subsequent Treatment (surgery)	Not applicable	**94%**	96.2%	96.5%	97.0%	n/a	92.7%	100.0%	83.3%
31 Day Subsequent Treatment (anti cancer drug)	Not applicable	**98%**	99.2%	100.0%	100.0%	n/a	100.0%	100.0%	99.2%
62 day 1st Treatment	Not applicable for 2016/17 - part of NHS England Sustainability and Transformation Fund (STF)	**85%**	85.8%	86.4%	84.3%	n/a	77.1%	77.8%	80.2%
62 day Screening	Not applicable	**90%**	90.4%	91.0%	92.5%	n/a	92.6%	94.9%	93.4%
62 Day Consultant Upgrade	Not applicable	**85%**	50.0%	-	-	-	-	-	-

Emergency Department

Indicator	Consequence of Breach (Monthly)	Threshold	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Oct	Nov	Dec
Percentage of A & E attendances where the Patient was admitted, transferred or discharged within 4 hours of their arrival at an A&E department	Not applicable for 2016/17 - part of NHS England Sustainability and Transformation Fund (STF)	**95%**	85.0%	87.3%	91.4%	82.9%	85.5%	81.8%	81.1%
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 30 minutes	Not applicable for 2016/17 - part of NHS England Sustainability and Transformation Fund (STF)	**0 > 30min**	559	592	559	834	245	302	287
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 60 minutes	Not applicable for 2016/17 - part of NHS England Sustainability and Transformation Fund (STF)	**0 > 60min**	425	591	425	709	184	250	275
Ambulance Handovers over 30 and 60 Minutes by CCG	**Ambulance Handovers over 30 and 60 Minutes by CCG**	**Breach Category**	**Q4 15/16**	**Q1 16/17**	**Q2 16/17**	**Q3 16/17**	**Oct**	**Nov**	**Dec**
	NHS VALE OF YORK CCG	30mins - 1hr	183	226	116	371	86	141	144
		1hr 2 hours	122	232	75	219	55	61	103
		2 hours +	69	62	12	66	6	22	38
	NHS SCARBOROUGH AND RYEDALE CCG	30mins - 1hr	184	165	215	222	70	82	70
		1hr 2 hours	128	101	131	164	44	64	56
		2 hours +	40	29	42	48	9	28	11
	NHS EAST RIDING OF YORKSHIRE CCG	30mins - 1hr	135	117	146	167	60	61	46
		1hr 2 hours	96	89	90	100	35	31	34
		2 hours +	35	22	23	38	10	19	9
	NHS HAMBLETON, RICHMONDSHIRE AND WHITBY CCG	30mins - 1hr	19	28	25	21	8	3	10
		1hr 2 hours	21	12	10	20	6	8	6
		2 hours +	9	1	3	4	1	1	2
	NHS HARROGATE AND RURAL CCG	30mins - 1hr	2	3	4	1	0	0	1
		1hr 2 hours	2	1	0	6	4	0	2
		2 hours +	1	0	1	0	0	0	0
	OTHER	30mins - 1hr	25	53	53	52	21	15	16
		1hr 2 hours	20	33	34	31	14	9	8
		2 hours +	12	9	4	13	0	7	6
Total number of patients waiting over 8hrs in A&E	General Condition 9	Q1 - Establish baseline	1656	1045	591	1865	479	666	720
Trolley waits in A&E not longer than 12 hours	Not applicable for 2016/17 - part of NHS England Sustainability and Transformation Fund (STF)	**0 > 12 hrs**	32	7	0	18	4	3	11
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%**	99.0%	98.8%	98.8%	To follow	98.2%	To follow	To follow

Mortality

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15	Jan 15 - Dec 15	Apr 15 - Mar 16	Jul 15 - Jun 16
Mortality – SHMI (YORK)	**Quarterly:** General Condition 9	**A banding of "Significantly higher that expected" in SHMI using the "Extract Poisson Distribution" method for deriving upper and lower confidence limits, applied to each sub-group reported**	97	96	95	93	94	95	96
Mortality – SHMI (SCARBOROUGH)	**Quarterly:** General Condition 9		107	108	107	107	108	107	106

Infection Prevention

Indicator	Consequence of Breach (Monthly)	Threshold	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Oct	Nov	Dec
Minimise rates of Clostridium difficile	*Schedule 4 part G* **Quarterly:** 1 Monitor point tbc	**48**	15	7	6	13	3	2	8
Number of Clostridium difficile due to "lapse in care"	Establish baseline and set trajectory	**TBC**	TBC	TBC	TBC	TBC	TBC	TBC	TBC
Number of E-Coli cases	**Quarterly:** General Condition 9	**(TBC)**	33	17	32	14	4	5	5
Number of Methicillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia cases	**Quarterly:** General Condition 9	**30**	7	13	7	17	8	4	5
Zero tolerance MRSA	£10,000 in respect of each incidence in the relevant month	**0**	2	2	2	3	2	0	1
Confirmed cases of MRSA Bacteraemia to be notified to commissioner by next working day	General Condition 9	**100%**	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Post Infection Review (PIR) of MRSA bacteraemia/SI report to be provided to the commissioner within 21 working days of the case being identified in line with national data capture system	General Condition 9	**100%**	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Post Infection Review (PIR) completed	TBC	**TBC**	n/a	n/a	n/a	n/a	n/a	n/a	n/a
All High Risk (non-day case) Elective admissions are screened for MRSA prior to admission	**Quarterly:** General Condition 9	**95%**	74.0%	84.5%	86.3%	86.8%	89.9%	86.4%	84.0%
Emergency admissions are screened for MRSA within 24 hours of admission	**Quarterly:** General Condition 9	**95%**	75.0%	83.4%	86.6%	85.2%	86.0%	85.8%	83.9%

Quality and Safety

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Oct	Nov	Dec
Percentage of Patients waiting less than 6 weeks from Referral for a diagnostic test	Not applicable for 2016/17 - part of NHS England Sustainability and Transformation Fund (STF)	**99%**	99.6%	99.3%	99.4%	99.0%	99.2%	99.2%	99.0%
Sleeping Accommodation Breach	£250 per day per Service User affected	**0**	3	0	0	0	0	0	0
All Patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days	Non-payment of costs associated with cancellation and non- payment or reimbursement (as applicable) of re-scheduled episode of care	**0**	4	13	2	3	1	2	0
No urgent operation should be cancelled for a second time	£5,000 per incidence in the relevant month	**0**	0	0	0	0	0	0	0
Cancelled operations within 48 Hours of the TCI due to lack of beds	General Condition 9	**65 per month**	210	61	22	220	48	101	71
VTE risk assessment: all inpatient undergoing risk assessment for VTE, as defined in Contract Technical Guidance	General Condition 9	**95%**	98.4%	98.7%	98.5%	98.4%	98.7%	98.3%	98.3%
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%**	99.9%	99.9%	99.9%	To follow	99.9%	To follow	To follow
All ELECTIVE patients to have an Expected Discharge Date (EDD) recorded in the patient case notes or patient management system within 24 hours of admission	General Condition 9	**Q1 - 91% Q2 - 91% Q3 - 93% Q4 - 93%**	92%	87%	88%	87%	88%	88%	85%
Delayed Transfer of Care – All patients medically fit for discharge and issued a 'notification notice' as per joint protocol for the transfer of care	As set out in General Condition 9 - Trust only to be accountable for Health delays.	**Set baseline in Q1 and agree trajectory**	Monthly Provider Report						
Trust waiting time for Rapid Access Chest Pain Clinic	General Condition 9	**99%**	100.0%	100.0%	100.0%	94.9%	100.0%	87.5%	100.0%
No patient cancelled more than twice by the Trust for non-clinical reasons. All new dates to be arranged within 6 weeks of the cancelled appointment	General Condition 9	**90%**	Annual statement of assurance						
Outpatient clinics cancelled with less than 14 days notice	General Condition 9	**180 per month**	482	519	531	603	218	240	145
Reduction in number of hospital cancelled first and follow up outpatient appointments for non-clinical reasons where there is a delay in the patient treatment	General Condition 9	**Not applicable**	2599	2760	2504	2328	828	818	682
% Compliance with WHO safer surgery checklist	General Condition 9	**100%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Readmissions within 30 days – Elective	The CCG will apply a % penalty following Flex and Freeze validation. (ER)	**08/09 outturn awaiting figure from CCG**	499	535	530	n/a	193	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**	1660	1624	1662	n/a	493	2 month coding lag	2 month coding lag
Reduction in avoidable transfers within the Trust after 10pm. Excludes transfers for clinical reasons or for patients transferred to a more appropriate ward	General Condition 9	**300 per Quarter**	317	235	239	300	98	105	97
Number/Percentage women who have seen a midwife by 12 weeks and 6 days (as per IPMR definition)	General Condition 9	**90%**	99.2%	99.8%	99.8%	99.8%	99.5%	100.0%	100.0%
Stroke Performance against Sentinel Stroke National Audit Programme (SSNAP)	General Condition 9	**Best Practice Standards**	Quarterly summary of performance against SSNAP indicators as submitted to RCP. Stroke service exception action plan to be produced quarterly .						
All Red Drugs to be prescribed by provider effective from 01/04/2016	Recovery of costs for any breach to be agreed via medicines management committee	**100% list to be agreed**	CCG to audit for breaches						
All Amber Drugs to be prescribed by provider effective from 01/04/2016	Recovery of costs for any breach to be agreed via medicines management committee	**100% list to be agreed**	CCG to audit for breaches						
NEWS within 1 hour of prescribed time	None - Monitoring Only	**None**	85.9%	87.3%	87.9%	87.6%	87.8%	87.9%	87.1%

Never Events

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Oct	Nov	Dec
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**	1	2	2	0	0	0	0

District Nursing Activity Summary

Indicator	Source	Threshold	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Oct	Nov	Dec
Community Adult Nursing Referrals (excluding Allied Health Professionals)	GP	-	3339	3345	3479	3636	1208	1376	1052
	Community nurse/service	-	1317	1463	1482	1618	528	575	515
	Acute services	-	1320	1327	1421	1400	430	476	494
	Self / Carer/family	-	882	863	1047	959	329	353	277
	Other	-	426	521	444	398	133	141	124
	Grand Total	-	7284	7519	7873	8011	2628	2921	2462
Community Adult Nursing Contacts	First	-	5089	5620	6018	6526	2131	2339	2056
	Follow up	-	61791	74408	84084	84989	28102	29085	27802
	Total	-	66880	80028	90102	91515	30233	31424	29858
	First to Follow Up Ratio	-	12.1	13.2	14.0	13.0	13.2	12.4	13.5
Community Hospitals average length of stay (days)	Archways	-	21.1	21.7	26.2	19.9	22.0	16.9	21.8
	Malton Community Hospital	-	18.2	18.8	18.5	18.6	14.6	22.2	17.0
	St Monicas Hospital	-	18.9	16.4	22.7	17.2	14.5	23.8	14.7
	The New Selby War Memorial Hospital	-	19.5	14.1	23.0	17.7	19.3	15.4	17.7
	Whitby Community Hospital	-	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Total	-	22.8	20.6	23.7	20.7	20.1	22.6	19.2
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	15	10	4	9	2	7	0
		Emergency	73	71	64	51	24	21	6
	Malton Community Hospital	Elective	44	34	39	41	13	17	11
		Emergency	82	84	93	76	23	25	28
	St Monicas Hospital	Elective	23	17	14	26	8	8	10
		Emergency	28	37	23	32	11	9	12
	The New Selby War Memorial	Elective	22	22	24	24	4	10	10
		Emergency	72	75	66	75	30	20	25
	Total	Elective	104	83	81	100	27	42	31
		Emergency	255	267	246	234	88	75	71

Monthly Quantitative Information Report

York Teaching Hospital NHS
NHS Foundation Trust

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Complaints and PALS												
New complaints this month	25	40	46	36	30	33	33	50	44	36	37	33
Top 3 complaint subjects												
All aspects of Clinical Treatment	21	39	49	21	26	18	17	26	71	40	36	18
Communications/information to patients (written and oral)	13	24	21	14	6	12	10	26	72	19	17	12
Patient Care	11	26	22	10	11	7	14	18	26	13	36	10
Top 3 directorates receiving complaints												
Acute & General Medicine	7	7	9	8	8	5	6	7	6	3	5	4
Emergency Medicine	4	4	8	5	3	3	6	7	6	10	5	7
General Surgery & Urology	2	7	5	4	3	1	5	6	3	3	7	4
Number of Ombudsman complaint reviews (new)[1]	0	4	0	2	3	4	2	2	0	0	2	0
Number of Ombudsman complaint reviews upheld	0	1	0	0	1	0	0	0	0	0	0	0
Number of Ombudsman complaint reviews partly upheld	0	2	1	2	1	3	0	1	2	0	2	0
New PALS queries this month	492	557	443	480	407	387	315	333	284	279	286	210
Top 3 PALS subjects												
Communication issues	42	48	48	36	25	23	60	60	51	51	76	52
Any aspect of clinical care/treatment	68	89	48	59	55	47	24	34	28	23	20	22
Appointments	54	52	45	56	37	50	31	61	60	50	44	43

Serious Incidents												
Number of SI's reported	11	28	21	19	12	31	15	17	12	9	18	14
% SI's notified within 2 working days of SI being identified*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
* this is currently under discussion via the 'exceptions log'												
Compliance with Duty of Candour for Serious Incidents:												
-Verbal Apology Given	7	7	8	9	6	20	8	6	7	3	4	2
-Written Apology Given *	0	2	1	1	1	2	1	1	1	0	0	0
-Invitation to be involved in Investigation	0	0	0	2	1	2	2	3	3	1	4	2
-Given Final Report (If Requested)	0	1	0	0	0	1	0	3	1	0	1	0

Pressure Ulcers**												
Number of Category 2	33	42	52	50	44	32	31	36	61	75	80	77
Number of Category 3	4	3	3	1	6	6	2	3	3	5	5	3
Number of Category 4	1	1	0	1	0	1	1	1	0	0	2	2
Total number developed/deteriorated while in our care (care of the organisation) - acute	37	44	57	44	53	37	28	39	57	87	101	91
Total number developed/deteriorated while in our care (care of the organisation) - community	24	25	29	24	20	25	28	26	36	36	25	31

Falls***												
Number of falls with moderate harm	3	7	4	1	3	3	3	3	2	0	0	3
Number of falls with severe harm	4	5	5	4	4	9	3	8	5	4	3	2
Number of falls resulting in death	0	0	0	0	0	0	0	0	0	0	0	1

Monthly Quantitative Information Report

York Teaching Hospital NHS
NHS Foundation Trust

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Safeguarding												
% of staff compliant with training (children)	82%	84%	85%	86%	86%	85%	86%	86%	86%	86%	86%	87%
% of staff compliant with training (adult)	83%	83%	84%	85%	85%	85%	85%	86%	86%	85%	86%	88%
% of staff working with children who have review CRB checks												
Prevent Strategy												
Attendance at the HealthWRAP training session												
Number of concerns raised via the incident reporting system												
Claims												
Number of Negligence Claims	12	12	12	18	16	17	12	10	10	13	14	11
Number of Claims settled per Month				3	6	2	5	9	5	1	8	2
Amount paid out per month **				£635,000	£66,500	£125,000	£342,500	£989,450	£262,750	£35,000	£780,500	£250,000
Reasons for the payment				Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability

* As not all SIs result in harm there will be instances where no written letter is required. The approach of the Trust is to bring the patient's relatives in to discuss the report and offer a summary if they require this. Meetings have been arranged with a number of relatives regarding this.
Note ** and *** - falls and pressure ulcers subject to validation. Falls resulting in deaths are investigated as Serious Incidents and the degree of harm will be confirmed upon completion of investigation.

All falls and pressure ulcer data is refreshed monthly to reflect ongoing monitoring and reporting of falls and pressure ulcers. A change on the way the Trust reports pressure ulcers was implemented on 01/09/16 resulting in a slight increase in the pressure ulcers reported as developing under our care. Category 3 pressure ulcer data excludes Category 3 ulcers which are recorded as having developed within 72 hours of admission to inpatient care.
* * one claim in April was settled for a lump sum payment of £450,000 (included in the data) with yearly payments of £145,000 to fund care needs, with the Claimant's life expectancy being between 3 and 5 years. The ongoing care costs are excluded from the above data as they cannot be quantified at present. Amount paid shows the damages.

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 January 2017

Capital Programme Update

Action requested/recommendation

The Finance & Performance Committee is requested to:

- Note the contents of the above review of the delivery of the 2016-17 capital programme to date.

- The Finance & Performance Committee is requested to endorse the forward capital plan for the 2017-18 financial year, noting the risks and scope for flexibility outlined above.

Executive Summary

The purpose of this paper is to review the delivery of the capital programme during the current 2016-17 financial year at the end of Quarter 3 and to provide a forecast for the remainder of the financial year. In addition this report will outline the forecast capital plan for the 2017-18 financial year in some detail and the following three years at high-level only.

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

Implications for equality and diversity

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

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

Reference to CQC regulations

There are no references to CQC regulations.

Progress of report	Capital Programme Executive Group
Risk	Any risks are identified in the report.
Resource implications	Resources implication detailed in the report.
Owner	Mr Brian Golding, Director of Estates & Facilities
Author	Dr Andrew Bennett, Head of Capital Projects
Date of paper	January 2017
Version number	Version 1

Board of Directors – 25 January 2017

FY2016-17 Q3 Capital Programme Review and 2017-18 Capital Plan

1. Introduction and Background

The purpose of this paper is to review the delivery of the capital programme during the current 2016-17 financial year at the end of Quarter 3 and to provide a forecast for the remainder of the financial year. In addition this report will outline the forecast capital plan for the 2017-18 financial year in some detail and the following three years at high-level only.

2. Delivery of the 2016-17 Capital Programme To Date

Overall, the current capital expenditure up to the end of December 2016 was outside of the forecast spending plan issued to Monitor (the Trust is allowed a +/- 15% tolerance). The forecast to Monitor was that the Trust would spend roughly £13.5m by the end of December 2016 whereas the ledger data shows an actual capital expenditure of £9.4m. The delivery of the capital programme, in terms of expenditure, was therefore behind its forecast trajectory at the end of the third quarter. There are various reasons for this, which are as follows:

- the York Endoscopy Development has not started the construction stage of work (£3.5m spend was assumed in the 2016/17 capital plan and circa £610K has actually been spent at the end of December 2016),
- the Scarborough Fire Alarm Replacement scheme has, due to its complexity, taken longer to reach the start of the construction phase of project delivery,
- a number of Radiology-related schemes have taken longer to progress through the equipment procurement stage than anticipated, and
- the delivery of estate backlog maintenance schemes has been slower than forecast at the start of the financial year.

A number of capital projects reached the construction phase of project delivery more slowly than forecast at the start of the year: nevertheless a number of them entered the construction phase late in Quarter 3 or are preparing to enter the construction phase at the beginning of Quarter 4 of 2016/17. Consequently expenditure against these projects will increase noticeably in the final quarter of the 2016/17 financial year. For example, the York Hospital Surgical Assessment Unit project was completed just before Christmas, as was the Scarborough Hospital Ambulance Handover Facility scheme, and the expenditure for these schemes has yet to be invoiced. The slow start to some of the projects may be explained as a hangover from the Quarter 4 of the FY 2015-16 financial year, when the Capital Projects Department was asked to slow / defer capital expenditure on 2015-16 projects in order to assist the Trust with protecting the organisation's cash reserves.

At the end of Q3 of the current financial year, nearly £5m had been spent on a variety of current capital projects, including almost £1.4m of expenditure on the Malton Hospital Urology Diagnostic Facility and £1m of expenditure to purchase Tanpit Lodge in Easingwold, which accommodates the Trust's Community Renal Service and which will enable expanded and upgraded accommodation for this important service as well as providing potential for estate rationalisation and associated cost avoidance. The Estates Department was

allocated £1.5m for backlog maintenance schemes in 2016-17 (£750K for Scarborough-based Estates projects and £750K for York-led projects). At the end of Quarter 3 of the 2016-17 financial year, the total spend against the £1.5m allocation was £912K. The Medical Equipment Programme received an allocation of £450K and had spent, up to the end of December 2016, £279K. The SNS Department had, at the end of December 2016, spent a total of £1m against its whole-year capital allocation of £1.6m. The remainder of the expenditure incurred in the financial year to date was related to the approved construction / refurbishment projects, capital programme management (salary capitalisation), fees incurred in relation to Table B and C schemes and fees incurred in relation to the development of the business case for the York Endoscopy Development project.

At the start of the current 2016-17 financial year, the total value of depreciation-funded schemes was roughly £12.9m from a total depreciation-based allocation of £11.7m, which entailed an over-commitment of almost £1.2m. At the end of Quarter 3 of the current financial year, the over-commitment has been reduced to less than £100K.

3. Forecast 2016-17 Outturn

The current forecast outturn expenditure for the 2016-17 capital programme is circa £17m comprised of a combination of spend from the annual depreciation-based capital fund, strategic capital, charitable funding and loan funding. Based on this planned expenditure, there is currently a circa £91K over-commitment of capital. This outturn figure - £17m – would entail that the Trust's capital expenditure in 2016-17 is below the amount of expenditure originally forecast to Monitor and outside of the +/- 15% tolerances allowed by Monitor. Part of the explanation for this is that the Trust's capital expenditure forecasts to Monitor included assumptions about two significant schemes – the York Hospital Endoscopy and Cardio-Vascular / PACU Development schemes – that were relying on sizeable sums of ITFF loan funding to progress and unfortunately the loan funding has not been forthcoming despite the fact that the ITFF has approved the business cases for these two schemes. As already indicated, the slow start to some of the projects in the current financial year may also be explained as a hangover from Quarter 4 of the FY 2015-16 financial year, when the Capital Projects Department was asked to slow / defer capital expenditure on 2015-16 projects in order to assist the Trust with protecting the organisation's cash reserves.

4. Draft 2017-18 Capital Plan

4.1 Available Funding

The funding available to invest in capital projects is split into four categories: depreciation-based funding, strategic funding that was granted to the Trust when it acquired the Scarborough Acute NHS Trust, loan funding from the Independent Trust Financing Facility (ITFF), and charitable funding. In principle, the amount of depreciation-based funding in 2017-18 is £12m. The Trust has allocated circa £8.8m from the remainder of the strategic funding for investment in specific capital projects in 2017-18. There is no fixed amount of charitable funding allocated to capital projects; individual projects have to submit requests to the Charitable Funds Committee for consideration and approval in order to access whatever charitable funds the Trust may have / make available. At present, the Capital Plan for 2017-18 shows charitable funding of £200K has been provisionally allocated to suitable schemes and there is a further £280K allocated to a project to upgrade the main entrance area of Bridlington Hospital and £143K to refurbish space at Scarborough Hospital for Care of the Elderly Services. Similarly, there is no fixed amount of loan funding allocated to capital

projects; the Capital Plan for 2017-18 shows that £2.6m of loan funding has already been obtained to fund the replacement of important radiology equipment in York and Scarborough hospitals. There is also an assumption that the Trust will have obtained £10.5m of the total loan funding from the ITFF for the progression of the York Hospital Endoscopy and Cardio-Vascular / PACU Development schemes. Both of these schemes have Trust Board-approved business cases and were submitted to, and approved by, the ITFF in July 2016 but to date no actual finance has been made available to the Trust subsequent to this approval. New projects may be considered, by the Capital Programme Executive Group initially, for loan funding in 2017-18 but given the NHS' financial position nationally, and the Trust's financial position specifically, it is by no means certain that the Trust will be able to borrow funding from the ITFF to invest in capital projects. Earlier this year, Trusts were issued with the guidance document 'Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21' in which it clearly states the following.

> 'Capital investments proposed by providers should be consistent with their clinical strategy and clearly demonstrate the delivery of safe, productive services with a business case that describes affordability and value for money. Given the constrained level of capital resource available from 2016/17, *there will be very limited levels of financing available and the repayment of existing and new borrowing related to capital investment will need to be funded from within the trust's own internally generated capital resource in all but the most exceptionally pre-agreed cases*. Trusts will need to procure capital assets more efficiently, consider alternative methods of securing assets such as managed equipment services, maximize disposals and extend asset lives. In January [2016], the DH will be issuing some revisions to how the PDC dividend will be calculated and a number of other changes to the capital financing regime.' (my italics).

Members of the Trust's Capital Programme Executive Group have, however, been exploring alternative sources of capital funding for the organisation's capital programme and will ensure the Finance and Performance Committee is made aware of any developments and/or recommendations in relation to external capital funding opportunities.

A summary of the Trust's funding sources for its 2017-18 capital programme is contained in the Appendix 1 below.

4.2 Planned Capital Expenditure in 2017-18

A summary/overview of the Trust's proposed 2017-18 capital plan expenditure is contained in the table in Appendix 2 below. The draft capital plan for 2017-18 shows a proposed expenditure of £11.6m from the Trust's depreciation-based capital funding of £12m. This proposed expenditure is being split between investment in projects and routine capital programme costs (equipment replacement programme, professional fees, staff salaries, minor capital scheme funding and a contingency allocation). The latter totals £2.95m. In addition to this amount, a provisional allocation of £1.5m has been made for investment in the SNS Department's capital investment schemes (IT equipment replacement and infrastructure upgrade / development work) and £2.5m for investment in the Estates Department's backlog maintenance work. Both departments will be expected to bid for funding from this allocation by assembling robust and substantiated and risk-based investment proposals for approval by the Capital Programme Executive Group.

At this stage, then, the capital plan contains an under-commitment of the Trust's depreciation-based capital funding of £363K. The table in Appendix 3 below contains a

detailed schedule of the schemes that are proposed for investment from depreciation-based capital funding in 2017-18.

The planned expenditure from the Trust's Strategic Fund totals £8.8m and is principally focussed on projects to eliminate significant estate-related risks at Scarborough Hospital: namely, the replacement of the site's fire alarm system, the replacement of three lifts that are crucial for the proper movement of patients and equipment around the hospital and the replacement of dilapidated Estates, Facilities and Procurement staff accommodation. In addition to this, the funding has also been allocated to some strategic developments such as the re-development of an operating theatre as a cardiac catheterisation lab, the Scarborough element of the Laboratory Medicine Strategy scheme and the conversion of the main kitchen in Scarborough to a 'receiving' kitchen for food produced at the central catering facility at York Hospital. Some of the Strategic Fund is also being invested in schemes to facilitate the replacement of Radiology Department equipment and the re-provision of some of its services that are currently in unsuitable accommodation. At the end of the 2017-18 financial year, the capital plan currently shows that only £205K of the Strategic Fund will remain unallocated. The planned expenditure of loan funding is £2.6m that has already been secured for replacement of radiology equipment in 2017-18. The capital plan for 2017-18 is assuming £10.5m loan funding for investment in the York Hospital Endoscopy and Cardio-Vascular / PACU Development schemes.

The planned expenditure of charitable funds is £623K, which is comprised of £280K funding to undertake a project to upgrade / refurbish the Bridlington Hospital main entrance area, £143K allocated to a project aimed at creating better facilities for the Care of the Elderly Service at Scarborough Hospital and a further £200K provision that may be allocated to suitable capital schemes.

5. Flexibility

There are three main sources of flexibility in the 2017-18 capital plan. Firstly, there is scope for slippage of schemes, as there is in every year's capital plan. Slippage may allow the Trust to approve more schemes to be delivered using depreciation-based capital funding in the knowledge that some of the approved schemes will slip and consequently the expenditure associated with them will move into the 2018-19 financial year, thereby balancing the planned capital expenditure with the available capital finance.

The second source of flexibility in the 2017-18 capital plan is attached to the £500K contingency funding that has been allocated.

The final source of flexibility is the possibility of obtaining loan funding for suitable projects from outside of the NHS / Department of Health. Members of the Capital Projects Department and the Finance Directorate have already held exploratory meetings with potential lenders with a view to identifying opportunities for obtaining additional capital finance so that we can deliver more of the Trust's estate development objectives than we otherwise could if we were totally dependent on our depreciation-based capital funds. These initial meetings have been very positive.

6. Risks

The main risk to the capital programme in 2017-18 is the potential impact of the Trust's financial position and the pressure on its cash resources in-year, which may require the Capital Projects Department, and other stakeholders, to slow or defer their planned projects until the 2018-19 financial year.

The second main risk in the draft capital programme for 2017-18 relates to the use of Strategic Fund. The proposed capital plan shows that the remaining strategic capital finance will be allocated to a combination of estate backlog maintenance schemes and some strategic developments (e.g. the Scarborough element of the Laboratory Medicine Strategy scheme and the conversion of the main kitchen to a 'receiving' kitchen for food produced at the central catering facility at York Hospital) at Scarborough then the funding will not be available in the future to invest in the major strategic capital schemes to redevelop emergency care and paediatric care facilities. This risk could be mitigated by identifying commercial funding sources for these schemes.

The scarcity of capital finance to invest in new projects is also a risk because it means that there may be insufficient finance to invest in priority TAP-related schemes in 2017-18. There are a number of schemes in Table B of the capital plan for 2017-18 that are fairly well-developed in relation to the project delivery process (i.e. they are in the detailed design stage) and will be shortly seeking approval to move into the construction/delivery phase. There are also a large number of other schemes that are having feasibility-/outline-stage assessments and business cases produced for them that will shortly be seeking approval to move into the detailed design stage. Both of these sets of schemes will bring pressure onto the available capital finance in 2017-18. This risk may, however, also be mitigated via further, more detailed, explorations of commercial funding opportunities (e.g. loans and/or other models of commercial funding).

A further risk is related to the need for continued grip and control over the commitment of capital finance to invest in the external professional services required to take a scheme from a project initiation request to a fully designed and specified proposal with a full capital cost plan. There are a number of schemes in Tables B and C of the capital plan for 2017-18 that are being invested in as far as professional fees are concerned and I would like approval to review the scale and timing of the investment in professional services and fees over the next two financial years as a minimum. The Capital Projects Department's project initiation and prioritisation process will certainly support this review to a large extent and the Business Case Panel is also aware that any initial cases received and approved by the Panel that require capital investment to develop them further may be paused for some time pending the availability of new capital finance to invest in them.

The final risk associated with the proposed capital programme for 2017-18 is that the provision of £2.5m will need to fund allocations to the Estates Department for backlog maintenance projects. In my opinion, this sum may be insufficient to meet the combined demand for capital finance from the Estates Department. This risk is being mitigated currently via work within the Estates and Facilities Directorate to risk assess and prioritise the estate-related backlog maintenance schedule.

7. Recommendations

The Finance & Performance Committee is requested to:

- Note the contents of the above review of the delivery of the 2016-17 capital programme to date.

- The Finance & Performance Committee is requested to endorse the forward capital plan for the 2017-18 financial year, noting the risks and scope for flexibility outlined above.

Author	**Dr Andrew Bennett, Head of Capital Projects**
Owner	**Mr Brian Golding, Director of Estates and Facilities**
Date	**January 2017**

Appendix 1 – Types of Funding Available for Investment in Capital Projects in 2017-18

Type / Source of Funding for Capital Projects	Amount of Funding 2017-18
Depreciation-based	£12m
Trust Charitable Funds	Subject to individual projects / proposals being considered and approved by the Trust's Charitable Funds Committee and the availability of general charitable funds. £200K allocated to schemes in 2017-18. £280K allocated to completion of a project to upgrade / refurbish the Bridlington Hospital main entrance area. £143K allocated to creation of facilities for the Care of the Elderly Service at Scarborough Hospital.
Loan Funding (ITFF)	£2.6m of already-secured ITFF loan funding allocated to the replacement of radiology equipment in 2017-18. £10.5m loan funding assumed – to fund the York Hospital Endoscopy and Cardio-Vascular / PACU Development schemes. Subject to individual projects / proposals being considered and approved for loan funding by the Trust's CPEG and subject to the Trust being able to secure loans from the ITFF.
Strategic Funding	£20m granted to the Trust. £20m received from DH to date. £8.8m allocated to schemes in 2017-18 FY. £205K remaining for allocation / expenditure in 2018-19.
Other	The Capital Projects Department is examining options for further property disposals, which may release capital for re-investment in the Trust's facilities, estate, equipment, IT services.

Appendix 2 – Planned Capital Expenditure in 2017-18

Source of Capital Funding for 2017-18 Capital Projects	Planned 2017-18 Expenditure
Depreciation-based	£11.6m planned expenditure. £363K under-commitment.
Trust Charitable Funds	£623K £200K allocated to schemes in 2017-18. £280K allocated to completion of a project to upgrade / refurbish the Bridlington Hospital main entrance area. £143K allocated to creation of facilities for the Care of the Elderly Service at Scarborough Hospital.
Loan Funding (ITFF)	£2.6m of already-secured ITFF loan funding allocated to the replacement of radiology equipment in 2017-18. £10.5m loan funding assumed – to fund the York Hospital Endoscopy and Cardio-Vascular / PACU Development schemes.
Strategic Funding	£8.8m

Appendix 3 – Detailed Capital Depreciation-Based Expenditure Plan for 2017-18

Project	Amount of Funding 2017-18 £000
York Hospital element of Lab Medicine Strategy Scheme	2,411
Bridlington Additional Operating Theatre	500
IT Network Upgrade	500
YH - Theatre 10 Vascular Imaging Unit	515
E-Prescribing	40
YH Admin Block Refurbishment (Level 5)	500
SGH – Care of the Elderly Facilities (Backlog Maintenance)	157
YH Ritual Washing Facility	64
Routine programme Costs	
Equipment Programme	500
SNS Plan & York /SGH Estates Backlog Maintenance	4,000
Fees (Table B & C Schemes)	500
Capital Staff	500
IT capital staff	450
Minor Schemes Unallocated Budget <£100k	500
Contingency	500
Total Depreciation Funded Schemes	**11,637**

York Teaching Hospital NHS Foundation Trust - 5 Year Capital Plan Forecast - 2017/18

Table A Approved Schemes

A1- Depreciation Funding	2017/18 £,000	2018/19 £,000	2019/20 £,000	2020/21	2021/22
IT Network Upgrade	500				
Theatre 10 to Cardiac/Vascular	515				
York Micro/ Histology integration	2,411	1,016			
BDH Additional Operating Theatre	500				
SGH - Relocate Elderly Medicine clinic/office - Charitable	157				
Ritual Washing Facility	64				
York Admin Block refurb	500				
Grant Aid - E-Prescribing York/SGH	40				
Routine programme Costs					
Equipment Programme	500	500	500	500	500
York /SGH Estates Backlog Maintenance	2,500	2,500	2,750	2,750	3,000
SNS Plan	1,500	1,800	1,500	1,950	1,500
Fees (Table B & C Schemes)	500	500	500	500	500
Capital Staff	500	500	500	500	500
IT capital staff	450	450	450	450	450
Minor Schemes Unallocated Budget <£100k	500	500	500	500	500
Contingency	500	500	500	500	500
A1 Total Depreciation Funded Schemes	**11,637**	**8,266**	**7,200**	**7,650**	**7,450**
Total Available Funds **	**12,000**	**9,301**	**10,051**	**13,500**	**13,500**
Over /under commitment	**363**	**1,035**	**2,851**	**5,850**	**6,050**

****Depn Funding of £12m to be confirmed by Exec Board**

A2 - Strategic Capital Funding					
Radiology Lift Replacement (SGH)	606				
Fire Alarm System (SGH)	790				
SGH Replacement of Estates & Facilities Portakabins	932				
SGH SPECT CT -	2,240				
SGH/MRI	275				
SGH 2nd CT Scanner	216				
SGH Theatre 4	450				
Refurbish body storage/ viewing facilities	800				
SGH Pathology /Blood Sciences	1,251	205			
Roll out cook freeze Patient Catering	1,000				
Bridlington Development	241				
A2. Total Strategic Funded Schemes	**8,801**	**205**	**-**	**-**	**-**
1. Available Funds	**8,801**	**205**	**-**	**-**	**-**
1. Variance	**-**	**-**	**-**	**-**	**-**

A3 - Other Funding					
York Endoscopy Development	9,500	1,500			
Cardiac/Vascular Extension	1,000	7,000	7,160		
Total Schemes Unapproved Loan funded	**10,500**	**16,500**	**24,860**	**10,000**	**-**
Radiology Plan - Equipment Only					
SGH SPECT CT - Equipment only	325				
SGH/MRI - Equipment only	990				
York - Replacement Cardiac/ VIU labs Equipment only	1,250				
Total Schemes Approved Loan funded	**2,565**	**-**	**-**	**-**	**-**
Charitable Funded Schemes					
Charitable Schemes	200	400	200	200	200
SGH - Relocate Elderly Medicine clinic/office - Charitable	143				
Front Entrance Bridlington	280				
Childrens ward Rapid Assesment unit (SCBU) Charitable	-	200			
Total Schemes charitably funded	**623**	**600**	**200**	**200**	**200**
A3. Total Funds Other Sources	**13,688**	**17,100**	**25,060**	**10,200**	**200**
Available Funds	**13,573**	**17,100**	**25,060**	**10,200**	**200**
Variance	**- 115**	**0**	**-**	**-**	**-**

Table A Total	**34,086**	**25,571**	**32,260**	**17,850**	**7,650**
Table A Funding	**34,374**	**26,606**	**35,111**	**23,700**	**13,700**
Total Variance/ expected slippage	**288**	**1,035**	**2,851**	**5,850**	**6,050**

Total Table A + B	**34,086**	**25,571**	**32,260**	**17,850**	**7,650**
Total Funding Table A + B	**34,374**	**26,606**	**35,111**	**23,700**	**13,700**
Variance of Table A+B	**288**	**1,035**	**2,851**	**5,850**	**6,050**

NHS Improvement plan	**34,374**	**26,401**	**35,111**	**25,599**	**13,700**

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Analysis of Capital Funding	2017/18	2018/19	2019/20	2020/21	2021/22
Depreciation Funding	12,000	12,000	13,000	13,500	13,500
Repayment of capital element of loans	-	2,699	- 2,949	-	-
Other unallocated funding source - Sales					
Charitable Funding	623	600	200	200	200

York Teaching Hospital NHS Foundation Trust - 5 Year Capital Plan Forecast - 2017/18

		2017/18	2018/19	2019/20	2020/21	2021/22
Strategic Capital (PDC)		8,801	205	-	-	-
Loan Funding		2,450	-	-	-	-
Loan Funding Not secured		10,500	16,500	24,860	10,000	-
Total	*	**34,374**	**26,606**	**35,111**	**23,700**	**13,700**
Balance of Strategic funding		205	-	-	-	-

York Teaching Hospital NHS Foundation Trust - 5 Year Capital Plan Forecast - 2017/18

Other unallocated funding source - Sales

Table B - Schemes in planning		2017/18	2018/19	2019/20	2020/21	2021/22
1. Master Plan						
BDH Additional Operating Theatre			4,000	9,000	5,500	
SGH - New ED			4,000	8,700	4,500	
Total		**-**	**8,000**	**17,700**	**10,000**	**-**
3. Scarborough/Bridlington						
SGH - Paediatric				1,500	1,500	
Front Entrance Bridlington			220			
SGH Pharmacy Robot				1,000		
Total		**-**	**220**	**2,500**	**1,500**	**-**
4. York						
Childrens ward Rapid Assesment unit (SCBU) Capital	**					
Fire Alarm System (York)		668	668			
Community Stadium (training and MSK outpatients)			1,000			
York combined Contact Centre		400				
Opthalomolgy Development			1,500	1,500		
Total		**1,068**	**3,168**	**1,500**	**-**	**-**
5. Community						
Malton Fire Compartmentation		275	275			
Tanpit Lodge Development		50		601	399	
Total		**325**	**275**	**601**	**399**	**-**
Total Table B - Schemes in planning		**1,393**	**11,663**	**22,301**	**11,899**	**-**

Table C - Schemes under consideration	2017/18	2018/19	2019/20	2020/21	2021/22
Proposed Schemes					
1. Scarborough/ Bridlington					
SGH CCU Relocation - merged with SGH Paed					
Third Endoscopy Treatment Room	500				
BDH Roads & Car Park Resurfacing	720				
Car Park Alterations (Improvements) Phase 3	1,000				
Theatre Storage	650				
SGH Breast Service Expansion	**x**				
Chemotherapy Unit/ Garden	**x**				
SGH Relocation of Physio	**X**				
SGH Maternity Ward Updgrade	**X**				
SGH Ward Security	**X**				
Sale of Beck House	175				
Lawrence Unit refurbishment (BDH)	**X**				
SGH Refurbishment of Springhill	1000				
2. York					
Child Development Centre improvements					
Decontamination Optimisation	1,000				
Ward Block Reconfiguration(inc AAU)	750		250		
SARC	250				
YH ED Asessment	**X**				
OPD improvements - Head/Neck & Max/Fax Lab	**X**				
Dermatology Adaptations	**X**				
Pharmacy Storage of IV's	**X**				
Equipment Library	**X**				
Omnicell Stock System York	**X**				
York - Max Fax reconfiguration					
York - Park House Extention	**x**				
York - Renal Unit Water plant	**x**				
York / Hull Cystic Fibrosis centre	**x**				
York - Development of Colposcopy OU	**x**				
York - Improvements to Labour ward facilities	**x**				
Opthalmology Development	**x**				
3. Community					
Malton Maternity phase 2	**X**				
Tanpit Lodge - Backlog maintenance	**x**				
Total	**6045**	**250**	**0**	**0**	**0**

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors - 25 January 2017

Development of Plastic Surgery Service Business Case (BC 2016/17-37)

Action requested/recommendation

The General Surgery and Urology Directorate are seeking Board of Directors approval for this business case.

Executive Summary

This business case requests funding to expand the plastic surgery service which has historically been provided by a single consultant surgeon based at the York site. The business case requests funding for an additional consultant plastic surgeon and a surgical nurse practitioner. These two posts (along with the associated theatre lists and clinics) would enable the directorate to provide a high quality plastic surgery service to patients located at the York and Bridlington sites as well as an out-reach service in Harrogate. This will attract additional income to the trust and further utilise the Bridlington site to provide elective day case surgery.

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

Implications for equality and diversity

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

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

Reference to CQC regulations

There are no references to CQC regulations

Progress of report	Business Case Panel Corporate Directors Executive Board
Risk	The risks associated with this Business Case are detailed in the report.
Resource implications	Resources implication detailed in the report
Owner	Steve Stojkovic, Clinical Director
Author	Liz Hill, Directorate Manager, Helen Franks, Deputy Directorate Manager
Date of paper	January 2017
Version number	Version 1

APPENDIX Bi

York Teaching Hospital NHS
NHS Foundation Trust

BUSINESS CASE SUMMARY

1. Business Case Number

2016/17-37

2. Business Case Title

Development of Plastic Surgery Service

3. Management Responsibilities & Key Contact Point

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

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

Business Case Owner:	**Steve Stojkovic, Clinical Director**

Business Case Author:	**Liz Hill, Directorate Manager and Helen Franks, Deputy Directorate Manager**
Contact Number:	**01904 725928/6097**

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

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

The Plastic Surgery Service currently provides outpatient clinics, day case and elective surgery for patients at the York locality only which has been delivered by a single consultant surgeon up until April 2015. From April 2015, a locum plastic surgeon has been employed to cope with the growing demand for the service and to enable the service to be delivered across multiple sites. At present, the service is delivered at York and Harrogate hospitals. Harrogate pay for 102.5 PAs (2.5 PAs per week over 41 weeks per year) of consultant time annually to provide outpatient clinics and day case operating at their hospital.

Prior to April 2015, the service experienced a number of 18 week breaches due to lack of capacity. This resulted in a need to deliver the capacity through expensive waiting list initiatives (14 WLI lists undertaken in 2014/15). Capacity issues have improved since the locum plastic surgeon has been in post but due to the temporary nature of the position,

additional clinics and theatres have been provided on an ad hoc basis and so we have been unable to realise the full benefits outlined within this business case. These benefits are:

- Achieve 18 week, 92% incomplete target for Plastic Surgery, Dermatology and Maxillofacial Services
- Maintain achievement of Skin 14 day fast track referral target (93%)

There is a demand for a plastic surgery service at the East Coast. At present, there is a plastic surgery outpatient service provided by Hull and East Yorkshire Trust by visiting consultant surgeons. The Directorate would like to provide this service and offer the patients a local day case operating service at Bridlington which is currently not provided. East Riding of Yorkshire CCG have expressed an interest in a locally provided service as patients are currently travelling to Hull for their operations. The Directorate would be able to provide a high quality, local service for patients on the East Coast if the preferred option in this business case was approved. The business case assumes that York Hospital's market share of East Riding day case activity would increase from 2% (current market share) to 30%. This is following discussion with East Riding of Yorkshire CCG (Gavin Robinson) and based on our market share of other General Surgery work from the East Riding area (e.g. Colorectal, GI and Vascular market shares are 20 – 50%). In addition to new activity coming from the East Riding, this Business case also includes the full year effect of Income/Activity/Costs linked to York's growth in activity (253 inpatients / 471 outpatients / £227k income (included in 2016-17 Plan) & £223k cost) as per the Plastic BC 15-16v1.

Furthermore, a service delivered by a single consultant carries risk which this business case aims to mitigate. With a single consultant delivering the service, we are unable to cover for periods of leave and governance arrangements are not robust. The appointments in this business case enable the Directorate to eliminate those risks to a large extent.

5. Options Considered

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

Description of Options Considered
Option 1 – Do nothing
Option 2 – Appoint Consultant Plastic Surgeon
Option 3 – Appoint Plastic Surgical Care Practitioner
Option 4 – Appoint Consultant Plastic Surgeon and Surgical Care Practitioner

6. The Preferred Option

6.1 Preferred Option

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

The Directorate considered the options based on the following criteria:

- Addresses lone practitioner risk

- Capacity, demand, activity and backlog
- Service provision across the locality

Option 4 is the Directorate's preferred option as it fully meets the criteria set out above.

Option 4 is the only option which allows the Directorate to repatriate activity at the East Coast which is currently being referred to Hull and East Yorkshire Hospitals NHS Trust and at the same time mitigates the risk identified at 6.2. The appointment of a substantive second Consultant Plastic Surgeon (10 PAs) would provide more robust cover arrangements, ensuring that patients are safely cared for 52 weeks of the year.

The preferred option would allow the directorate to deliver a high quality service on the East Coast with the Consultant Plastic Surgeon being assisted by a Band 6 Surgical Care Practitioner (SCP). The SCP will allow the number of patients being seen in clinic to be increased from 12 to 20 and potentially more as the Practitioner's skills develop. This reduces reliance on the junior doctor workforce to which it is difficult to recruit. Conversely, recruitment to Surgical Care Practitioner posts is not challenging and would offer a development opportunity for an existing member of staff.

The additional capacity required would be:

- 1 GA theatre list and 1 LA theatre list per week at York
- 2 outpatient clinics per week at York
- 1 GA theatre list per week at Bridlington
- 1 outpatient clinic per week at Bridlington

<u>Capacity</u>

The consultant plastic surgeon who has been in post since April 2015 has not been able to fully deliver his 10 PA job plan due to lack of theatre lists and clinics. In 2015/16, this resulted in a capacity surplus of 3 PAs. In 2016/17, this resulted in a capacity surplus of 2 PAs. If this business case is approved, the directorate will use these 2 PAs along with the new Surgical Care Practitioner post to bridge the capacity gap of 175 day cases and 1626 outpatients in 2017/18 (please see Summary Analysis of Activity and Capacity for Plastic Surgery attachment for more information).

With the new clinic capacity, we would expect to see fast track patients within 7-10 days. The current wait time is 10-14 days. Urgent patients would be seen within 2 weeks, the current is 3 weeks. Routine patients would be seen within 6 weeks, current polling range is 11 weeks.

We expect to meet 62 day targets and 18 week targets for our patients. This is currently being met and we expect to maintain this.

All clinics and theatre lists are fully utilised and option 4 will ensure that this position is maintained with the new capacity.

<u>Funding</u>

The General Surgery and Urology Directorate have identified 7 PAs from within the current budget, to contribute to the funding of the substantive Consultant Plastic Surgeon Post.

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

Yes	x
No	

Please tick

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

Risk Reg. No.	Risk	Extent		
		Minimally	Partially	Fully
13	Plastic Surgery Service delivered by a single consultant surgeon with no cover for planned or unplanned leave. There is no one to respond to concerns from patients, GP or other members of staff at these times leaving patients vulnerable.			x

Please tick
x1 per risk

6.3 Other Options

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

Option 1 – Do nothing

This option is rejected because the service would return to being delivered by a single consultant surgeon with the risks as outlined above. Furthermore, there is no opportunity for expansion to the East Coast and deliver the service in that area.

Option 2 – Appoint Consultant Plastic Surgeon

This option would eliminate the risk identified at 6.2 but would not provide enough resource to deliver all of the activity which is currently being delivered by Hull and East Yorkshire Trust at the East Coast. The Plastic Surgical Care Practitioner is essential to being able to deliver this activity as the theatre list will run more efficiently and the number of patients seen in clinic can be increased. The Plastic Surgical Care Practitioner will also support the service at York, ensuring that the service can deal with growth in referrals in the future.

Option 3 – Appoint Plastic Surgical Care Practitioner

This option would not adequately address the risks outlined at 6.2. Having a Surgical Care Practitioner as the designated cover for a consultant surgeon who is on leave is not appropriate. In addition, appointing a Plastic Surgical Care Practitioner in isolation, would not allow the service to repatriate the activity on the East Coast.

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

7.1 Alignment with the Trust's Strategic Objectives

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

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

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

Strategic Objective	Aligned? Yes/No	If Yes, how is it Aligned?
Improve quality and safety - To provide the safest care we can, at the same time as improving patients' experience of their care. To measure our provision against national indicators and to track our provision with those who experience it.	Yes	A service provided by a single practitioner is not a safe service as there is no cover for either planned or unplanned leave. By appointing a second substantive consultant surgeon along with a surgical care practitioner, the risk of not being able to provide a service due to unplanned leave is greatly reduced. Furthermore, with these appointments, the Directorate can provide greater assurance that care can be delivered in a timely manner, meeting national and local targets.
Develop and enable strong partnerships - To be seen as a good proactive partner in our communities - demonstrating leadership and engagement in all localities.	Yes	These appointments allow the plastic surgery service to be delivered at both Harrogate and the East Coast. This strengthens our relationship with Harrogate and District Foundation Trust as well as providing a consistent service across the whole of York Teaching Hospital FT patch.
Create a culture of continuous improvement - To seek every opportunity to use our resources more effectively to improve quality, safety and productivity. Where continuous improvement is our way of doing business.	Yes	With the locum consultant appointment, the plastic surgery service has undertaken a series of process mapping exercises in order to reduce wasted time in theatre sessions. This would not have been possible with only the single consultant.
Improve our facilities and protect the environment - To provide a safe environment for staff, patients and	Yes	At the moment, the theatre complex at Bridlington Hospital is underutilised on a Friday. By

visitors, ensuring that all resources are used as efficiently as possible.		providing a plastic surgery service out of Bridlington Hospital on a Friday, the Trust will utilise the resource more effectively.

8. Benefit(s) of the Business Case

8.1 Benefit(s)

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

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

Quality and Safety						
Description of Benefit	**Metric**	**Quantity Before**	**Quantity After**	**At 3m**	**At 6m**	**At 12m**
The appointment of a substantive second Consultant Plastic Surgeon will ensure the provision of robust cover arrangements, ensuring that patients are cared for 52 weeks of the year.	Weeks of the year without Consultant presence	10 weeks without cover (A/L, S/L, NHS leave)	0	0	0	0
Improved patient experience by offering a day-case facility on the East Coast (Bridlington). Patients currently travel to Hull.	FFT	N/A	90% of patients likely or extremely likely to recommend the service	0	90% FFT	90% FFT
How will information be collected to demonstrate that the benefit has been achieved? FFT Timetables						

Access and Flow						
Description of Benefit	**Metric**	**Quantity Before**	**Quantity After**	**At 3m**	**At 6m**	**At 12m**
Reduce routine clinic wait times	Number of weeks	11 weeks	6 weeks	9 weeks	6 weeks	6 weeks
Reduced length of stay on Ward 11 (York) for patients with complex wounds, due to more capacity within the Plastics Team.	Reduce by 0.5 days	Average – 7 days (2015/16)	6.5 days	0	6.75 days	6.5 days

Maintaining achievement of the 92% incomplete target, for the Plastics, Dermatology and Maxillofacial Services	92% incomplete target	At July 2016: Plastics – 95.29% Dermatology – 89.58% Maxillofacial – 83.33%	All services achieving 92% or above	-	-	92% compliance
Maintain achievement of Skin 14 day fast track referral target (93%)	93% target	At July 2016: 87.32%	93% or above	-	-	93% compliance
How will information be collected to demonstrate that the benefit has been achieved? Management information for LOS data Checking target compliance through SIGNAL						

Finance and Efficiency						
Description of Benefit	**Metric**	**Quantity Before**	**Quantity After**	**At 3m**	**At 6m**	**At 12m**
Presence on the East Coast (Bridlington), repatriating outpatient and day case activity currently being undertaken by Hull	Activity	0	362 day cases 470 NP 894 FUP (full year)	0	181 day cases 235 NP 447 FUP	Full year: 362 day cases 470 NP 894 FUP
The appointment of a Surgical Nurse Practitioner (SCP) will increase the number of patients being seen in clinic	No. of patients seen per clinic	12 patients (6N, 6FUP)	20 patients (10N, 10 FUP)	12	20	20
The SCP would be able to undertake outpatient procedures, freeing up Surgeon theatre capacity	No. of cases undertaken by SCP per month	0	5	0	0	5
CIP Contribution	£	£0	£144k	£36k	£72k	£144k
How will information be collected to demonstrate that the benefit has been achieved? **SLAM**						

8.2 Corporate Improvement Team Review

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

Date of Review	18 August 2016
Comments by CIT	Discussion by phone with Gordon Cooney

9. Summary Project Plan

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

of systems, change in business and/or clinical processes, etc. ***All fields must be completed****.*

Description of Action	Timescale	Actioned By
Business Case Panel Discussion	26 September 2016	Liz Hill/Helen Franks
Corporate Directors/Board of Directors Discussions	January 2017	Liz Hill/Helen Franks
Advertise Consultant Plastic Surgeon Post	February 2017	Medical Staffing
Discussions with East Riding of Yorkshire and Scarborough and Ryedale CCGs regarding transfer of activity to YTHFT	February 2017	Liz Hill/Tim Watts
Assessment Centre and Interview	March 2017	Liz Hill/Medical Staffing
Appointment to substantive post	March 2017	Liz Hill/Steve Stojkovic
Advertise Plastic Surgical Care Practitioner Post	April 2017	HR
Interview for Plastic SCP Post	May 2017	Helen Franks
Appointment to Plastic SCP Post	May 2017	Helen Franks
YTHFT provide plastic surgery service on the East Coast	Timescale to be confirmed, following discussions with ERY CCG/SR CCG	Liz Hill/Helen Franks

10. Risk Analysis:

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

Identified Risk	Proposed Mitigation
Inability to recruit to the new posts funded through this business case	Locum consultant in post who will apply for the substantive post and other interested applicants who have contacted the DM and CD. Past experience of recruitment to Surgical Care Practitioner posts has been straightforward so there is no risk
Demand for the service increases to higher numbers of referrals than the levels of activity within this business case	As the Surgical Care Practitioner undergoes further training, this individual will be able to provide more clinic appointment and will (after 2 years of training) be able to do some minor operating. There would be an option to cease the service to Harrogate should the demand increase at Bridlington or York.
Demand for the service decreases to below the projected activity within this business case	Discussions have already taken place with the CCGs regarding transfer of work from HEY Trust to YTHFT and those discussions have been positive. The consultants in post are proactive in speaking to GPs and have a good reputation in the York area which has led to a steady demand for the service. This can be replicated at the East Coast.

11. Risk of Not Proceeding:

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

The risks outlined at section 6.2 would not be addressed if this business case was not approved. The other risk of not proceeding would be that the Directorate would need to stop providing a plastic surgery service at Harrogate Hospital and would never be able to provide the service at the East Coast.

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

Yes	
No	x

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

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

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

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

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

	Before	After
Average number of PAs	11	20
On-call frequency (1 in)	N/A	N/A

Consultant/ Non-Training Grade Doctor Team Work Profile				
Name of Consultant/ Non-Training Grade Doctor	**Working Weeks v 41 Week Requirement**		**PA Commitment**	
	Before	**After**	**Before**	**After**
Tom Macleod	**41**	**41**	**11**	**10**
2nd Plastic Consultant	**0**	**41**	**0**	**10**

Surgeon				

13.2 Executive Job Planning Committee:

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

Date of Approval	N/A
Comments by the Committee	

14. Stakeholder Consultation and Involvement:

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

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

Stakeholder	Details of consultation, support, etc.
Mandatory Consultation	
Corporate Improvement Team	Phone call with Gordon Cooney
Radiology Directorate	Discussed with FM and DM and costs included in BC
Laboratory Medicine	Discussed with FM and DM and costs included in BC
Pharmacy	N/A
AHP & Pyschological Medicine	Discussion with DM and DDM
Theatres, Anaesthetics and Critical Care	Discussed with FM and DM and costs included in BC. Space in theatres and outpatients identified for new theatres and outpatient clinics
Community Services	No consultation required
Other Consultation	
Trauma and Orthopaedics Directorate	Discussion with CD and FM

15. Sustainability

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

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

Will this Business Case:	Yes/No	If Yes, Explain How

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

16. Alliance Working

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

The Business Case allows the Directorate to continue to provide consultant plastic surgeon cover to Harrogate and District NHS Foundation Trust for one day per week. This was only possible with the recruitment of the locum plastic surgeon and would need to cease should this business case not be approved.

17. Impact on the Ambulance Service:

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

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

18. Market Analysis:

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

Each GP practice within East Riding CCG was allocated a target market share of either 5%, 65%, 92% or 100% (based on proximity to Bridlington Hospital), and so potential new activity is defined as the gap between current market share and the achievement of their target market share.

Overall, the BC assumes that York Trust's market share of East Riding day case activity

would increase from 2% (current market share) to 30%, which would result in re-patriation of 362 additional day cases, 470 first attendances and 894 follow ups (assuming current FA/FU ratio of 1.9) at Bridlington Hospital.

Sensitivity Analysis

The Sensitivity Analysis (attached - *I&E Summary position Sensitivity Analysis Plastic BC*) shows contribution for 6 different scenarios, that is 5%,10% and 15% increase and 5%, 10% and 15% decrease in new activity when compared with the original assumptions in the business case (ie. additional activity of 362 inpatients and 1,364 outpatients from East Riding which is currently being sent elsewhere).

The net impact on I&E based on the original BC's assumptions is £144k contribution. This contribution varies slightly (between £137k – the lowest for 15% decrease in activity and £149k – the highest for 15% increase in activity) depending on activity assumptions with regard to activity coming from East Riding - for detail please see the attached sensitivity analysis. This Business Case includes both costs and income associated with the York's growth (253 inpatients & 471 outpatients) to show the full contribution from the Plastic service, despite that activity being included in 16-17 Activity / Income Plans. It is therefore worth highlighting that the costs (pay and non-pay) associated with the existing/York activity remain static in all 6 scenarios, while the overall costs linked with the additional activity coming from East Riding do change depending on the activity change in each scenario. Despite the potential challenge in reducing the staffing costs if / when activity is lower than planned, both Directorates (General Surgery and Urology & Theatres) will endeavour to reduce the staffing costs accordingly as per the Business Panel recommendation/e-mail dated 11.01.17.

19. Financial Summary

19.1 Commissioning Team Review:

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

Date of Review	Discussion with Tim Watts.
Comments by CT	Tim put the Directorate in touch with East Riding CCG and further discussions are required if business case is approved.

19.2 Estimated Full Year Impact on Income & Expenditure:

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

	Baseline	Revised	Change
	£000	£000	£000
Capital Expenditure	0	0	0
Income	36,577	37,175	598
Direct Operational Expenditure	21,044	21,570	526
EBITDA	15,533	15,605	72
Other Expenditure			0
I&E Surplus/ (Deficit)	15,533	15,605	72
Existing Provisions	n/a	72	72
Net I&E Surplus/ (Deficit)	15,533	15,677	144
Contribution (%)	42.5%	42.2%	24.1%
Non-recurring Expenditure	n/a		0

Supporting financial commentary:

The Income / Activity baseline figures reflected in this BC are based on General Surgery Directorate Income / Activity Plan 16/17. This Business case is seeking to gain approval for a permanent appointment of Consultant Plastic Surgeon. This appointment would secure capacity requirement to deal with growing demand for the plastic service across multiple sites as well as re-patriation of patients currently going to East Coast. The BC assumes that York Hospital's market share of East Riding day case activity would increase from 2% (current market share) to 30%, which would result in re-patriation of 362 additional day cases, 470 first attendances and 894 follow ups (assuming current FA/FU ratio of 1.9). Based on 16-17 PbR tariff, this activity would bring a total of £370k (£255k day case & £116k outpatients). In addition, this BC also includes York's additional activity (243 EL, 5 DC, 5 NEL, 193 FA & 278FU & additional income of £227k included in 16-17 Activity/Income Plan) as per the Plastic BC 15-16v1. Total revenue expenditure is £526k (direct surgery costs £216k & support costs £311k). More specifically additional costs relate to a Consultant Plastic Surgeon 10 PAs (£103k), 1 WTE Band 6 Nurse Practitioner (£39k), surgery non-pay costs incl. drugs (£71k), additional theatre costs for providing 1 GA & 1 LA extra theatre list in York and 1 extra GA list in Bridlington (£233k), costs linked to providing 2 additional clinics in York and 1 additional clinic in Brid (£42k), Lab Med/Radiology and domestic costs - £23k and £12k respectively. Profiling of all new activity/ income and support costs non-pay and support services' costs assume to commence from Feb '17. The activity , income & costs asociated with the York's activity are shown in full year terms. Consultant Surgeon's costs are shown in full year terms as well as Directorate's internal funding included in the provisions (£72K - which relates to: reduction in Consultant PAs (2 PAs), Harrogate funded PAs for Plastic SLA (2.5 PAs) and existing vacancy (2.5 PAs). Nurse Practitioner's costs are expected to start from April '17. This BC is resulting in £144k contribution in full year terms (£6k in 16-17).

20. Date of Completion:

17.01.17

York Teaching Hospital NHS
NHS Foundation Trust

BUSINESS CASE FINANCIAL SUMMARY

REFERENCE NUMBER:	2016/17-37
TITLE:	Development of Plastic Surgery Service
OWNER:	Steve Stojkovic, Clinical Director
AUTHOR:	Liz Hill, Directorate Manager and Helen Franks, Deputy Directorate Manager

Capital

	Total	Planned Profile of Change			
		2016/17	2017/18	2018/19	Later Years
	£'000	£'000	£'000	£'000	£'000
Expenditure	0	0	0	0	0

Capital Notes *(including reference to the funding source)*:
There is no Capital Expenditure associated with this Business Case.

Revenue

	Total Change				Planned Profile of Change			
	Current	Revised	Change		2016/17	2017/18	2018/19	Later Years
	£'000	£'000	£'000	WTE	£'000	£'000	£'000	£'000
(a) Non-recurring								
(b) Recurring								
Income								
NHS Clinical Income	36,225	36,823	598		289	598	598	598
Non-NHS Clinical Income	76	76	0		0	0	0	0
Other Income	275	275	0		0	0	0	0
Total Income	**36,577**	**37,175**	**598**		**289**	**598**	**598**	**598**
Expenditure								
Pay								
Medical	7,566	7,669	103	1.00	103	103	103	103
Nursing	8,162	8,201	39	1.00		39	39	39
Other (please list):								
Executive Board & Senior Managers	234	234	0			0	0	0
Administrative & Clerical Staff	1,148	1,148	0			0	0	0
WLIs	369	369	0			0	0	0
Vacancy Factor	-343	-343	0			0	0	0
Theatre Costs (Support costs)		191	191		138	191	191	191
Outpatient Costs (Support costs)		37	37		26	37	37	37
	17,135	**17,505**	**370**	**2.00**	**267**	**370**	**370**	**370**
Non-Pay								
Drugs	854	868	14		7	14	14	14
Medical & Surgical Purchases	3,197	3,254	57		28	57	57	57
Establishment Expenses & Other non-pay	224	227	3		3	3	3	3
CIP	-1,381	-1,381	0		0	0	0	0
Internal SLAs	1,014	1,014	0		0	0	0	0
Other - Support Costs:								
Theatre Costs		43	43		30	43	43	43
Outpatient Costs (Support costs)		6	6		4	6	6	6
Domestics		12	12		6	12	12	12
Lab Med/Radiology		23	23		9	23	23	23
	3,908	**4,065**	**157**		**88**	**157**	**157**	**157**
Total Operational Expenditure	**21,044**	**21,570**	**526**		**355**	**526**	**526**	**526**
Impact on EBITDA	**15,533**	**15,605**	**72**	**2.00**	**-66**	**72**	**72**	**72**
Depreciation			0					
Rate of Return			0					
			0					
Overall impact on I&E	**15,533**	**15,605**	**72**	**2.00**	**-66**	**72**	**72**	**72**
								+ favourable (-) adverse
Less: Existing Provisions	**n/a**	**72**	**72**		**72**	**72**	**72**	**72**
Net impact on I&E	**15,533**	**15,677**	**144**		**6**	**144**	**144**	**144**

Revenue Notes *(including reference to the funding source)*:
The Income / Activity baseline figures reflected in this BC are based on General Surgery Directorate Income / Activity Plan 16/17. This Business case is seeking to gain approval for a permanent appointment of Consultant Plastic Surgeon. This appointment would secure capacity requirement to deal with growing demand for the plastic service across multiple sites as well as re-patriation of patients currently going to East Coast. The BC assumes that York Hospital's market share of East Riding day case activity would increase from 2% (current market share) to 30%, which would result in re-patriation of 362 additional day cases, 470 first attendances and 894 follow ups (assuming current FA/FU ratio of 1.9). Based on 16-17 PbR tariff, this activity would bring a total of £370k (£255k day case & £116k outpatients). In addition, this BC also includes York's additional activity (243 EL, 5 DC, 5 NEL, 193 FA & 278FU & additional income of £227k included in 16-17 Activity/Income Plan) as per the Plastic BC 15-16v1. Total revenue expenditure is £526k (direct surgery costs £216k & support costs £311k). More specifically additional costs relate to a Consultant Plastic Surgeon 10 PAs (£103k), 1 WTE Band 6 Nurse Practitioner (£39k), surgery non-pay costs incl. drugs (£71k), additional theatre costs for providing 1 GA & 1 LA extra theatre list in York and 1 extra GA list in Bridlington (£233k), costs linked to providing 2 additional clinics in York and 1 additional clinic in Brid (£42k), Lab Med/Radiology and domestic costs - £23k and £12k respectively. Profiling of all new activity/ income and support costs non-pay and support services' costs assume to commence from Feb '17. The activity , income & costs asociated with the York's activity are shown in full year terms. Consultant Surgeon's costs are shown in full year terms as well as Directorate's internal funding included in the provisions (£72K - which relates to: reduction in Consultant PAs (2 PAs), Harrogate funded PAs for Plastic SLA (2.5 PAs) and existing vacancy (2.5 PAs). Nurse Practitioner's costs are expected to start from April '17. This BC is resulting in £144k contribution in full year terms (£6k in 16-17).

			Board of Directors Only
	Owner	Finance Manager	Director of Finance
Signed		Sanya Basich	
Dated		10.10.2016	

York Teaching Hospital NHS
NHS Foundation Trust

BUSINESS CASE - ACTIVITY & INCOME

Activity

	Total Change			Planned Profile of Change			
	Current	Revised	Change	2016/17	2017/18	2018/19	Later Years
Elective (Spells)	13,807	14,417	610	308	610	610	610
Non-Elective (Spells)							
Long Stay	5,825	5,830	5	5	5	5	5
Short Stay	1,494	1,494	0				
Outpatient (Attendances)							
First Attendances	15,055	15,718	663	271	663	663	663
Follow-up Attendances	23,862	25,034	1,172	427	1,172	1,172	1,172
A&E (Attendances)			0				
Other (Please List):							
Best Practice Tariff #NOF			0				
			0				

Income

	Total Change			Planned Profile of Change			
	Current £'000	Revised £'000	Change £'000	2016/17 £'000	2017/18 £'000	2018/19 £'000	Later Years £'000
NHS Clinical Income							
Elective income							
Tariff income	14,705	15,125	419	207	419	419	419
Non-Tariff income			0				
Non-Elective income							
Tariff income	16,551	16,572	21	21	21	21	21
Non-Tariff income			0				
Outpatient							
Tariff income	4,969	5,127	157	61	157	157	157
Non-Tariff income			0				
A&E							
Tariff income			0				
Non-Tariff income			0				
Other							
Tariff income	0	0	0				
Non-Tariff income			0				
	36,225	**36,823**	**598**	**289**	**598**	**598**	**598**
Non NHS Clinical Income							
Private patient income	76	76	0	0	0	0	0
Other non-protected clinical income			0				
	76	**76**	**0**	**0**	**0**	**0**	**0**
Other income							
Research and Development			0				
Education and Training			0				
Other income	275	275	0	0	0	0	0
	275	**275**	**0**	**0**	**0**	**0**	**0**

I&E SUMMARY POSITION - SENSITIVITY ANALYSIS PLASTICS BUSINESS CASE								
	Original Business Case	**5% increase in activity**	**10% increase in activity**	**15% increase in activity**	**5% decrease in activity**	**10% decrease in activity**	**15% decrease in activity**	**COSTING ASSUMPTIONS**
INPATIENT ACTIVITY	615	633	651	669	597	579	561	
OUTPATIENT ACTIVITY	1,835	1,903	1,971	2,040	1,767	1,699	1,630	
TOTAL PATIENT ACTIVITY	**2,450**	**2,536**	**2,623**	**2,709**	**2,364**	**2,277**	**2,191**	
INPATIENT INCOME	£440,556	£453,283	£466,009	£478,736	£427,829	£415,103	£402,376	change in income in line with activity growth/decline
OUTPATIENT INCOME	£157,427	£163,225	£169,023	£174,821	£151,629	£145,831	£140,033	change in income in line with activity growth/decline
TOTAL PATIENT INCOME	**£597,983**	**£616,508**	**£635,032**	**£653,557**	**£579,458**	**£560,934**	**£542,409**	
PAY COSTS	£369,602	£376,858	£389,264	£401,670	£362,346	£350,575	£339,337	Please note that this BC also includes the pay costs associated with York's activity (51% and/or £191k of overall pay costs) which remain constant in all scenarios (ie. costs included in this BC, income included in 16/17 plan & NOT this BC). The remaining pay costs have been proportionally increased and decreased in line with the activity increase and decrease respectively. Despite the potential challenge in reducing the staffing costs if/when activity is lower than planned, both Directorates (General Surgery and Urology & Theatres) will endeavour to reduce the staffing costs accordingly as per the Business Panel recommendation/e-mail dated 11.01.17.
NON-PAY COSTS	£156,706	£162,815	£168,923	£175,032	£150,597	£144,489	£138,380	change in non-pay costs in line with activity growth/decline
TOTAL PAY & NON-PAY COSTS	**£526,308**	**£539,673**	**£558,187**	**£576,702**	**£512,943**	**£495,064**	**£477,717**	
IMPACT ON EBITDA	**£71,675**	**£76,835**	**£76,845**	**£76,855**	**£66,515**	**£65,870**	**£64,692**	
DEPN, RATE OF RETURN & INTEREST	**0**	**0**	**0**	**0**	**0**	**0**	**0**	
OVERALL IMPACT ON I&E	**£71,675**	**£76,835**	**£76,845**	**£76,855**	**£66,515**	**£65,870**	**£64,692**	
LESS EXISTING PROVISIONS	£72,102	£72,102	£72,102	£72,102	£72,102	£72,102	£72,102	same provision available in each scenario
NET IMPACT ON I&E	**£143,777**	**£148,937**	**£148,947**	**£148,957**	**£138,617**	**£137,972**	**£136,794**	
cumulative change in I&E position when compared with the original BC		**£5,160**	**£5,170**	**£5,180**	**-£5,160**	**-£5,805**	**-£6,983**	

SUMMARY ANALYSIS OF ACTIVITY / CAPACITY FOR PLASTICS SURGERY

	14-15			15/16	(activity based on Apr-Jun 16) profiled in full year16/17			BC ER (17/18)	17/18 Plan
	Mr MacLeod	Mr Lim	Mr MacLeod	Total	Mr Lim	Mr MacLeod	Total		
TOTAL PLASTIC ACTIVITY - ACTUAL (spells)									
INPATIENTS (EL+DC)	**356**	186	302	**488**	380	228	**608**	**362**	**970**
OUTPATIENTS (FA&FU&PROC)	**785**	708	623	**1,331**	1,180	620	**1,800**	**1,364**	**3,164**

	14-15			15/16			16/17	BC ER (17/18)	17/18 Plan
	Mr MacLeod	Mr Lim	Mr MacLeod	Total	Mr Lim	Mr MacLeod	Total		
TOTAL PLASTIC CAPACTY (spells)	**11 PAs**	**10 PAs**	**8.5 PAs (2.5 PAs Hgte)**	**18.5 PAs**	**10 PAs**	**8.5 PAs (2.5 PAs Hgte)**	**18.5 PAs**		**10 PAs + 8.5 PAs less 1 PA reduction = 17.5 PAs**
INPATIENTS (EL+DC)	**500**	455	386	**841**	455	386	**841**		**795**
OUTPATIENTS (FA&FU&PROC)	**967**	879	747	**1,626**	879	747	**1,626**		**1,538**

	14-15			15/16			16/17	BC ER (17/18)	17/18 Plan
	Mr MacLeod	Mr Lim	Mr MacLeod	Total	Mr Lim	Mr MacLeod	Total		
CAPACITY GAP/SURPLUS (spells)									
INPATIENTS (EL+DC)	**144**	269	84	**353**	75	158	**233**		**-175**
OUTPATIENTS (FA&FU&PROC)	**182**	171	124	**295**	-301	127	**-174**		**-1,626**
CAPACITY GAP/SURPLUS (lists)	**36**	67	21	**88**	19	40	**58**	**0**	**-44**
CAPACITY GAP/SURPLUS (clinics)	**11**	11	8	**18**	-19	8	**-11**	**0**	**-102**
CAPACITY GAP/SURPLUS (PAs - approx)	**1 PA**			**3 PAs**			**2 PAs**		**-3.5 PAs**

PLEASE NOTE:

in 2014-15, based on actual activity seen in 14-15, there was a spare capacity of 1 PA approx (Consultant appointed on 11 PAs).

in 2015-16, P Lim was appointed (on 10 PAs) and Plastic Service started to be provided to Harrogate (2.5 PAs). There is an overall capacity surplus of 3 PAs approx - mainly due to lack of theatre capacity.

in 2016-17 (capacity provided as in 15-16) - there is an overall capacity surplus of 2 PAs approx - all due to lack of theatre capacity.

In 2017-18 Directorate plans to utilise the existing spare capacity 2 PAs (16-17) and appoint a nurse practicioner to bridge capacity gap in 17-18 (175 DC and 1,626 Outpatients).

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 January 2017

Revision of Powers and Scheme of Delegation, Standing Orders and Standing Financial Instructions

Action requested/recommendation

The Board of Directors is asked to consider and approve the revised documents – Standing Orders, Standing Financial Instructions and Reservation of Powers and Scheme of Delegation.

Summary

The Audit Committee reviewed the document at the December meeting and agreed to recommend approval of the documents by the Board of Directors.

The Audit Committee asked for the key changes to be highlighted to the Board.

Reservation of Powers and Scheme of Delegation has been reviewed. The amendments are Monitor being changed to NHSI together with some changes in the scope of delegation on pages 9, 13, 14, 15 and 21.

Standing Orders were amended following discussions about the possible increase in the number of Non-Executive Directors, which was approved by the Board of Directors in August 2016 and the Council of Governors in September 2016.

Standing Financial Instructions have also been reviewed. The amendments are Monitor being changed to NHSI together with some changes to appendix 1 EU Thresholds.

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

This paper supports the overall principles of good governance as laid out in the Well-Led Framework and the Code of Governance

Progress of report	Audit Committee
Risk	Associated risks have been assessed and identified.
Resource implications	There are no resource implications.
Owner	Board of Directors
Author	Lynda Provins, Foundation Trust Secretary
Date of paper	January 2017

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: January 16
Version: 10
Approved By: Audit Committee and Board of Directors
Review date: December 2016

Table of content

Reservation of Powers to the Board of Directors and Delegation of Powers

Introduction

The NHS Foundation Trust Code of Governance requires that there should be a formal schedule of matters specifically reserved for decision by the Board of Directors. This document sets out the powers reserved to the Board of Directors and the Scheme of Delegation including financial limits and approval thresholds. Notwithstanding any specific delegation, the Board of Directors remains accountable for all of its functions, including those which have been delegated. Therefore the Board of Directors 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 or other Executive Directors. 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.

Purpose

1.1 The purpose of this document is to define the control framework set by the Board for committing trust resources. The Board reserves certain matters to itself which are set out in the Schedule of Matters Reserved to the Board. The Scheme of Delegation identifies which powers and functions the Chief Executive shall perform personally and those which he has delegated to other Directors and Officers.

1.2 All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise. In the absence of the Chief Executive the powers of the Chief Executive are delegated to the Deputy Chief Executive.

1.3 The Scheme of Delegation shows only the top level of delegation with the Trust. The Scheme is to be used in conjunction with the Trust's Standing Orders, Schedule of Matters Reserved to the Board, Standing Financial Instructions including the system of budgetary control and other established policies and procedures within the Trust.

1.4 In the absence of a director or officer to whom powers have been delegated those powers shall be exercised by that Director of Officer's superior unless alternative arrangements have been approved by the Board. If the chief Executive is absent, powers delegated to him may be exercised by the Director who has been duly authorised to act up for him taking appropriate advice from the Chairman.

Scope

2.1 To ensure that all staff, particularly budget managers and authorised signatories are aware of their authorities and responsibilities for compliance with the relevant procedures.

2.2 The Scheme of Delegation is consistent with the NHS Code of Conduct and Accountability and Monitor's Code of Governance. Directors and Officers are reminded

that powers are delegated to them on the understanding that they would not exercise delegated powers in a manner which in their judgement was likely to be a cause for public concern. The Code of Conduct of Accountability in the NHS and the Code of Governance sets out the core standards of conduct expected of NHS managers.

2.3 Provide details of delegated limits to all officers holding responsibilities. Budget Holders agree to operate within the budget limit and within the delegated limits as outlined in this document. It is their responsibility to manage within their budget and to identify any changes to the budget assumptions surrounding activity, timing and staffing issues which may result in changes to financial risk. If a proposed transaction is beyond their authority and outside the Annual Plan, it should be referred to their manager. Failure to do so may result in disciplinary action.

2.4 The document forms part of the Trust's corporate governance framework, which is the regulatory framework for the business conduct of the Trust within which all Trust officers are expected to comply. The aim is not to create bureaucracy but to protect the Trust's interests and to protect staff from any accusation that they have acted less than properly. It does this by ensuring that all staff, particularly budget managers and authorised signatories are aware of their authorities and responsibilities for compliance with the relevant procedures. The key documents in this framework include the following and should be read in conjunction with the Reservation of Powers by the Board of Directors and Delegation of Powers:

- Standing Orders.
- Standing Financial Instructions

Principles of the Scheme of Delegation

3.1 Principles that are followed by the Scheme of Delegation

- There is no spend beyond authorised limits except with the approval as appropriate
- The business case process is mandatory.

Governors' legal responsibilities

4.1 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 accounts annual 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

Scheme of matters reserved for the Board

5.1 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, subject to any restrictions contained in the Trust's Constitution and/ or terms of the Licence.

5.2 Constitutional Powers

- To exercise all powers of an NHS foundation trust set out in the NHS Act 2006, subject to any restrictions in the Trust's Licence; enforcement undertakings given to regulators or as delegated in accordance with this Scheme of Delegation. (Constitution paragraph 4)
- Determine the composition of the Board of Directors (Constitution paragraph 9)
- Make available for inspection by members of the public the following: register of Members; register of members of the Council of Governors; register of interest of members of the Council of Governors; register of members of the Board of Directors; register of interests of members of the Board of Directors; Constitution; Licence; latest Annual Accounts and Auditor's report on them; latest Annual Report and Forward Plan; and any notice issued by the Monitor under Section 52 of the NHS Act 2006.
- Appoint the Returning Officer
- Approve payment of expenses and remuneration to Returning Officer
- Make available for inspection by members of the public statements of nominated candidates and nomination papers.
- Approve and deliver to the Returning Officer a list of Members eligible to vote
- Retain documents relating to elections to the Council of Governors and make these for inspection by members of the public, subject to any restriction in the Election Rules.
- Approve proposals to amend the Constitution which must be approved by the Council of Governors.
- Specify Partnership Organisations
- Receive and determine disputes under the Constitution, including disputes between the Council of Governors and the Board of Directors.
- Present Annual Accounts, any reports of the Auditor on them and the Annual Report at the Annual General Meeting.
- Prepare the Annual Report
- Prepare the Forward Plan

5.3 Regulation and controls

- Approval, suspension, variation or amendment of Standing Orders, Reservation of Powers and Delegation of Powers and Standing Financial Instructions for the regulation of its proceedings and business
- Approval of the Reservation of Powers and Delegation of Powers 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 establish terms of reference and reporting arrangements of all committees established by the Board of Directors
- 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
- 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
- Approval of arrangements relating to the discharge of the Trust's responsibility as a corporate trustee for funds received in trust and Funds Held on Trust
- Approval of the Trust's banking arrangements (SFI 5.2)
- Authorise use of the common seal of the Trust (SO10)
- Ratify or otherwise instances of failure to comply with Standing Orders (SO3.13)
- Discipline members of the Board of Directors or Officers who are in breach of statutory requirements or Standing Orders
- Call meetings of the Board of Directors (SO3.1)
- Resolve to require withdrawal of the press and public from meetings of the Board of Directors
- Approve minutes of the proceedings of the meetings of the Board of Directors (SO 3.12)
- Resolve to adjourn any meeting of the Board of Directors

5.4 Appointments/ Dismissal

- The appointment and dismissal of Board Committees
- The appointment of the Vice Chairman in consultation with the Council of Governors
- 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

5.5 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.

5.6 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 annually Trust budgets (SFI 3.1.1)
- Approve final business cases for the use of private finance for capital schemes (SFI 10.2)
- Approve proposals for action on litigation against or on behalf of the Trust
- Review use of NHSLA risk pooling schemes, commercial insurers and self-insurance (SFI 18.3)

5.7 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
- Purchase and maintain insurance against liability.
- Approve opening and closing of any bank or investment account (SFI 5.1.3)
- Approve proposals for action on litigation against or on behalf of the Trust

5.8 Financial and reporting management 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

Summary of Delegated Authorities

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. All reference material is available from staffroom

General Area	Delegated matter	Authority delegated to	Scope of Delegation	Details/ Reference
Accountability	Accountable through NHS Accounting Officer to NHS Improvement for the stewardship of Trust Resources	Chief Executive	Full	Accountable Officer Memorandum
	Ensure the expenditure by the Trust complies with NHS Improvement requirements	Chief Executive	Full	Accountable Officer Memorandum
	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		
	Delivery of the Turnaround Avoidance Programme – Delivering Success	Chief Executive		
Declaration of Interests	The keeping of a declaration of board members and officers' interests	Foundation Trust Secretary		SO 6
Receipt of Gifts and Hospitality	Receipt or provision of hospitality and gifts	All Trust employees have a duty to declare		Standards of business conduct policy
	Approve procedures for declaration of hospitality and sponsorship	Board of Directors		
	Maintenance of gifts and hospitality register	Foundation Trust Secretary		
	Approval of receipt of both individual and collective hospitality	Prime budget holder		
Financial Procedures and Trust	Approve and communicate all financial procedures and Trust accounting policies	Finance Director Audit Committee	All	FReM and NHS Improvement

accounting policies				guidance SFI 1.1.3
Asset Register	Maintenance of the asset Register	Deputy Head of Corporate Finance	All	SFI 10.3
Investment of funds	Investments – Annual programme agreed by the Board of Directors	Finance Director	All	Treasury Management Policy
Capital Investment and Business Cases		Capital Programme Executive Group	Up to £100k	SFI 10
		Chief Executive & Finance Director through Capital Programme Management Group	£100k-£500k	
		Executive Board	£500k - £1m	
		Board of Directors	Over £1m and all PFI proposals	
All Business Cases revenue investment	Captured in the business cases (Any expenditure over £25k must be advertised under procurement rules. Further advice should be sought from procurement)	Prime budget holder	Up to £50k	
		Chief Executive	£50k - £500k	
		Executive Board	£ 500k-£1m	
		Board of Directors	Over £1m and all PFI proposal	
Expenditure variations on capital schemes	Variations	Capital Programme Management Group	Up to 10k	SFI 10
		Chief Executive and Finance Director through Capital Programme Executive Group	Up to £500k	
		Executive Board	£500k-£1m	
		Board of Directors	Unlimited	
Planning & Budgetary	Prepare and submit an Annual Plan	Finance Director		SFI

Control	Management of budgets for the totality of services	Chief Executive		SFI
	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
	Virement (planned transfer) of resources between directorate or specialty/department budgets (per annum):	Finance Director		SFI Trust Finance Manual Section 8.2.3
	Non pay requisitions – Decisions to rent or lease in preference to outright purchase	Head of Corporate Finance		SFI
	Authority to change clinical template activity	Chief Operating Officer and Finance Director		
Non-pay revenue expenditure within budgets (Note: over £50K the Business Case procedure shall apply)		Prime budget holder (if within available budget resources as agreed with the Finance Director)	Prime budget holders are expected to set delegated limits for delegated budget holders and advise the Head of Corporate Finance for inclusion in	SFI Trust Finance Manual Section 5.2 Section 8.2.1

			the authorised signature list	
	Medical equipment (i.e. medical, scientific, technical and x-ray equipment) – individual items. Funding to be managed within Capital Programme allocation	Medical Equipment Resource Group (MERG)	over £1k and up to £50K supported by a MERG Form	
	Establishment of escalation facilities at short notice and associate costs	Chief Operating Officer		
	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 9.2.6(e)
	Purchasing Cards: Authority to issue purchasing cards and setting of limits	Head of Corporate Finance		
Quotations, Tendering and Contracts	Obtaining a minimum of 3 written competitive tenders for goods/services over £25K	Head of Procurement	Over £25k	
	Waiving of quotations and tenders subject to SFIs and SOs (including approval of single tenders)	Head of Procurement Chief Executive and Finance Director	Under £50k Over £50k	SFI 9.5
	Opening tenders – manual	All Executive Director and the Foundation Trust Secretary		SFI 9.5
	Opening tenders – electronically the system prevents quotes/tenders from being opened before the deadline	Head of Procurement		
	Acceptance of quotations/ permission to consider late quotations	Head of Procurement	Under £50k	

	Acceptance of tenders/permission to consider late tenders	Chief Executive	Over £50k	SFI 9.5
	Accepting contracts and signing relevant documentation	Head of Procurement Chief Executive and Finance Director	Under £50k Over £50k	
Attestation of sealing in accordance with standing orders	Attestation of sealing	Chairman or designated NED and Chief Executive or designated Executive Director	All	SO10
	The keeping of the seal	Foundation Trust Secretary		
Insurance policies	Insurance	Head of Corporate Finance		
	Review of all statutory compliance legislation and Health and Safety requirements including Control of Substances Hazardous to Health Regulations	Health and Safety Manager		
Bank accounts and loans	Loan arrangements	Finance Director		SFI 5
Petty cash disbursements	Expenditure	Petty cash holder	Up to £50 per item	
		Finance Director	Over £50 per item	
	Reimbursement of patient monies	Delegated budget holder	Up to £250	
		Prime budget holder	Over £250	
Property transactions	Disposal and acquisition of land and buildings	Chief Executive, Finance Director Capital Programme Executive Group	Up to £500k	SFI
		Executive Board	£500k - £1m	
		Board of Directors	Above £1m	

	Lets and Leases			
	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		
Setting of Fees and Charges	Private patient, overseas visitors, income generation and other patient related services	Finance Director		SFI 6.2.3 Provider Licence
	Financing content of NHS contracts	Finance Director		
	Approval of healthcare contracts and other agreements resulting in income to the Trust	Finance Director		
	Approval of variations of healthcare contracts:	Finance Director		
Losses and compensation	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	Audit Committee		SFI
	Maintain a losses and special payments register	Finance Director		SFI
	Clinical Cases	Settled by NHS Litigation Authority		
	Non-clinical cases	Finance Director	Up to £150k	
		Chief Executive	£50k - £500k	

		Executive Board	£500k-£1m	
		Board of Directors	Over £1m	
	Review schedules of losses and compensations and make recommendations to the Board	Audit Committee		
	Special payments – outside the terms of any contract obligation	Treasury approval		
Condemning and disposal - Equipment	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 Disposal and Transfer policy
Provision of services to other organisations	Legal and financial arrangements for the provision of services to other organisations and individuals	Director of Finance		SFI 6.2.3
	Signing agreement with other organisations and individuals			
Audit and Accounts	Approve the appointment and where necessary dismissal of the External Auditors	Council of Governors		SFI 4
	Receive the annual management letter from the External Auditor.			
	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		
	Receive an annual report from the Internal Auditors and agree action	Audit Committee		
Annual Report and Accounts	Receive and approve the Annual Report and Accounts and Quality Report	Board of Directors		SFI 4
	Receive the Annual Report and Accounts and Quality Report	Council of Governors		

	and any comments on them at the Annual General Meeting			
	Sign the annual statements including the annual accounts on behalf of the Board of Directors	Chair, Chief Executive and Finance Director		
	Implementation of internal and external audit recommendations	Finance Director		SFI 2.2
Retention of Records	Maintaining archives of records to be retained	Chief Executive		SFI 17
Research and development	Approval of research and development contracts to be supported by a business case including workforce implications (including variations or extensions):	Medical Director or Finance Director or Chief Executive	Up to £500K	
		Executive Board	£500k -£1m	
		Board of Directors	£1m and over	
Personnel and Pay	Approve management policies including personnel policies incorporating arrangements for the appointment, removal and remuneration of staff	Chief Executive		
	Authorisation of timesheets (including agency timesheets)	Delegated budget holder		
	Agency nursing staff	Chief Nurse's Office		
	Authority to fill funded post on the establishment with permanent staff	Chief Executive		SFI 3.3
	Authority to appoint staff to post not on the formal establishment	Chief Executive		SFI 3.3
	Granting of additional increments to staff within the context of policy (HR process up to 2 incremental points	Deputy Director of Workforce	All subject to compliance with A4C regulations	SFI 3.3
	Above policy level	Chief Executive		
	Chief Executive and Director posts including Corporate and Executive Directors	Remuneration Committee Chairman of the Trust as Chair of the Remuneration Committee		

	Non-executive Directors and Chair	Council of Governors		SO 2.2
	Upgrading and re-grading Subject to compliance with regulations	Deputy Director of Workforce		SFI 3.3
	Variations to existing consultant contracts/job plans Subject to compliance with regulations	Medical Director Deputy Director of Workforce and Chief Operating Officer		
	Authorising overtime	Delegated Budget Holder		SFI 8.4.3
	Authorising travel and subsistence	Delegated Budget Holder		
	Authority to pay clinical excellence awards to Consultants	Board of Directors endorse decision of Committee chaired by the Chief Executive or Deputy Director of Workforce		
	Authority to pay discretionary points to staff grade and associate specialist doctors	Medical Director and Deputy Director of Workforce		
	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 the Trust's circumstances and performance and to the provisions of any national arrangements for such staff	Remuneration Committee		
	Approval of annual leave	Delegated budget holder		Annual Leave and Bank Holiday Policy and Procedure
	Annual leave – approval of carry forward			
		Delegated budget	Up to a	

		holder	maximum of 5 days:	
		Over 5 days:		
		Medical Director	Medical Staff	
		Prime budget holder	Other Staff	
	Approval of compassionate leave			Special Leave Guidance
		Delegated budget holder	Up to 5 days	
		Prime budget holder in consultation with HR	Up to 10 days	
	Special leave			Special Leave Guidance
		Delegated budget holder	Paternity	
		Delegated budget holder	Other	
		Delegated budget holder	Maternity leave	
		Delegated budget holder	Leave without pay	
		Chief Executive	Medical staff leave of absence – paid and unpaid	Special Leave Guidance
		Prime budget holder	Time off in lieu	Special Leave Guidance
		Delegated budget holder	Flexible working arrangements	Flexible Working Policy
		Deputy Director of Workforce	Extension of sick leave on half pay up to three months	Sickness Absence Policy

		Deputy Director of Workforce	Return to work part time on full pay to assist recovery	
	Study Leave			
		Clinical Director	Study leave outside the UK – medical	Learning Leave Guidance
		Prime budget holder	Study leave outside the UK – other	
		Clinical Director Delegated budget holder	Medical staff study leave (UK)	
		Delegated budget holder	All other study leave (UK)	
	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
		Prime Budget Holder Finance Director	up to £6,000 (non-medical staff)	
		Chief Executive Medical Director Finance Director	up to £6,000 (medical staff)	
		Chief Executive Medical Director Finance Director	£6,000 - £8,000	
		Chief Executive	Over £8,000	
	Requests for new posts to be authorised as car users or mobile phone users	Prime budget holder		Lease Car and Mobile Communication Equipment Policies

	Renewal of fixed term contracts Must be linked to business needs and available funding	Prime budget holder Deputy Finance Director		
	Authorisation of retirement on the grounds of ill health.	Deputy Director of Workforce (the decision can only be made by the NHS Pensions Agency)		
	Authorisation of staff redundancy	Chief Executive Finance Director		Redundancy Policy
		Finance Director (with HM Treasury approval where required)	Any termination settlement	
	Authority to suspend (non clinical) staff	Prime budget holder Deputy Director of Workforce		Disciplinary Policy and Procedure
	Authority to exclude clinical staff	Chief Executive		
	Authority to restrict practice	Chief Executive		MHPS guidance
	Authorisation of staff dismissal	Anyone reporting directly to a Director e.g. Directorate Manager/Head of service (or delegated deputy),Senior Nursing Team		
	Engagement of staff not on the establishment supported by a business case	Corporate Directors		
	Booking of bank and agency staff			
		Prime budget holder	Medical Locums	
		Prime budget holder and through the Chief Nurse's office	Nursing	

		Prime budget holder	Clerical	
Facilities for staff not employed by the Trust to gain practical experience	Professional recognition, honorary contracts and insurance of medical staff, work experience students	Deputy Director of Workforce and Medical Director		
Security and risk management	Corporate responsibility for implementation of the Security Policy	Director of Estates and Facilities		Security Policy
	Overall statutory responsibility for security management within the Trust	Chief Executive		
	Where an offence is suspected	Head of Security	Criminal offence of a violent or clinical nature	
		Head of Security (theft)/ Local Counter-Fraud Specialist (fraud)	Where a fraud or theft is involved	
	Authority for the issue of ID and security badges and car park passes	Delegated budget Holder		Security Policy ID Badge policy
Authorisation of new drugs	Yearly cost of drugs	Directorate managers Chief Pharmacist	Estimated total yearly cost per individual drug up to £25,000	
		DTC recommendation, subject to business case procedure and Executive Board approval	Estimated total yearly cost per individual drug above £25,000	
	Authority to purchase/contract:			
		Senior Technician	Up to £5K	

		Countersigned by Principal Pharmacist	£5K - £50K	
		Countersigned by Chief Pharmacist	£50K - £100K	
		Finance Director	£100K to £150K	
		Chief Executive	£150K to £500K	
		Executive Board	£500K - £1m	
		Board of Directors	Over £1m	
	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
Patients and relatives' complaints	Overall responsibility for ensuring that all complaints are dealt with effectively	Head of Patient Experience		Concerns and Complaints Policy and Procedure
	Responsibility for ensuring complaints relating to a Directorate are investigated thoroughly	Head of Patient Experience		Concerns and Complaints Policy and Procedure Complaints Policy
	Agreement of financial compensation	Finance Director		Losses procedure
Extra Contractual Payment	Authority to undertake and approval to pay waiting list initiatives	Finance Director or Chief Operating Officer		
Engagement of Trust's Solicitors		All Directors, Foundation Trust Secretary, Deputy Director of Healthcare Governance ,		

		Head of Procurement		

Annex 5

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.

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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.

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"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

7 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)
- three other Executive Directors.

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
- Corporate Risk Committee
- Environment and Estates 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:	**Head of Corporate Finance**
Owner:	**Andrew Bertram, Finance Director**
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CONTENTS

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 NHS Improvement, the Independent Regulator of NHS Provider Trusts**

"**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.

"**Legal Adviser**" means the properly qualified person appointed by the Trust to provide legal advice.

"**NHS Improvement**" means the Independent Regulator of NHS Provider 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 NHS Improvement.

"**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 Teaching Hospital 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 Clinical Audit, 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;

(f) approval of non-audit services by External Audit.

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;

(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.

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.

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.

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 Council of Governors from an approved list recommended by the Audit Committee 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 NHS Improvement.

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:

(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 in accordance with the Budget section of the Trust Finance Manual.

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;

(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.

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. NHS Improvement.

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 NHS Improvement with the approval of HM Treasury.

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 NHS Improvement FT Annual Reporting Manual (FT ARM).

5 BANK 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 NHS Improvement guidance/directions.

5.1.2 The Board of Directors shall approve the banking arrangements.

5.2 Bank 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 Audit Committee, 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.

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 Monitor's guidance 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 all services provided to other organisations and individuals.

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 NHS Improvement
- 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 for Health and Care 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.

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) determine the appropriate remuneration and terms of service for the Chief Executive, and Corporate Directors employed by the Trust 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) determine the terms of service for the Chief Executive, and Corporate Directors 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;

(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 Board of Directors will after due consideration and amendment if appropriate approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees not covered by the Committee.

8.1.4 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.

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 Deputy Director of Workforce.

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 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.

(c) The hire of agency staff and locums must comply with the guidelines laid out in the Reservation of Powers and Scheme of Delegation

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 Deputy Director of Workforce);

(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 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.

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 Deputy Director of Workforce 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 Reservation of Powers and Scheme of Delegation.

9.1.2 The Chief Executive, as the accountable officer, will determine:

(a) prime budget holders 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 Corporate 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).

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health/NHS Improvement. For 2016-17 Monitor determined the threshold for this to be £50,000.

(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) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(h) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(i) changes to the list of directors/employees and officers authorised to certify invoices are notified to the Finance Director;

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 Procure 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 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. Responsible officers must follow the single tender action guidance available from the Procurement Department. 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 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, in line with the limits set out in the Reservation of Powers and Scheme of Delegation, 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 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:

(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 NHS Improvement 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;

(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.

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 and in accordance with the Reservation of Powers and Scheme of Delegation, 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. 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.

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 Audit Committee shall receive a report of losses and Special Payments. 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.

12.2.6 For any loss, the Finance Director should consider whether any insurance claim could be made.

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 Treasury.

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 NHS Improvement 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.

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.

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.

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.

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 NHS Improvement .

18.3 The Board of Directors shall review insurance arrangements for the Trust.

APPENDIX 1

EU Thresholds

	Supply, Services and Design Contracts	Works Contracts	Social and other specific services
Central Government (inc Non-FT Trusts)	£106,047 €135,000	£4,104,394 €5,225,000	£589,148 €750,000
Other contracting authorities (FT Trusts)	£164,176 €209,000	£4,104,394 €5,225,000	£589,148 €750,000
Small Lots	£62,842 €84,000	£785,530 €1,000,000	n/a

Time Limits (Minimum Timescales

MINIMUM TIME	IF ELECTRONIC TENDER PERMITTED	IF URGENT	WHERE PIN PUBLISHED*
Open Procedure (1 stage progress) Minimum time limit for receipt of tenders: 35 days	Minimum time limit for receipt of tenders: 30 days	Minimum time limit for receipt of tenders: 15 days	Minimum time limit for receipt of tenders: 15 days
Restricted Procedure (2 stage process) Minimum time limit for requests to participate: 30 days	-	Minimum time limit for requests to participate 15 days	Minimum time limit for requests to participate 30 days
Minimum time limit for tenders: 30 days	Minimum time limit for receipt of tenders: 25 days	Minimum time limit for tenders: 10 days	Minimum time limit for tenders: 10 days
Competitive Negotiated Procedure/ Innovation Partnerships Minimum time limit for requests to participate: 30 days		Minimum time limit for requests to participate: 15 days	Minimum time limit for requests to participate: 30 days
Minimum time limit for initial tenders: 30 days	Minimum time limit for receipt of initial tenders: 25 days	Minimum time limit for tenders: 10 days	Minimum time limit for tenders: 10 days
Competitive Dialogue Minimum time limit for requests to participate: 30 days No explicit time limits for submission of initial/subsequent tenders			

Help choosing the right procedure

The choice of procedure requires a careful balancing act. Often, you may be able to use an existing framework agreement but, if not, then the open procedure or the restricted procedure is often the most appropriate. The table on the next page indicates some of the key considerations.

For any uncertainty, or for further guidance on which procedure is likely to be appropriate for your needs please ask any questions via purchasingenquiries@york.nhs.uk and we'll do our best to help.

	Open procedure	*Restricted procedure*	*Competitive dialogue OR Competitive procedure with negotiation*	*Dynamic purchasing system*	*Innovation partnerships*
Few bidders expected	✓	(✓)	✓	✓	✓
One-off purchases	✓	✓	✓	✗	✓
Low cost/effort to bidding	✓	✓	✗	(✓)	✗
Commodity products	✓	(✓)	✗	✓	✗
Adaptation of available	(✗	(✓)	✓	(✗)	(✓)
Frequent similar purchases	✓	(✓)	✗	✓	✗
Many bidders expected	✗	✓	✓	(✗)	✓
Complex projects	(✗	(✓)	✓	✗	✓
Research and development needed	✗	✗	✓	✗	✓
Specification cannot be set	✗	✗	✓	✗	✓

NHS Guide to Procurement, Foot Anstey LLP, 2015

Key: ✓ Yes, ✗ No, (✗) means probably not, (✓) means probably yes.

York Teaching Hospital NHS Foundation Trust

Board of Directors – 25 January 2017

Environment & Estates Committee meeting minutes

Action requested/recommendation

The Board of Directors is asked to receive the minutes of the Environment & Estates Committee meeting held on 6 December 2016 noting the assurance taken from these discussions and the key items that have been highlighted for the attention of the Board.

Summary

The purpose of the Committee is to receive assurance and to provide challenge and scrutiny around environment and estates matters within the Director of Estates & Facilities areas of responsibility.

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 this paper is not likely to have any particular impact upon the requirements of, or the protected groups identified, by the Equality Act.

Reference to CQC outcomes

CQC outcome regulation 15: premises and equipment.

Progress of report	Prepared for presentation to the Board of Directors.
Risk	None
Resource implications	None
Owner	Michael Sweet, Non-executive Director and Chair of the Environment & Estates Committee
Author	Brian Golding, Director of Estates & Facilities
Date of paper	January 2017
Version number	Version 1

Environment & Estates Committee Meeting – 6.12.16

York Teaching Hospital NHS
NHS Foundation Trust

Attendees: Mike Sweet (MS) (Chair), Jennie Adams (JA), Brian Golding (BG), David Biggins (DB), Colin Weatherill (CW), Jane Money (JM), Jacqueline Carter (JC)

In Attendance: Carol Birch (CB) (for item 8.)

	Agenda item	AFW /CRR	Paper	Comments	Assurance	Attention to Board
1.	**Apologies for absence.**			Lynda Provins, Foundation Trust Secretary.		
2.	**Directorate Risk Register**			CW presented the revised Directorate Risk Register (DDR) to the EEC. To complement the documentation he explained there is an electronic record keeping file path in place that provides a library of previous risk registers and a log of any action taken against a risk which provides an evidence trail. The revised DRR had been set out in such a way that it shows corporate risks first followed by directorate risks in priority order, with an additional column added to identify which E&F meeting group is responsible for overseeing the management of the risk and the frequency it should be discussed. CW said every month he would be reviewing the RR. The following risks were discussed: EF01 – Estates capital availability – JA asked whether this had arisen because we do not have the capital to undertake the maintenance or whether it was because we cannot progress the master plan? BG confirmed it was both; he said the Trust was focussing on backlog maintenance work however, this was leaving the Trust with little opportunity for development. He suggested that this risk should be reviewed again as a 6 facet (condition) survey was due to be undertaken next year which DB		This is the first edition of the EEC's consolidated Risk Register. Issues arising are: Limited capital and fire alarm systems.

				was overseeing. The recommendations arising from the survey would feature in the capital plan and at that point he could be confident it was being managed. BG assured the Committee this was a high priority and as E&F worked through the different aspects of the survey we might identify some elements that were a corporate risk. This was noted. EF02 – Estates ageing fire alarm system, equipment failure – JA felt this could be a regulatory issue. BG confirmed it was although he assured the Committee that we have a good understanding of the issues; a 5yr capital programme development paper was due to be presented to the BoD early next year which included the fire alarm upgrade. CW explained that the fire alarm was classed as a high risk as parts were becoming obsolete but a plan had been worked up for an April start; we had not let the contract out due to lack of capital availability. This was noted. EF06 – A chiller unit has failed in ICU – CW confirmed awaiting confirmation of funding for replacement. MS and JA confirmed they liked the format of the revised RR as it prioritised the risks and fitted with the performance assurance model. DB said it also complemented the PAM E&F Procedure model that was approved at the last meeting. BG was confident that E&F have a suite of documents that now support each other that his team were using. MS asked the Committee whether there were any amber ratings that they wished to escalate / discuss further: JMo asked about EF05 climate change. The CRG has suggested that E&F have their own Sustainable Development RR as the topic is too broad and not specific enough to be managed at the corporate level. CW said it would be important to understand who would be responsible for such a register and what the impact would be on the business. This was noted. JA asked about EF09 – inadequate ICU ventilation at SGH. BG said in general terms this was a large topic for Estates. He said		

				there was national and hospital based legislation covering the matter. In a way it was linked to climate change and covered a range of items including air conditioning. He explained the Trust had appointed a number of Authorised Persons (AP) who undertake annual inspections of our plants reporting to himself and the Director of Infection Prevention. In relation to ICU, SGH, there were some gaps where areas do not have the correct ventilation however, he said he felt there was no justification for an overall air handling risk on the RR. Any risks had been separated out and dealt with on an individual basis. He confirmed DB had set up a new Ventilation Group from January 2017 which would report into the new overarching Premises Assurance Group. Their remit will be to review the RR and drive compliance and action plans. BG assured the Committee that work was in progress to address these risks. BG asked CW if he had reviewed other departmental RRs for anything that linked to E&F? CW said he knew of some potential E&F risks in maternity. JA asked about the Radiology scanner breakdowns. CW agreed to speak to FJ as to whether there was a way of sharing other departments RRs. **Action: CW.** JA asked about EF16 – Estates equipment failure, nurse call system for York – CW agreed to check with A Betts about the SGH call system as to whether it should be included or not. **Action: CW.** MS said that in terms of this Committee it would focus on red ratings at its meetings plus those amber ratings that were of potential concern. At every meeting the EEC would review any and all changes since the previous meeting. At every second meeting it would undertake a full review of the register. BG also suggested that CW link up with items raised during the leadership walk rounds. This was agreed. CW confirmed this was a working document. He will be seeking assurance that it is working operationally and is being managed effectively so that we are left with only significant risks as the green risks will reduce as they become managed through other		

				Committees. The EEC took assurance from this document and thanked CW for a very thorough piece of work which should be taken as best practice. POST MEETING NOTE: MS has passed the register to the Chair of Audit for review and comment on its format.	The EEC was assured that an effective Risk Register is now in place for E&F.	
3.	**Internal Audit Reports**			**Y1663 Doctors Accommodation May '16** - following discussion at the last meeting, BG provided an update to the Committee on the latest position in relation to Doctors accommodation. James Hayward was following up actions in the IA report and significant work had already been undertaken. BG said accommodation was dealt with on a locality basis and that a lot of the findings in the report were around process and rent collection. He explained that in York the majority of accommodation was within the private sector, but the Trust still retained 10 flats at York St John University for on-call doctors. It was intended in the longer term to develop Archways patient rooms into bedrooms ready for leasing and a BC was in the process of being developed. It was also noted that the University of York was developing new student accommodation and it was intended for the Trust to pursue that as an option for HYMS students. For SGH, the Trust had secured a deal with Hull University for HYMS students to rent out accommodation from them. The Trust also owns a number of properties but they require significant investment. Due to the Carter requirement around space occupancy MS anticipated that the preferred option might be to sell the properties for social housing and for the Trust to then rent back some of them which would give us access to modern premises. BG confirmed this as one potential outcome. JA reminded the Committee that there was a lot of cross site working and to attract the right calibre of staff it was vital for the Trust to have available good accommodation facilities. This was noted.		

				The Committee noted that: **Y1721 Carbon Reduction Commitment (CRC) Scheme Nov '16** – had received high assurance, **Y1703 – Decontamination**, **Y1740 - Estates Strategy**, **Y1725 - Infrastructure repairs and maintenance**, had each received significant assurance**.** Re Y1275 JA queried the assurance rating given as there were recognised risks appertaining to backlog maintenance currently on the RR. BG said it would be important to ensure that the Capital Plan addressed backlog maintenance. The following IA report received limited assurance: **Y1713 - Compliance with statutory regulations through use of PAM** – BG explained there were 2 key areas that required improvement; limited assurance against the PAM model and low compliance re. the correct completion of action plans and the process for escalating risk to either the departmental or CRR. DB said a meeting had been arranged for January and he was confident he would see progress being made and action plans reduce as we become more compliant. MS was concerned that the report had only just been received from Internal Audit when it was dated July '16, and asked if it were to be re-audited today whether we would see improvement? DB confirmed "yes", we now have a proposed work programme in place for PAG work. As a general point MS asked whether there was a way for IA investigations to reflect our main RR risks. BG confirmed we have an opportunity to influence our IA programme for each business planning cycle. The Committee noted the documentation.	The EEC was assured that the CRC scheme is being implemented correctly and that it fits with the overall Strategic Objective in respect of sustainable development.	
4.	**Minutes of last meeting held**			The minutes of the last meeting held on 15th September 2016		

	on 15th September 2016.			were agreed as a correct record.		
	Matters Arising: **H&S Strategy** **Efficiency Scheme** **Smoking on site** **Business Cases**			Outstanding. CW to consider the Audit Report (Y1621) and link in all other elements of risk management. It is now planned to have a strategy available by the end of the financial year. Charitable Rate Relief exemption – on-going through Hempsons. BG explained that smoking was still tolerated on site; BG would arrange for a self-assessment review of the situation to be undertaken. CCGs were also coming under pressure to include a no smoking policy into contracts - a Steering Group had been formed; BG and Polly McMeekin are involved. BG agreed to provide feedback to the EEC in due course. JM confirmed there was now a Sustainability section included on the main BC pro forma. MS reminded the EEC there was some onus on us to challenge at Board level if required when BCs are presented. It was agreed that JMo would audit the recent Laboratory Medicine BC from an SD point of view and send any comments to Graham Lamb and Andrew Bennett. **Action: JM.**		
5.	**Sustainable Development Group meeting** **SDMP action plan progress report**			The Committee received the latest progress report for consideration. JM highlighted the key areas from the action plan: **SD engagement and communication work** The Trust had received recognition for 2 projects at a building better healthcare awards ceremony 1) capital project efficiency award for Lilac ward at Scarborough, and 2) runner up for the CEF Combined Heat and Power project at York**.** **Procurement** Work was on-going to develop tender documentation to appoint external consultant support to expand initial engagement work and integrate sustainability throughout the whole organisation. They would undertake a baseline assessment to create an action		BG to provide

				plan. Any subsequent work would require a BC for implementation and would be paid for out of savings achieved. JM assured the EEC a robust process had been put in place to ensure there were no shortfalls. As an example, JA felt the taxi contract tender exercise would be an interesting initiative to pursue with an opportunity to procure companies using low carbon vehicles. **District Heating Scheme** JM confirmed that the Trust had agreed to participate in a CYC feasibility study subject to it being a cost effective investment. MS felt this potentially looked very positive and asked for it to be kept under review by the EEC. **Completion of energy projects** The SGH CHP project did not go live as anticipated in November. Expected "go live" date 1st December. This was noted. **Good Corporate Citizenship (GCC) Assessment** Progress has been reviewed against the GCC template and the Trust has achieved a score of 44% which was an improvement on last year's score. Whilst there has been significant progress in most areas, lack of progress against "adaptation" and "models of care" has significantly reduced the overall average score. It was noted that "adaptation" is linked to business continuity and a suggestion has been made as to whether the STP work could influence progress although it was thought this was something for providers (CCG) to address. This was noted. Following discussion BG/MS agreed to approach Wendy Scott regarding "models of care". It was also agreed to provide information to the EEC on those GCC items that generally we are having difficulty in progressing. BG/JM agreed to discuss further. MS asked whether there was a role for the Comms team – BG confirmed that we have a comms team representative on the	The EEC was assured by the progress	an overview of what is proposed BG to remind the Board of what GCC encompasses

				Sustainable Development Group.	being made.	
6.	**Premises Assurance Model (PAM)** **YTH PAM compliance quarterly Report**			The EEC received an update on the current position against the PAM model; the Trust is showing limited assurance. Population of the model has improved since the last meeting, although completion of action plans has not yet been undertaken satisfactorily in order to improve the overall assurance rating. Some elements of the" safety" and "patient experience" domains required to be addressed, therefore, some focus work with Facilities Managers at SGH and BDH had been undertaken and it is hoped this work will assist in improving the position at these sites. The STP work streams should enable the Trust to develop stronger partnerships and links with other NHS organisations which is a key requirement of NHS PAM. This was noted. JA asked for more detail in relation to the patient experience domain as the observations and findings compliance graphs for the period ending November '16 showed a predominantly red rating for this area. DB explained that a red rating meant that there was not an action plan in place He said that at the moment the mechanism uses PLACE results as assurance for patient experience, but one of the key questions is around whether you have additional systems available other than PLACE and that was where we were demonstrating weakness. Within Facilities we have now asked for more information via the PALS system. A new Facilities Operational Group had also been established and we are also analysing information from areas such as the Complaints process and the Friends & Family initiative. Overall BG is of the opinion that we are seeing positive improvements across the board and good progress is being made. This was noted.		
7.	**Carter Report – E&F efficiencies**			DB reported on progress against the Carter report recommendations. The E&F CIP programme has now been aligned with the Carter dashboard and reflects our Carter metrics going forward. In the last 2 months these have been further developed to include individual CIP treatment plans for all EFM		

				registered CIPs. The DoHs model hospital portal is now live and is a really useful tool for the Trust to view when seeking to compare and validate costs. JA asked when we might get something that is more up to date – DB said a new dashboard was due to be issued shortly. He would circulate it to members ahead of the next meeting. It was agreed to use the cleaning contract example from the model hospital portal at the next meeting to demonstrate how York compared to others. **Action : DB** JA felt we were quite disappointing on utilised space and MS asked if this was partly due to the "spread out" nature of the organisation. DB said Tony Burns was still working on completing his analysis of our sites. An update on this was required to include information on the Groves Chapel sale and critical infrastructure (backlog maintenance) which links back to the RR information. MS thanked DB for this update and the EEC noted the challenges faced.		
8.	**PLACE report**			CB attended for this item. As a follow up to the PLACE assessment results presented at the last meeting CB provided information on her feedback sessions that took place in October. As part of those sessions they discussed what improvements might be made to the process. The ideas raised included: - introducing a breakfast meal assessment. At the moment only lunch and evening meals are assessed. - adding a weekend assessment to the process. - introducing adolescent assessors to the process. - For training, a recent health watch policy report had highlighted how they could better provide support and in relation to that they had developed a half day training event in February, so that going forward any assessor we use from Health watch would have received national training.		

				The PLACE assessment results were seen by BoD in September and the Committee welcomed the suggested improvements to the process. MS thanked CB for this update.		
9.	**Health, Safety & Security**			Item deferred to next meeting.		
10.	**Date of next meeting**			Tuesday 7th February 2017 @ 10am, Malton Hospital.		