

Board of Directors (Public Meeting)

Wednesday 28 March 2018



BOARD OF DIRECTORS MEETING

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

On: Wednesday 28 March 2018

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

TIME	MEETING	LOCATION	ATTENDEES
9.00am – 10.15am	Financial Recovery Board Meeting	Boardroom, Foundation Trust Headquarters	Board of Directors
10.45am – 1.00pm	Board of Directors meeting held in public	Boardroom, Foundation Trust Headquarters	Board of Directors
13.30pm – 15.25pm	Board of Directors meeting held in private	Boardroom, Foundation Trust Headquarters	Board of Directors



Board of Directors (Public) Agenda

SUBJECT	LEAD	PAPER	PAGE	TIME
1. Apologies for absence and quorum To receive any apologies for absence <ul style="list-style-type: none"> Libby Raper 	Chair	Verbal	-	10.45 – 10.55
2. Declaration of Interests To receive any changes to the register of Directors' declarations of interest, pursuant to section 6 of Standing Orders.	Chair	A	7	10.45 – 10.55
3. Minutes of the meeting held on 31 January 2018 To receive and approve the minutes from the meeting held on 31 January 2018.	Chair	B	13	10.45 – 10.55
4. Matters arising from the minutes and any outstanding actions To discuss any matters or actions arising from the minutes	Chair	Verbal	-	10.45 – 10.55
Governance				
5. Governance Documents The Board is asked to approve the Reservation of Powers and Scheme of Delegation, Standing Orders, Standing Financial Instructions.	FT Secretary	C	25	10.55 – 11.00
6. Modern Slavery Act To consider and approve the draft statement	Foundation Trust Secretary	D	127	11.00 – 11.05



SUBJECT	LEAD	PAPER	PAGE	TIME
Our Quality and Safety Ambition: Our patients must trust us to deliver safe and effective healthcare				
7. Patient Story	Deputy Medical Director	Verbal	-	11.05 – 11.15
To receive the details of a patient letter.				
8. Chief Executives Update	Chief Executive	E	131	11.15 – 11.30
To receive an update from the Chief Executive				
9. Quality and Safety Committee	Medical Director & Chief Nurse	E	137	11.30 – 11.50
To receive the minutes of the last meeting and be advised of any specific issues to be discussed. Papers for information.				
	<ul style="list-style-type: none"> • Patient Safety & Quality Report • Medical Directors Report • Chief Nurse Report • Enhanced Supervision Report 	F1 F2 F3 F4	147 179 191 199	
10. Out of Hospital Care Strategy	Chief Operating Officer	G	215	11.50 – 12.00
To receive an update on the OoHC strategy.				
Our Finance and Performance Ambition: Our sustainable future depends on providing the highest standards of care within our resources				
11. Finance and Performance Committee	Committee Chair	H	223	12.00 – 12.20
To receive the minutes of the last meeting and be advised of any specific issues to be discussed. Papers for information.				
	<ul style="list-style-type: none"> • Finance Report • Efficiency Report • Performance Report 	H1 H2 H3	231 251 257	



SUBJECT	LEAD	PAPER	PAGE	TIME
Our Facilities and Environment Ambitions: We must continually strive to ensure that our environment is fit for our future				

12. Environment and Estates Committee	Committee Chair	I	271	12.20 – 12.40
To receive the minutes of the last meeting and be advised of any specific issues to be discussed.				

Our People and Capability Ambition: The quality of our services is wholly dependent on our teams of staff				
-----------------------------------------------------------------------------------------------------------	--	--	--	--

13. Workforce and Organisational Development Committee	Committee Chair	J	To follow	12.40 – 13.00
To receive the minutes of the last meeting and be advised of the Committee of any specific issues to be discussed. Papers for information:				

- Workforce Metrics [J1](#) 281
- Developing People Strategy [J2](#) 293
- Gender Pay Gap [J3](#) 327

14. Any other business		Verbal	-	13.00
<ul style="list-style-type: none"> • Reflections on the meeting • BAF Alignment • Associate NED Induction 				

15. Time and Date of next meeting

The next meeting will be held on Wednesday 30 May 2018 in the Boardroom, Foundation Trust Headquarters, York Hospital.

Items for decision in the private meeting: ---

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



'That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1(2), Public Bodies (Admission to Meetings) Act 1960.



Additions: Dianne Willcocks **Director**— York Media Arts Festival Community Interest Company

Changes: Jenny McAleese (Council changed to read Court)

Deletions: No deletion

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 foundation trust including but not limited to, lenders
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	Spouse is a Consultant Anaesthetist at the Trust	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 Trustee —York Music Hub	Nil
Mr Michael Sweet (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 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
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 Director —Clifton Estates Ltd (linked to JRF) 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 — York Media Arts Festival Community Interest Company	Director —London Metropolitan University Board Member —York Museums Trust Chair of Steering Group - York Mediale Festival	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
Michael Keaney <i>(Non-Executive Director)</i>	Nil	Nil	Nil	Act as Trustee –on behalf of the York Teaching Hospital Charity	Nil	Nil
Jenny McAleese <i>(Non-Executive Director)</i>	Non-Executive Director —York Science Park Limited Director —Jenny & Kevin McAleese Limited	50% shareholder and Director —Jenny & Kevin McAleese Limited	Nil	Act as Trustee –on behalf of the York Teaching Hospital Charity Trustee —Graham Burrough Charitable Trust Member —Audit Committee, Joseph Rowntree Foundation	Member of Court —University of York	Nil
Mr Patrick Crowley <i>(Chief Executive)</i>	Nil	Nil	Nil	Act as Trustee –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mr Andrew Bertram <i>(Executive Director Director of Finance)</i>	Nil	Nil	Nil	Act as Trustee –on behalf of the York Teaching Hospital Charity	Member of the NHS Elect Board as a member representative	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 Mike Proctor <i>(Deputy Chief Executive)</i>	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 <i>(Chief Nurse)</i>	Nil	Nil	Nil	Act as Trustee –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mr James Taylor <i>(Medical Director)</i>	Nil	Nil	Nil	Act as Trustee –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mrs Wendy Scott <i>(Director of Out of Hospital Care)</i>	Nil	Nil	Nil	Act as Trustee –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mr Brian Golding <i>(Director of Estates and Facilities)</i>	Nil	Nil	Nil	Act as Trustee –on behalf of the York Teaching Hospital Charity	Spouse is Director of Strategy and Planning at HEY NHS FT	Spouse is a Director at HEY NHS FT and Trustee of St Leonards Hospice

Blank page

Board of Directors – 28 March 2018 Public Board Minutes – 31 January 2018

Present: **Non-executive Directors**

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

Executive Directors

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

Corporate Directors

Mr B Golding	Director of Estates & Facilities
--------------	----------------------------------

In Attendance:

Mrs L Provins	Foundation Trust Secretary
---------------	----------------------------

Observers:

Sheila Miller – Public Governor – Ryedale and East Yorkshire
Margaret Jackson – Public Governor – York
Jeanette Anness - Public Governor – Ryedale and East Yorkshire
Ann Bolland – Public Governor – Selby
Sylvia Graves – Defend Our NHS
Susan Snelgrove – Defend Our NHS
Ann Weerakoon – Defend Our NHS
Lu Bastiman - Defend Our NHS
Josephine Mary Smith - Defend Our NHS
Michael Reakes – Public Governor – York
Nigel Smith – Defend Our NHS
Sheena Foxwell – Defend Our NHS
Julie Southwell – HR

Abbie Myers – Healthwatch York
Brook Adams – Radiology Registrar
Sharon Hurst – Staff Governor
Peter Blackeby – Member of the public
Terry Cunliffe – Unite
Sarah Keig – Unison

Ms Symington welcomed everyone to the meeting.

18/01 Apologies for absence

No apologies were received.

18/02 Declarations of interest

No further declarations of interest were raised.

18/03 Minutes of the meeting held on the 29 November 2017

The minutes of the meeting held on the 29 November 2017 were approved as a correct record subject to the following amendments:

17/098 – page 16, 2nd paragraph – the 9 flow practitioners had been employed to support the SAFER agenda.

17/104 – page 20 – Reflections on the meeting – Ms Raper stated that the changes to the Board Committee reporting to the Board for Executives and NEDs should be reviewed in March. Add to the Action Log.

18/04 Matters arising from the minutes

No further items were discussed.

18/05 Petition Presentation

Mrs Symington stated that the Board would normally start with a patient story, however, this had been replaced by members of the public who wanted to present petitions.

Mr Smith, a member of Defend Our NHS presented a petition of 900 signatures which had been collected and opposed the setting up of a limited liability company by the Trust. He stressed that the members of the public talked to in York were against any form of privatisation of the NHS.

Ms S Foxwell presented a petition of 1700 signatures which had been collected since the group had heard about the plans to explore the possibility of setting up an alternative delivery model. She noted the groundswell in the country against privatisation of the NHS and stated that any savings made would be at the expense of staff due to the revised terms and conditions that would be introduced, which would also create a 2 tier system. Ms Foxwell stated that there were a number of campaign groups that had been set up and



despite appreciating the financial position, the public wanted to keep the NHS in the public domain.

Ms Symington thanked both Mr Smith and Ms Foxwell for coming to present the petitions to the Board.

18/06 Union Presentation on the Alternative Delivery Model

Sarah Keig from Unison and Terry Cunliffe from Unite came to the Public Board to provide their views on the establishment of an Alternative Delivery Model (ADM). Ms Keig stated that the Unions were opposed to the creation of an ADM and the transfer of staff into any such model. Ms Keig listed a number of reasons why the Unions were against the ADM and stated that members wanted to stay part of the NHS family and that creating an ADM would lead to a 2 tier workforce giving rise to equal pay claims and would also affect staff morale. Ms Keig stated that the Unions had spoken to Rachel Maskell MP. The Unions were of the opinion that the creation of an ADM was about tax avoidance which was morally reprehensible. Ms Keig listed a number of organisations that had gone down this route and the positions they had taken. She stated that the only ADM created that had delivered on values and staff terms and conditions was Northumbria. Ms Keig stated that members would be balloted for action where ADMs are being created.

Ms Symington thanked Ms Keig and Mr Cunliffe for presenting the Unions view on the ADM.

18/07 Chief Executive Report

Mr Crowley gave an overview of the pressures experienced by the acute system over the Christmas and New Year period describing the pace and pressure on clinical staff as frenetic at best. He wished in the first instance to extend his thanks and the Board's thanks to staff for their commitment during an incredibly difficult time.

Mr Crowley stated that this year had been worse than last year and this had been compounded by an outbreak of flu and he noted that York had been described as a hotspot for flu incidence. The flu outbreak had resulted in the Trust seeing the highest level of admissions and an inability to utilise all its capacity due to the spread of illness. The patients admitted had a high level of acuity at a time when staffing across the NHS had never been more fragile.

Mr Crowley stated that the Prime Minister had taken unprecedented action in suspending elective care and he reflected on times when the NHS had more freedoms than currently. Mr Crowley hoped that there would be a change of emphasis as the Trust begins to plan for next winter. Mr Crowley stated that the Trust had cancelled some elective activity, but only if this provided staff or resources which could be redeployed to help the acute situation. He anticipated that full activity would be resumed in February.

Mr Crowley stated that the Trust had hosted the NHSI support team for cancer which had remarkably coincided with a fully green scorecard for cancer, but it was hoped that they would provide shared learning which the Trust could use.

Mr Crowley highlighted the financial situation and the need to preserve quality and safety across the organisation, but stated that this requires everyone at all levels to commit to the



agenda. He noted the congratulations from NHSE regarding the improvements made around sepsis and he took huge pleasure from this as it was during a period of huge pressure.

In relation to the flu vaccine uptake, Mr Crowley informed the Board that over 70% of staff had received the vaccine and so the Trust would receive the CQUIN money attached to it. He commended staff for being professional and committed, but did note that there had been slight flurry of staff wanting the vaccine when the flu outbreak occurred and he suggested that this may be leaving things a little late.

Mr Crowley highlighted that the NHS was celebrating its 70th birthday this year and that the Trust would be engaged in a number of events to celebrate, including an event at York Minster on the 5 July.

Ms Raper supported the comments on sepsis as over the years the NEDs have challenged the operational team over initiativeitis, but this evidenced that they had their eye on the ball.

18/08 Finance and Performance Committee

Mrs Scott provided the performance figures for December. ECS attendance increased by 5.3% from December 2016 and the number of ambulance attendances increased by 11.4% equating to 447 extra patients by ambulance than in December 2016 and YAS stated that they were receiving an extra 40 calls a day. Paediatric attendances were up by 23.6%. Mrs Scott stated that the Trust had achieved an 83% score for ECS in December, which in light of the increases was a significant achievement by the staff involved. She noted that elective work has been cancelled as per the national mandate and this continued into January, however, this has been minimised wherever possible and only done if staff can be redeployed. Risk assessments were done and urgent surgery continued wherever possible.

Mrs Scott stated that cancer performance had been a huge achievement in December 2017 with all targets achieved which was the first time since December 2015. This has mainly been due to the work with GPs and the CCGs to redesigned the skin fast track pathway. She noted that a proactive decision was taken to invite the national cancer intensive support team into the Trust to seek assurance that the Trust was doing all that it possibly could to support the cancer pathways. The focus has been on upper GI and lung pathways and is also being used as an opportunity to learn from others. The Trust has not received the report, but the verbal feedback has been positive.

Mrs Scott stated that the Trust was not where it would like to be in relation to the 18 week target, which was at 87.9% as decisions had been taken to cancel elective work. She highlighted that the position is likely to deteriorate further and the Trust is currently in discussion with the regulators about how the Trust recovers the position and the estimated timescale.

Mrs Scott stated that the delayed transfer of care (DToC) position had been discussed at the Committee and a presentation had been received at the private Board on the CQC report on the City of York system. Mrs Scott stated that one of the national figures suggested that the country wide DtoC equated to 11 medium sized hospitals, which is a



significant issue nationally. Mrs Scott stated that there was focus locally and a number of workstreams have been set up to address this issue.

Ms Symington asked whether there was an indication of the January position and Mrs Scott stated that it is anticipated that the position will deteriorate further. Currently with one day to go the position is at 85% which is the worst position the Trust has been in, but this is being replicated across the country due to the cancelled elective procedures. In the short term the Trust is awaiting national guidance from regulators and the Dept. of Health.

Mrs Scott stated that ED continues to be challenging and performance is up and down depending on attendances and acuity with Scarborough achieving 100% on one of the days. Multiple flu strains has made cohorting patients challenging.

Mrs Adams asked about the national pressures in relation to ambulance attendances and turnaround and how was the Trust performing in relation to its peers. Mrs Scott stated that the Trust does not currently validate the ambulance data as it previously had done and has therefore expressed some concern over the data being submitted. A deep dive audit is being performed and conversations are being held with YAS over the data submitted. A report will be brought to the Committee in the near future.

Mr Keaney wished to thank staff on behalf of the Committee for all the hard work over Christmas and the New Year. He noted that the Committee had had a significant debate over the 18 week position and once there is a recovery plan in place, this will be brought to the Board, however, it will be difficult to recover the position.

Mrs Adams asked about theatre efficiency in light of the business case which was approved approximately 18 months previously and whether there had been an evaluation of the project. Mr Bertram stated that this was a key topic in the directorate performance management meetings and that the surgical directorates were piloting different ways of working in order to achieve productivity gains.

Mr Bertram provided an overview of the financial position and stated that currently no information is available nationally about the month 9 position although our peers are reporting similar issues. The Trust at the end of December had a £23m deficit, which is £9m adrift of the target and shows a deterioration from the previous position of £21m. Mr Bertram stated that this was due to loss of income from elective work, but stressed that control has been maintained over expenditure. He noted that the Trust lost approximately £500k per day over the Christmas period as elective work stops, but the costs are still there.

Mr Bertram stated that the Board discussed the possibility of a £40m deficit in August 2017 and to date actions had resulted in a £6m decrease in that total. He noted that the Trust is currently behind on its CIP delivery by £2.7m and that it was unlikely that the £8m remaining would be wholly delivered, but this had been taken account of in the risk adjusted position.

Mr Bertram stated that the cash position had been discussed on a number of occasions and the Trust has currently borrowed £20m from the Distressed Cash Regime and a further request would require Board approval for £3m in February to ensure payroll and supplier commitments. Mr Bertram was keen to stress that the Trust has never been in



this position before and has been working with NHSI and their operational productivity team and he believed that the Trust had provided a good account of itself and it was about understanding the position and taking any and all corrective actions required.

Mr Keaney asked about risks around winter funding and the achievement of CIPs some of which were out of the Trust's control. Mr Bertram explained that the Trust should have received a share of the £200m promised in the budget, but the £1.2m had been withheld from the Trust because of the Trust's financial position. The Trust had been able to bid for some of the extra £140m promised in the budget and had received £500k, which had mainly been used to secure extra doctors over the Christmas and New Year period. Mr Keaney likened this to fighting a battle with one arm tied behind your back.

Ms Symington stated that the Trust was in discussions with the regulators, who essentially were demanding that the Trust did everything in its power to better the position, however, she noted that there was no definitive list of actions available. Ms Symington stated that the pressure lies firmly with the Board and this would be covered at the strategic time out being held in February.

18/09 Quality and Safety Committee

Mr Taylor reflected on the impact of winter pressure and patient safety including waiting times in ED and flow through the hospital which put additional risk in the system. He stated that the resilience of staff and resources had been stretched due to bed occupancy levels. Mr Taylor stated that junior doctor numbers had not increased to the level that the Trust would like and it was also difficult to recruit. Mr Taylor stated that he had attended a meeting with Health Education England and due to the fact that the majority of Trust's in the Deanery not having a problem with junior doctor numbers, this had not been escalated nationally.

Mr Taylor stated that all his clinical colleagues were committed and were currently putting aside other important work and training to lessen the problems being faced. Mr Taylor stated that the biggest issue was staff recruitment which takes additional resource.

Mrs Adams asked if a look back exercise was being performed to look at any issues with delays and patient safety and what the Trust can learn. Mr Taylor stated that delays are a risk, but do not always result in any harm being caused. Mr Taylor stated that there is always an increased number of respiratory deaths at this time of the year and that there is learning from mortality, but there will be a time lag in the availability of data.

Mrs Geary stated that the Trust was continuing to see quite high levels of flu at both hospitals and the response from teams has been overwhelming. The Infection Prevention Team is new and they are holding daily meetings during outbreaks to look at the root cause and the lead doctor or nurse is also attending the weekly Quality and Safety Group meetings. Mrs Geary stated that is unlikely the Trust will see a sustained reduction for sometime.

Ms Symington asked about staff sickness in respect of flu and Mrs Geary stated that there has been some. Flu vaccine uptake was discussed and that it would be useful if some staff did not wait until there was an outbreak to get vaccinated.



Mrs Geary stated in relation to nurse staffing there had been a reduction in agency spend which was about a revised way of dealing with 1-2-1 staffing and a reduction in off framework spend, which the Trust had been working on for the last 12 months. Mrs Geary stated that a quality impact assessment had been produced and signed off by the Committee last week. In relation to the 1-2-1 staffing an inequity in requests had been looked at and initiatives such as using the Dementia Café, volunteers and distraction therapies had been introduced and led to a reduction in falls.

Mrs Geary stated that fill rate is low and there is an inability locally and nationally to get RNs, but there is a more positive picture for HCAs. A detailed report had been provided to the Committee along with the initiatives around 1-2-1 supervision. Mrs Geary stated that NHSI and E were looking at recruitment and retention.

Mrs Adams stated that she was not assured by what Mrs Geary had said and that she felt the report provided a slightly skewed impression. She noted the positive position in York, but remained concerned about Scarborough and the very acute wards being left with unfilled shifts, which represents a risk to patient safety. Mrs Geary stated the graph on page 51 appeared to be wrong.

Mr Bertram stated that the chart was correct. In November and December a process had been gone through following discussions with NHSI around looking at all aged accruals which had decreased the position by £300k. He likened this to a form of financial housekeeping.

Mrs Geary stated again that recruitment was really challenging and that is why the Trust is looking at working with different roles such as ACPs and Band 4s. The Trust has difficulty recruiting to the Scarborough site and has taken an opportunity to work with Coventry University and a pre-registration group is due to start in September as unfortunately, the February cohort could not be filled. She also noted that the matrons at Scarborough look at staffing on a shift by shift basis, looking at acuity and staff numbers on the ward and will move staff in order to try to cover gaps.

Mrs Adams stated she appreciated the work being done, but the fact remains that as the Board were sat there today, she was not assured that the Trust was keeping patients safe.

Mr Proctor stated that there were nuances around assurance in that it was difficult to not be assured around safety when the Trust was doing all it possibly could versus doing nothing, however, despite this the Trust still had significant problems recruiting.

Ms Symington stated that it was the job of the Board to look at sustainability and not just in terms of money, but also staffing.

Mrs Geary also stated that staff are regularly moved from Bridlington to cover the Scarborough wards.

Mrs Adams stated that the Committee is also looking at gaining assurance around clinical effectiveness and having data around Duty of Candour in the performance report.

Prof. Willcocks stated she was interested in the national audits and the issues which prevented collaborative working. Mr Taylor stated that asthma patients are returning to the



community and there is uncertainty as to whether they are being followed up by their GP and it was important to understand these elements and follow through. It was noted that these areas should be part of the Health & Wellbeing Board's focus.

18/10 Environment and Estates Committee

Mr Golding stated that the Committee's December minutes were included in the pack. He noted that Dr Bennet had given an overview of capital planning and that despite the lack of access to capital, the projects on ED and Paeds were moving forward on both sites. Residential accommodation is being sold at Scarborough to a social landlord, which is nearing completion and this will be leased back to the Trust.

Mr Golding noted that the BAF had been reviewed and a further full review will take place at the next meeting and the Committee has adopted the trend arrows. A sustainability update had been provided to the Committee, which noted that a new tool was being adopted. The Trust has also received a rating of excellent for the sustainability section in the annual report.

Mr Golding stated that the Trust has put in place a new system called Trust Assessment of Patient Environment (TAPE) which will provide quarterly monitoring of the PLACE system on all 8 sites. The ambition is that any poor scores can be discussed to assess how limited resources are best utilised.

The Committee received the detailed Carter metrics showing the ratio of non-clinical space to clinic space at 36.2% with a target of 35% and vacate space at 3.6% with a target of 2.5%. Initiatives are in place to improve the percentages, but there are still some plans required and also as other initiatives are put in place such as closures, these need to be monitored as it will increase the Trust's percentages instead of decreasing.

The Health & Safety report showed a reduction in fire/equipment related incidents and also RIDDOR reportable incidents. However, Mr Golding noted that some further work is being taken to understand a discrepancy in reporting on the patient experience data used.

Mr Sweet stated that the Committee had a broad portfolio and as a consequence were looking at how the meeting was conducted to the best effect and he would share any findings with the other committees.

Mr Golding stated that the Carter work utilised the model hospital data and as an example laundry costs were higher so this would be looked into as well as any space changes.

18/11 Workforce and Organisational Development Committee

Mr Proctor stated that links had been drawn between a number of areas and workforce today and it was clear that workforce was one of the root causes to the issues facing the Trust. Mr Proctor stated that a medical workforce report had come to the Committee detailing the current vacancies on the Scarborough and York site and whilst these numbers were similar as a proportion of the total the vacancies at York were 8.5%, but at Scarborough this amounted to 19%. Mr Proctor stated that all sorts of initiatives were being taken forward to improve this position and he highlighted the recent video made in



critical care in Scarborough, however, the recruitment campaign had not received any applicants.

Mr Proctor linked in the GMC training report which had also been brought to the Committee and noted that there had been a deterioration in experience. The number of medical vacancies could therefore become a vicious cycle. He stated that junior doctors were increasingly expressing a preference to be in the south of England or major centres, which meant lower numbers here and therefore greater pressure on the positions.

Mr Proctor stated that he had met with Health Education England (HEE) who were supportive, but had stated that this element of choice is not about to change as well as an increased number of juniors choosing not to take up training posts. HEE have agreed to a new type of position which will look at giving juniors greater experience rather than the current silo working. However, Mr Proctor also noted that juniors may soon not be expected to travel for more than an hour which will also affect parts of the Trust.

Mr Proctor stated that sickness rates have increased month on month since March and despite being below the national average, the difference was being rapidly eroded. He also noted that the incidence of stress, depression and anxiety was increasing and that the flu outbreak will also impact on the numbers. Mr Proctor stated that there were lots the Trust is offering staff to combat stress, depression and anxiety and those staff accessing interventions had given positive evaluation. This led Mr Proctor on to discussing one of the elements of the Board Assurance Framework, which stated 'we fail to care for the wellbeing of staff', which was green as obviously the Trust is doing a number of things, but on discussing this the Committee felt it was more about failing to get staff to engage, so there was concern over the wording as this would then be amber.

Mr Golding gave an overview of the apprenticeship levy which was introduced in April 2017 and that there was a target for the Trust of having 200 apprentices in place by April 2019. Currently the Trust has 27 across a range of functions and levels and will have a total of 90 by the end of the year. Mr Golding highlighted that the financial risk is having an effect on the apprenticeship position due to some non-clinical vacancies being delayed. He also noted that the Trust has Employer Provider status, but currently is not delivering any training as the nursing standards are still being worked on nationally.

Mrs McAleese stated that in relation to sickness she was of the opinion that this would continue to go up due to the operational pressures and staff working extremely hard.

Prof. Willcocks stated that the Board talk continuously about patient safety and that it was now time to start talking about staff safety. However, despite the pressures she was pleased that there were a number of things in place to enable staff to speak up.

Mr Proctor stated that there are a number of challenges for the Trust including how to take some of the chaos out of the system and some of this will be about persuading staff to work differently which may also be to some extent an additional stressor. He noted that this would be a difficult balance to achieve.

Prof. Willcocks was concerned about the training experience of junior doctors due to receiving a previously positive HYMS report. Mr Proctor stated that there is a different expectation between medical students and junior doctors.



Mrs Adams noted she was pleased to read about the Jupiter survey and how the Trust is perceived as an employer which is vital work for the Trust.

18/12 Freedom to Speak Up/Safer Working Guardian Annual Report

Ms Smith provided the Board with the key elements of the Freedom to Speak up Annual Report. She noted that 2 extra questions had been added to the staff survey and they have produced pleasing results which showed that 48% of staff were aware of her role and 51% felt more confident about speaking up due to her role being in place. Ms Smith highlighted the work of the Fairness Champions, noting that there were 39 in place and a launch was planned for February. Ms Smith noted that some feedback had been received that staff had suffered a detriment, but that on exploring these comments it was found that some of the items mentioned were actually in place to support staff, so Ms Smith had decided to change the request for feedback to whether staff felt they had suffered unfair treatment. Ms Smith noted the priorities for year 2.

Mrs McAleese stated that the Audit Committee had been encouraged that there were no anonymous concerns raised which spoke well of the culture. However, she noted the bullying and harassment hot spots and that robust action plans were being developed. Mr Crowley commented on one of the hot spots which was a remote unit with a static, long serving workforce and that this was about the Trust understanding and providing managerial support, but he also stated that bullying and harassment could also be a very subjective subject and that staff being asked to comply with something could take this as bullying and harassment.

Mr Crowley thanked Ms Smith for her contribution to the Trust and the impact that she has had in a short space of time.

Ms Symington stated that the Board had been discussing staff sickness and asked Ms Smith to be aware of this area and whether staff felt unfairly treated.

Prof. Willcocks commended the diversity that Ms Smith has brought to the Fairness Champions stated that there are all levels of staff from all parts of the organisation. She stated that she hoped one of the Champions would eventually come to the Workforce and Organisational Development Committee to provide greater understanding of the role. Mr Crowley stated that this role would be the opportunity to test communication and how staff respond around the values of the organisation as he was concerned that at times elements like the personal responsibility framework were used as a tool to judge staff against.

Ms Smith provided a brief overview of the Safer Working Guardian Annual Report stating that 167 exception reports had been received from 45 individuals and that these differed between Scarborough and York. Mr Taylor stated that this may be due to the large proportion of locums working at Scarborough which does have an effect on the training experience. 3 guardian fines had been implemented and that some of this money had been used by the Junior Doctors Forum to provide all junior doctors with a Christmas present if they were working on Christmas day. She noted that the presents were well received. Ms Smith stated that the Junior Doctors Forum was gaining momentum and that there were a number of priorities for year 2.

Ms Symington thanked Ms Smith for her reports.



18/13 Standards of Business Conduct Policy

Mrs Provins stated that the existing Trust policy had been updated to include the model guidance from NHSE. This would require a number of extra staff to make declarations and had already been approved by the Executive Board.

Mrs Adams asked if there was any sort of Tsar in place to check these declarations and Mrs Provins noted that the declarations for the year would go to the Audit Committee in March.

The Board approved the policy.

18/14 February Board Time Out

Ms Symington stated that she had included the February Time Out agenda in the pack which will take place over 2 days and incorporate the private Board meeting in February. The paper set out some preparation required by both the NEDs and Executives. Ms Symington stressed that although the Trust was paying for the accommodation as the Board would be working late and starting early.

18/15 Any other Business

Reflections on the meeting – Ms Symington stated that she felt the Board had gone well and kept to time. She asked the observers to feed back to her if they had any comments regarding the meeting. The Lead Governor advised that it was not always possible to hear all that was said.

Alignment of the BAF – it was agreed in the private meeting that the BAF will be revised following revision of the Trust's Our Shared Commitment document and strategic ambitions.

Organ Donation – Mr Keaney stated that the Trust in the 6 months from April to September had 34 potential donors which resulted in 7 actual donors and 14 patients receiving lifesaving donations. The Trust had been moved from a grade 3 to a grade 2 Trust last year. Overall figures showed that 158 people had benefitted in the Yorkshire and Humber area although 11 patients had died during that time awaiting transplants. There were currently 485 people on the waiting list. He stated that the Trust were highly regarded and that 14 patients receiving donations was fantastic.

18/16 Date and Time of next meeting

The next public meeting of the Board will be held on Wednesday 28 March 2018 in the Boardroom at York Hospital.



Outstanding actions from previous minutes

Minute No. and month	Action	Responsible Officer	Due date
17/012	Parity of other staff groups with junior doctors in relation to exception reporting criteria (20 mins) to be added to the work programme.	Mrs Provins	Review Jan 2018 Feb 2018
17/054	Mrs Rushbrook to provide an Action Plan to cover 12 to 18 months of the IT Strategy.	Mrs Rushbrook	Completed
17/104	Board Committee reporting changes to be reviewed in March.	Ms Symington	March 2018



Board of Directors – 28 March 2018

Review of Corporate Documents

(Revision of the Reservation of Powers and Scheme of Delegation, Standing Orders and Standing Financial Instructions)

Recommendation

For information	<input type="checkbox"/>
For discussion	<input type="checkbox"/>
For assurance	<input type="checkbox"/>
For approval	<input checked="" type="checkbox"/>
A regulatory requirement	<input type="checkbox"/>

Current approval route of report

Audit Committee
Board of Directors

Purpose of report

The Audit Committee approved the amendments to the SOs, SFIs and Reservation of Powers and Scheme of Delegation in December and also approved a further amendment to the SFIs regarding EU Procurement thresholds at their meeting in March.

A further issue was raised last week by the Head of Research & Development in relation to the Reservation of Powers and Scheme of Delegation, which has not had time to go to the Audit Committee. The details of the change requested has been added below.

The Board is asked to consider and approve the revised documents.

Key points for discussion

The Trust reviews the corporate governance documents on an annual basis.

Reservation of Powers and Scheme of Delegation has been reviewed. The amendments are as follows:

- To include at 2.5: 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. This aligns with section 1.2.2 of the Standing Financial Instructions.
- 3.1 written approval added as required for all expenditure beyond authorised limits

Summary of Delegated Authorities

- Turnaround Avoidance Programme removed – Financial Recovery Plan added.
- Capital Group Structure defined as Capital Programme Management Group and Capital Programme Executive Group.
- All business cases revenue Investment (Board of Directors) – over £1m and all All PFI proposals.
- Some reference numbers to the finance manual have been changed.
- Non-pay revenue expenditure – Head of Corporate Finance removed, Ast. Director of Finance – Financial Management added.

The Head of Research & Development has raised an issue with the Reservation of Powers and Scheme of Delegation last week which has not had time to go to the Audit Committee. The document needs amending in order for the Head of Research and Development to be able to sign off research and development contracts up to a certain level as there is a significant number of documents. The issue was discussed with the Director of Finance and the following amendment is suggested (added text in red).

Research and development	Approval of Trust research and development contracts to be supported by a business case including workforce implications (including variations or extensions): NB: Generic research to be signed off by Deputy CE or Finance Director or Chief Executive	Head of Research & Development	Up to £200K	
		Medical Director	£200K Up - £500K	
		Deputy CE or Finance Director or Chief Executive		
		Executive Board	£500k - £1m	
		Board of Directors	Over £1m	

Standing Orders have been reviewed. The amendments are as follows:

- Monitor being changed to NHSI;
- Chairman revised to Chair;
- Director of Finance to Finance Director;
- Workforce Strategy Committee to Workforce & Organisational Development Committee
- References to other paragraphs corrected to ensure they reference the right paragraph

Standing Financial Instructions have also been reviewed. The amendments are Monitor being changed to NHSI together with some a change of year from 2016-17 to 2017-18.

Following the approval of the SFI's at the 4th December 2017 Audit Committee, the EU procurement thresholds have been updated and are included for agreement and incorporation into the SFI's. These changes have been incorporated into the document.



Trust Ambitions and Board Assurance Framework

(<https://www.yorkhospitals.nhs.uk/about-us/our-values/>)

The Board Assurance Framework is structured around the four ambitions of the Trust. How does the report relate to the following ambitions:

- Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.
- Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.
- People and Capability** - The quality of our services is wholly dependent on our teams of staff.
- Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

Reference to CQC Regulations

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

17

Version number: v0.01

Author: Lynda Provins, Foundation Trust Secretary and Steven Kitching, Head of Corporate Finance & Resource Management

Executive sponsor: Patrick Crowley, Chief Executive and Andrew Bertram, Finance Director

Date: March 18



RESERVATION OF POWERS AND SCHEME OF DELEGATION

Author: Foundation Trust Secretary
Owner: Chief Executive
Publisher: Compliance Unit
Date of Issue: January 17~~6~~
Version: 11~~0~~
Approved By: Audit Committee and Board of Directors
Review date: December 2017~~6~~

Table of content

- Reservation of Powers to the Board of Directors and Delegation of Powers.....3
 - Purpose3
 - Scope3
 - Principles of the Scheme of Delegation4
 - Governors’ legal responsibilities4
 - Scheme of matters reserved for the Board5
 - 5.1 General enabling provision.....5
 - 5.2 Constitutional Powers5
 - 5.3 Regulation and controls6
 - 5.4 Appointments/ Dismissal6
 - 5.5 Policy Determination.....7
 - 5.6 Strategy and plans.....7
 - 5.7 General matters7
 - 5.8 Financial and reporting management arrangements7
- Summary of Delegated Authorities8

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 or 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

2.5 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. This aligns with section 1.2.2 of the Standing Financial Instructions.

Formatted: Indent: Left: 0.5", No bullets or numbering

Formatted: No bullets or numbering

Principles of the Scheme of Delegation

3.1 Principles that are followed by the Scheme of Delegation

- There is no ~~expenditurespend~~ beyond authorised limits except with the express written approval of the Chief Executive or Finance Director, 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 – <u>Delivering Success Financial Recovery Plan</u>	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 accounting policies	Approve and communicate all financial procedures and Trust accounting policies	Finance Director Audit Committee	All	FReM and NHS Improvement 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 Management Executive Group	Up to £100k	SFI 10
		Chief Executive & Finance Director through Capital Programme Management Executive 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 All and all PFI proposals <u>All new (non-replacement) consultant appointments</u>	
Expenditure variations on capital	Variations	Capital Programme Management	Up to 10k	SFI 10

schemes		Group		
		Chief Executive and Finance Director through Capital Programme Executive Group	Up to £500k	
		Executive Board	£500k-£1m	
		Board of Directors	Over £1m Unlimited	
Planning & Budgetary Control	Prepare and submit an Annual Plan <u>including any in year adjustment to the Annual Plan</u>	Finance Director		SFI
	Management of budgets for the totality of services	Chief Executive		SFI
	At Directorate level Prime budget holders are <u>C</u> linical <u>D</u> irectors and <u>D</u> irectors 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 non-pay) Prime <u>B</u> udgets <u>H</u> olders 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 Assistant Director of Finance – Financial Management Head of Corporate Finance for inclusion in the authorised signature list	SFI Trust Finance Manual Section 5.2 Section 8.2.1
	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		
Clinical and Contract income credit notes		FRAC Analyst/Senior Analyst	Up to £250	

		<u>Income Accountant</u>	<u>£250 to £10k</u>	
		<u>Deputy Director of Contracting</u>	<u>£10k to £1m with a retrospective report to the Finance Director and Deputy Finance for all transactions over £100k</u>	
		<u>Finance Director</u> <u>Deputy Finance Director</u>	<u>Over £1m</u>	
<u>Non clinical income credit notes</u>		<u>Prime budget holder</u>	<u>Up to £50k</u>	
		<u>Assistant Director of Finance – Financial Management</u>	<u>£50k to £500k</u>	
		<u>Deputy Finance Director</u>	<u>£500k to £1m</u>	
		<u>Finance Director</u>	<u>Over £1m</u>	
<u>Credit notes to correct posting errors</u>		<u>Accounts Receivable Team Leader</u>	<u>Up to £1k</u>	
		<u>Financial Accountant</u>	<u>£1k to £10k</u>	
		<u>Deputy Head of Corporate Finance</u>	<u>£10k to £500k</u>	
		<u>Head of Corporate Finance</u>	<u>£500k to £1m</u>	
		<u>Finance Director</u>	<u>Over £1m</u>	

<u>Write offs</u>		<u>Accounts Receivable Team Leader</u>	<u>Up to £50</u>	
		<u>Financial Accountant</u>	<u>£50 to- £250</u>	
		<u>Deputy Head of Corporate Finance</u>	<u>£250 to- £1000</u>	
		<u>Head of Corporate Finance</u>	<u>£1000 to- £10,000</u>	
		<u>Finance Director</u>	<u>Over £10,000</u>	
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	£150k - £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 Signing agreement with other organisations and individuals	Director of Finance		SFI 6.2.3
Audit and Accounts	Approve the appointment and where necessary dismissal of the External Auditors 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 Receive an annual report from the Internal Auditors and agree action	Council of Governors Board of Directors Audit Committee		SFI 4
Annual Report and Accounts	Receive and approve the Annual Report and Accounts and Quality Report Receive the Annual Report and Accounts and Quality Report 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 Implementation of internal and	Board of Directors Council of Governors Chair, Chief Executive and Finance Director Finance Director		SFI 4 SFI 2.2

	external audit recommendations			
Retention of Records	Maintaining archives of records to be retained	Chief Executive		SFI 17
Research and development	Approval of Trust research and development contracts to be supported by a business case including workforce implications (including variations or extensions): NB: Generic research to be signed off by Deputy CE or Finance Director or Chief Executive	Head of Research & Development Medical Director or Finance Director or Chief Executive	Up to £200K Up to £500K	
		Deputy CE or Finance Director or Chief Executive	£200K Up - £500K	
		Executive Board	£500k -£1m	
		Board of Directors	Over £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 above policy level)	Deputy Director of Workforce	All subject to compliance with A4C regulations	SFI 3.3
	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

Formatted Table

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 holder	Up to a maximum of 5 days <u>in exceptional circumstances</u>	

			<u>es only:</u>	
		Over 5 days <u>in exceptional circumstances only:</u>		
		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/CS P 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 [NHSI \(formerly Monitor\)](#), 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
- NHS Framework
- Delegation of Powers

Interpretation

1

The Board of Directors

2

- Composition of the Board 2.1
- Appointment of the Chair and Non-Executive Directors 2.2
- Terms of Office of the Chair and Non-Executive Directors 2.3
- Appointment of Vice Chair of the Board of Directors 2.4
- Powers of Vice Chair 2.5
- Joint Directors 2.6

Meetings of the Board of Directors

3

- Calling Meetings 3.1
- Notice of Meetings 3.2
- Setting the Agenda 3.3
- Chair of Meeting 3.4
- Annual Public Event 3.5
- Notices of Motion 3.6
- Withdrawal of Motion or Amendments 3.7
- Motion to Rescind a Resolution 3.8
- Motions 3.9
- Chair's Ruling 3.10
- Voting 3.11
- Minutes 3.12
- Suspension of Standing Orders 3.13
- Variation and Amendment of Standing Orders 3.14
- Record of Attendance 3.15
- Quorum 3.16

Arrangements for the Exercise of Functions by Delegation

4

- Emergency Powers 4.1
- Delegation to Committees 4.2
- Delegation to Officers 4.3
- Overriding Standing Orders 4.4

Committees

5

- Appointment of Committees 5.1
- Confidentiality 5.2

Declarations of Interest

6

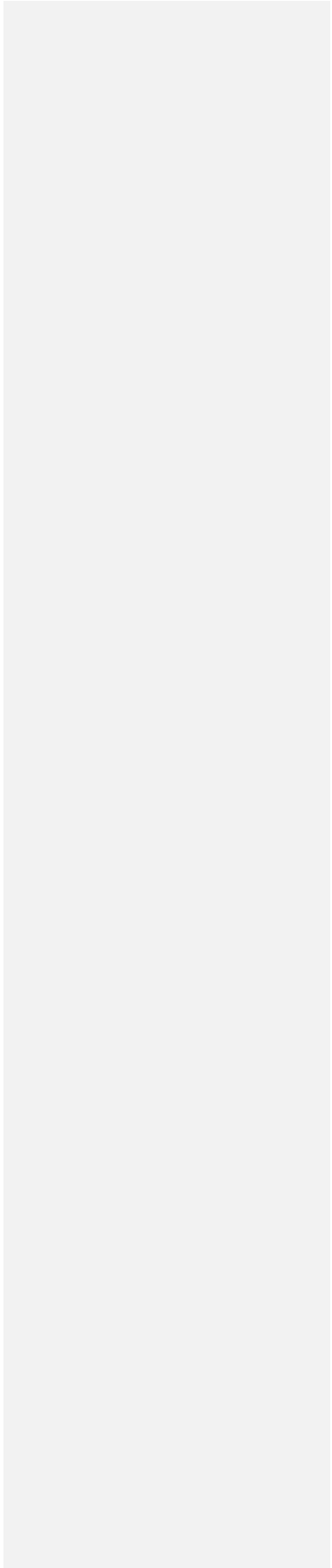
Disability of Chairman and Directors in Proceedings on account of pecuniary interest

7

Standards of Business Conduct

8

	Standing Orders
Policy	8.1
In-house Services	9
Custody of Seal and Sealing of Documents	10
Custody of Seal	10.1
Sealing of Documents	10.2
Register of Sealing	10.3
Signature of Documents	11
Miscellaneous	12
Standing Orders to be given to Directors and Officers	12.1
Documents having the standing of Standing Orders	12.2
Review of Standing Orders	12.3



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 [NHSI \(formerly Monitor\)](#) under the Health and Social Care (Community Health and Standards) Act 2003 ("the 2003 Act") now superseded by the National Health Service Act 2006 ("the 2006 Act") and amended by Health and Social Care Act 2012.

The principal place of business of the Trust is:

York Hospital
Wigginton Road
YORK
YO31 8HE

For administrative purposes, York Hospital is the Trust Headquarters

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

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

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

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

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

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

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

- Expenses

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

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

NHS Framework

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

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

~~NHSI's (formerly 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, ~~N~~on-executive ~~D~~irectors and the ~~E~~xecutive ~~D~~irectors 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 ~~C~~hief ~~O~~fficer of the Trust.

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

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

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

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

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

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

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

“**Finance Director**” means the Executive Director of Finance who is the Chief Finance Officer of the Trust.

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

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

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

“**Licence**” means the NHS Provider Licence issued by NHSI (formerly 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-eExecutive 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. 3.614 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 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 Chair.

Formatted: Indent: Left: 0.39"

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.

Formatted: Indent: Left: 0.39"

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.

Formatted: Indent: Left: 0.39"

The Chair~~man~~ 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.

Formatted: Font: Bold

3.3 Notice of Extraordinary Meetings

Formatted: Indent: Left: 0.39"

—At the request of the Chair~~man~~ 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 Chair~~man~~ or four Board Members shall call such a meeting.

Formatted: Font: Bold

3.4 Notice of Urgent Meetings

Formatted: Indent: Left: 0.39"

-At the request of the Chair~~man~~, 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 Foundation Trust Secretary fails to call such a meeting, then the Chair~~man~~ or four Board Members shall call such a meeting.

Formatted: Indent: Left: 0.39"

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 Deirector, 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).)

Formatted: Indent: Left: 0.39"

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

Formatted: Indent: Left: 0.39"

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

Formatted: Indent: Left: 0"

3.5 Setting the Agenda

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

A Deirector who requires an item to be included on the agenda should advise the Foundation Trust Secretary prior to the agenda being agreed with the Chair~~man~~ 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 Chair~~man~~ is absent from a meeting temporarily on the grounds of a declared conflict of interest the Vice-Chair, if present, shall preside. If the Chair~~man~~ and Vice-Chair~~man~~ 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 Chair~~man~~ 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 Chair~~man~~ 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 Chair~~man~~ 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.

Formatted: Font: (Default) Arial, 12 pt, Condensed by 0.15 pt

Formatted: Normal, Indent: Left: 0.49", First line: 0", Right: 0.5", Bulleted + Level: 1 + Aligned at: 0.3" + Tab after: 0.55" + Indent at: 0.55", Don't hyphenate, Tab stops: -1", Left + -0.5", Left + 0", Left + 0.5", Left + 0.89", Left + 6.25", Left

3.13 Chair's Ruling

Statements of **D**irectors 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 **D**irectors 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 **D**irectors present so request.

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

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

In no circumstances may an absent **D**irector 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 ~~m~~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 ~~De~~irectors' 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 ~~E~~xecutive ~~D~~irectors and two ~~N~~on-executive ~~D~~irectors, 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 ~~D~~irectors.

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 ~~D~~irectors 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 Chair~~man~~ 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 Chair~~man~~ or Vice Chair~~man~~ 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 Chair~~man~~ 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 Chair~~man~~ after having consulted at least two Non-executive Directors. The exercise of such powers by the Chief Executive and the Chair~~man~~ 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 Finance Director ~~of Finance~~ or other Executive Director (this is because the Scheme of Delegation does not discharge accountability to ~~Non-executive~~ EDirectors to provide information and advise the Board of Directors in accordance with any statutory requirements. Outside these statutory requirements the roles of the Finance 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 NHSI (formerly Monitor), the Board of Directors may and, if directed by NHSI (formerly 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 and Organisational DevelopmentStrategy 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 **D**irector 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 **D**irectors should declare such interests. Any **D**irectors appointed subsequently should do so on appointment.

Interests, which should be regarded as “relevant and material”, are:

- a) Directorships, including **N**on-executive **D**irectorships 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 **D**irectors' 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 **C**hair**m**an. 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 **D**irectors' 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' **De**irectorships 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 **De**irector 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 Chair**man** and Directors in procedures on account of pecuniary interest**

Subject to the following provisions of this Standing Order, if the Chair or a **De**irector 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 Chair**man** or a **De**irector 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 Chair**man** 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 Chair**man** or a **De**irector 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 **De**irector 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~~ Director 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 Chair~~man~~ (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~~ Director (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 ~~De~~irectors and ~~Oe~~fficers 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.

STANDING FINANCIAL INSTRUCTIONS

Author:	Head of Corporate Finance
Owner:	Andrew Bertram, Finance Director
Publisher:	Andrew Bertram, Finance Director
Date of Issue:	January 2017 6
Version:	109
Approved By:	Board of Directors
Review date:	December 2017 6 (annually, along with Standing Orders and Reservation of Powers and Scheme of Delegation)

CONTENTS

1.	INTRODUCTION	4
1.1	GENERAL	4
1.2	TERMINOLOGY	5
1.3	RESPONSIBILITIES AND DELEGATION	7
2	AUDIT	10
2.1	AUDIT COMMITTEE	10
2.2	FINANCE DIRECTOR	10
2.3	ROLE OF INTERNAL AUDIT	11
2.4	FRAUD AND CORRUPTION	12
2.5	EXTERNAL AUDIT	13
3.	BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING	14
3.1	PREPARATION AND APPROVAL OF BUSINESS PLANS AND BUDGETS	14
3.2	BUDGETARY DELEGATION	15
3.3	BUDGETARY CONTROL AND REPORTING	15
3.4	CAPITAL EXPENDITURE	16
3.5	MONITORING RETURNS	16
4.	ANNUAL ACCOUNTS	17
5.	BANK AND GBS ACCOUNTS	18
5.1	GENERAL	18
5.2	BANK AND GBS ACCOUNTS	18
5.3	BANKING AND INVESTMENT PROCEDURES	18
5.4	INVESTMENTS	19
5.5	EXTERNAL BORROWING	19
5.6	TENDERING AND REVIEW	19
6.	INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS	20
6.1	INCOME SYSTEMS	20
6.2	FEES AND CHARGES	20
6.3	DEBT RECOVERY	20
6.4	SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS	21
7.	NHS SERVICE CONTRACTS FOR PROVISION OF SERVICES	22
8.	TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE BOARD OF DIRECTORS AND EMPLOYEES	23
8.1	REMUNERATION AND TERMS OF SERVICE	23
8.2	FUNDED ESTABLISHMENT	24
8.3	STAFF APPOINTMENTS	24
8.4	PROCESSING PAYROLL	24
8.5	CONTRACTS OF EMPLOYMENT	26
9.	NON-PAY EXPENDITURE	27
9.1	DELEGATION OF AUTHORITY	27
9.2	CHOICE, REQUISITIONING, ORDERING, RECEIPT AND PAYMENT FOR GOODS AND SERVICES	27
9.3	PETTY CASH	30
9.4	BUILDING AND ENGINEERING TRANSACTIONS	31

9.5	TENDERING, QUOTATION AND CONTRACT PROCEDURE	31
10.	CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS	34
10.1	CAPITAL INVESTMENT	34
10.2	PRIVATE FINANCE	35
10.3	ASSET REGISTERS	36
10.4	PROTECTED PROPERTY	36
10.5	SECURITY OF ASSETS	37
11.	STORES AND RECEIPT OF GOODS	38
12.	DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS	40
12.1	DISPOSALS AND CONDEMNATIONS	40
12.2	LOSSES AND SPECIAL PAYMENTS	40
12.3	BANKRUPTCIES, LIQUIDATION AND RECEIVERSHIPS	42
13.	COMPUTERISED FINANCIAL SYSTEMS	43
14.	PATIENTS' PROPERTY	45
15.	CHARITABLE FUNDS	47
15.1	INTRODUCTION	47
15.2	INCOME	47
15.3	EXPENDITURE	48
15.4	INVESTMENTS	48
16.	ACCEPTANCE OF GIFTS BY STAFF	49
17.	RETENTION OF DOCUMENTS	50
18.	RISK MANAGEMENT	51

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. [This can be income, capital or revenue expenditure.](#)

“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 [NHS Improvement 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 2017-18 [Monitor NHSI](#) 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 split 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 issue 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

The European public contracts directive (2014/24/EU) applies to public authorities including, amongst others, government departments, local authorities and NHS Authorities and Trusts.

The directives set out detailed procedures for the award of contracts whose value equals or exceeds specific thresholds. Details of the thresholds, applying from 1st January 2018 are given below. Thresholds are net of VAT.

-	Supply, Services¹ and Design Contracts	Works Contracts²	Social and other specific services³
Central Government ⁴	£118,133 €144,000	£4,551,413 €5,548,000	£615,278 €750,000
Other contracting authorities	£181,302 €221,000	£4,551,413 €5,548,000	£615,278 €750,000
Small Lots	£65,630 €80,000	£820,370 €1,000,000	n/a

¹With the exception of the following services which have different thresholds or are exempt:

- Social and other specific services (subject to the light touch regime) Article 74. (Referred to as the Light Touch Regime or new Part b)
- Subsidised services contracts specified under Article 13.
- Research and development services under Article 14 (specified CPV codes are exempt).

²With the exception of subsidised works contracts specified under Article 13.

³As per Article 74. Services are listed in Annex XIV.

⁴Schedule 1 of the Public Contracts Regulations lists the Central Government Bodies subject to the WTO GPA. These thresholds will also apply to any

Formatted: Space Before: 0 pt, After: 0 pt

successor bodies.

THE EUROPEAN UTILITY CONTRACTS DIRECTIVE (2014/25/EU)
The European utility contracts directive (2014/25/EU) applies to certain utility companies operating in the Energy, Water, and Transport sectors. With the exception of social and other specific services the following thresholds will apply to procurement carried out under the existing Utilities procurement directives from 1st January 2018.

	<u>Supply, Services and Design Contracts</u>	<u>Works Contracts</u>	<u>Social and other specific services</u>
-			
Utility authorities	<u>£363,424</u> <u>€443,000</u>	<u>£4,551,413</u> <u>€5,548,000</u>	<u>£820,370</u> <u>€1,000,000</u>

Formatted: Line spacing: single

Formatted: Space Before: 0 pt, After: 0 pt

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.

	<i>Open procedure</i>	<i>Restricted procedure</i>	<i>Competitive dialogue OR Competitive procedure with negotiation</i>	<i>Dynamic purchasing system</i>	<i>Innovation partnerships</i>
Few bidders expected	✓	(✓)	✓	✓	✓
One-off purchases	✓	✓	✓	✗	✓
Low cost/effort to bidding	✓	✓	✗	(✓)	✗
Commodity products	✓	(✓)	✗	✓	✗
Adaptation of available solutions	(✗)	(✓)	✓	(✗)	(✓)
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.

Board of Directors – 28 March 2018 Modern Slavery and Human Trafficking Act 2015

Recommendation

- | | |
|--------------------------|-------------------------------------|
| For information | <input type="checkbox"/> |
| For discussion | <input checked="" type="checkbox"/> |
| For assurance | <input type="checkbox"/> |
| For approval | <input checked="" type="checkbox"/> |
| A regulatory requirement | <input type="checkbox"/> |

Current approval route of report

Board of Directors – 28 March 2018

Purpose of report

The Board is asked to approve the declaration and the agreed statement should be signed by the Chair and the Chief Executive and placed on the website.

Key points for discussion

The Modern Slavery Act 2015 is designed to consolidate various offences relating to human trafficking and slavery. The provisions in the act create a requirement for an annual statement to be prepared that demonstrates transparency in supply chains. In line with all businesses with a turnover greater than £36 million per annum, the NHS is also obliged to comply with the Act.

The legislation addresses slavery, servitude, forced or compulsory labour and human trafficking, and links to the transparency of supply chains.

Section 54 of the Act specifically addresses the point about transparency in the supply chains. It states that a commercial organisation (defined as a supplier of goods or services with a total turnover of not less than £36 million per year) shall prepare a written slavery and human trafficking statement for the financial year. The statement should include the steps an organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any part of the supply chain or its business. The statement must be approved by the Board of Directors.

The aim of the statement is to encourage transparency within organisations, although it is possible to comply with the provision by simply stating that no steps have been taken during the financial year to ensure that the business and supply chain is modern slavery free. It should be noted that although this may be an acceptable approach for the first

year's statement, there is an expectation that further work will be undertaken to provide these assurances. There are potential consequences for those organisations that do not appear to make progress in this area; especially for those that are funded wholly, or in part, by public money.

On-going assurance

The Trust will be required to review and /or prepare a similar statement on an annual basis. Plans are in place to raise awareness of modern slavery through Staff Matters, policies and training.

Trust Ambitions and Board Assurance Framework

(<https://www.yorkhospitals.nhs.uk/about-us/our-values/>)

The Board Assurance Framework is structured around the four ambitions of the Trust. How does the report relate to the following ambitions:

- Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.
- Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.
- People and Capability** - The quality of our services is wholly dependent on our teams of staff.
- Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

Reference to CQC Regulations

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

17

Version number: v0.01

Author: Lynda Provins, Foundation Trust Secretary

Executive sponsor: Patrick Crowley, Chief Executive

Date: March 2018



Modern Slavery and Human Trafficking Act 2015

Annual Statement 2018

York Teaching Hospital NHS Foundation Trust offers the following statement regarding its efforts to prevent slavery and human trafficking in its supply chain.

The Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps the organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business.

York Teaching Hospital NHS Foundation Trust provides a comprehensive range of acute hospital and specialist healthcare services for approximately 800,000 people living in and around York, North Yorkshire, North East Yorkshire and Ryedale - an area covering 3,400 square miles. The annual turnover is over £400million. We manage 8 hospital sites, 1,127 beds (including day-case beds) and have a workforce of over 8,500 staff working across our hospitals and in the community.

The Trust has internal policies and procedures in place that assess supplier risk in relation to the potential for modern slavery or human trafficking. The top 50% of suppliers nationally, affirm their own compliance with the modern slavery and human trafficking act within their own organisation, sub-contracting arrangements and supply chain. The Trust has written to its top supplier requesting them to affirm their compliance with the legislation.

The Procurement Department's senior team are all Chartered Institute of Purchasing and Supply (CIPS) qualified and abide by the CIPs code of professional conduct. The trust intranet includes a link to an ethical procurement training module which is available to all members of staff. Competency assessments are currently being developed for all bands in the department some of which will include requirements around modern slavery.

Modern Slavery is referenced in the Trust Safeguarding Adults Policy and features as part of the safeguarding adults training following the changes in the Care Act. The Safeguarding Adults Staff intranet resource includes signposting to help and advice for patient's affected by Modern Slavery.

The Trust has evaluated the principle risks related to slavery and human trafficking and identify them as:

- Reputational
- Lack of assurances from suppliers
- Lack of anti-slavery clauses in contracts
- Training staff to maintain the trust's position around anti-slavery and human trafficking.

Aim

The aim of this statement is to demonstrate the Trust follows good practice and all reasonable steps are taken to prevent slavery and human trafficking.



All members of staff have a personal responsibility for the successful prevention of slavery and human trafficking with the procurement department taking responsibility lead for overall compliance.

The Board of Directors has considered and approved this statement and will continue to support the requirements of the legislation.

.....
Susan Symington
Chair

.....
Patrick Crowley
Chief Executive

28 March 2018



Board of Directors – 28 March 2018

Chief Executive's Overview

Recommendation

For information	<input checked="" type="checkbox"/>
For discussion	<input checked="" type="checkbox"/>
For assurance	<input type="checkbox"/>
For approval	<input type="checkbox"/>
A regulatory requirement	<input type="checkbox"/>

Current approval route of report

This report was drafted for the Board of Directors.

Purpose of report

This report provides an overview from the Chief Executive.

Key points for discussion

There are no specific points to raise.

Trust Ambitions and Board Assurance Framework

(https://www.yorkhospitals.nhs.uk/about_us/our_values/)

The Board Assurance Framework is structured around the four ambitions of the Trust.
How does the report relate to the following ambitions:

- Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.
- Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.
- People and Capability** - The quality of our services is wholly dependent on our teams of staff.
- Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

Reference to CQC Regulations

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

Version number: 1

Author: Patrick Crowley, Chief Executive

Executive sponsor: Patrick Crowley, Chief Executive

Date: March 2018



1. Care Quality Commission Report

The Care Quality Commission (CQC's) latest report into the services we provide was published on 28 February. The CQC inspected the Trust as part of its planned inspection programme, carrying out visits between 19-21 September and 17-19 October 2017.

Following that inspection they have given the Trust an overall rating of Requires Improvement.

Summary of ratings:

Area assessed	Rating
Trust Overall	Requires Improvement
York Hospital	Good
Scarborough Hospital	Requires Improvement
Bridlington Hospital	Requires Improvement
Community Services*	Good

*Community services were not reassessed as part of this inspection, and retain a rating of Good overall.

The media statement and staff briefing in response to the report have been shared with Board members, and work is underway to develop an action plan in response to the Improvement Notices. We must submit this to the CQC by 6 April, and assuming a timely response from the CQC we will bring the action plan to the April Board meeting for discussion.

2. CQC letter regarding emergency and acute care

Last week all chief executives received a letter from the CQC's Chief executive Sir David Behan and Professor Edward Baker, chief inspector of hospitals.

The letter reaffirms their findings, both from their inspections and local system reviews, and from two workshops they have held with frontline clinical staff, in relation to key themes they have previously identified to ensure patient safety in emergency departments working under pressure.

Clinicians have consistently fed back that, where they had successfully implemented action to address these issues, this was critically dependent on strong leadership, engagement and support by the board and executive team of the trust.

The letter emphasises the importance of strong leadership at Board level to maintaining patient safety, and that the approach must be across all clinical services and not just ED-focussed.

I know that every member of this Board recognises the pressures facing our staff, particularly over the past few months when increased demand and staffing pressures have no doubt been a cause for concern. Nonetheless it is vital that as a Board we do not simply accept this as the way things are, and we ensure that we are playing our part in tackling these challenges by providing leadership and direction, as well as support, to all of our staff.



3. 2017 NHS staff survey

The results of the 2017 Staff Survey are now available. As in the previous year's staff survey, the survey questions were used to calculate 32 Key Findings structured around nine themes including appraisal and support for development, equality and diversity, errors and incidents, health and wellbeing, working patterns, job satisfaction, managers, patient care and experience and violence, harassment and bullying.

The Trust's scores have been benchmarked against 43 other Combined Acute and Community Trusts, and the Trust's scores from the last three surveys to provide a picture of staff engagement.

The Trust's scores in 2017 do appear to reflect some of the financial and operational challenges it has faced during the previous 12-months. Overall, 14 of 32 findings were below average when compared with the benchmark group; 13 were average; and five were above average.

Initial analysis has been undertaken, and we will receive further detailed Directorate-level reports which will provide question-level data and a comparison with responses from 2016.

4. Strategy and planning

The Government's Mandate to NHS England, along with the Health Minister's remit for NHS Improvement, has now been published.

Last year's mandate set out some longer term objectives up to 2020, and the latest mandate contains steps keep health services on track to meet those objectives. These offer a sense of the national priorities and general direction of travel for the provider sector, with the key deliverables in the following areas:

- A&E performance and the A&E recovery plan
- Reducing NHS-related delayed transfers of care
- Continued roll-out of seven day services priority clinical standards
- Achievement of the 62-day cancer standard and maintenance of other cancer targets

Last month the Board of Directors met as a group to review and refresh the organisation's strategy, and in some ways the mandate and general national direction provides us with some context for these discussions.

The Trust produced a five year strategy during 2013, following of the merger of York and Scarborough Trusts and the acquisition of community services and this has been refreshed annually since then.

In the past five years the context we are working in has changed significantly, and it is important that we revisit our longer-term strategic direction and set a clear way forward means we can work within the constraints we face whilst not losing sight of our ambitions.

There is the opportunity in a later part of the Board meeting to discuss an early draft of the strategy.



The Cancer Strategy Time Out also took place earlier this month. Around 50 staff attended the half-day event, which included presentations on the local and national perspective from the Trust's lead clinician for cancer Mr David Alexander, Leon Green and Dr Clare Beard from North Yorkshire County Council's Public Health team, and Dr Stuart Baugh from the Humber Coast and Vale STP. The event was an important opportunity for our clinical and operational staff to define our vision and contribute to developing our strategy for the coming years.

5. NHS pay deal

Board members may have seen the media coverage in the past few days regarding the potential agreement that has been reached on a refresh of the NHS Terms and Conditions of Service (Agenda for Change).

The trade unions will now consult their members on the proposals, and if the details set out in the framework agreement are accepted, this will result in a three year pay deal as well as the reform of the pay scales. The new pay scales will:

- increase starting salaries
- reduce the number of pay points
- shorten the amount of time it takes to reach the top of the pay band for most staff.

If agreed, Agenda for Change staff will see wage rises of between 6.5% and up to 29% in some cases as a result of pay reform over the next three years. It is understood that the increase would be funded from the Treasury rather than existing NHS budgets.

We will keep the Board updated as to the outcome of the national consultation.

6. Paper-based referrals

The Trust's contract with Commissioners for 2018/19 requires the full use of the NHS e-Referral Service (eRS) by GPs for all consultant-led first outpatient appointments.

The first part of this was to ensure all our services and first consultant-led outpatient appointment slots were available on eRS, including a review of the Directory of Services (DoS). Following this, the contract states that from 1 October 2018, providers will only be paid for activity resulting from referrals made through eRS. Paper referrals will no longer be accepted.

We have worked closely with NHS England and Commissioners over the last year to implement these changes and in March this year were shown by NHSE to be one of only 16 organisations (out of 150) that was compliant.

This has been a significant piece of work and the efforts of those involved, particularly our patient access team, should be commended. Furthermore, completing the work has meant that the Trust has successfully achieved a CQUIN target worth £1.28m.



7. Additional training places for HYMS

It has just been announced that Hull York Medical School (HYMS) has been allocated 75 additional medical school places as part of the Higher Education Funding Council for England's expansion of undergraduate medical education. Of these places 10 will be for 2018 entry and 65 for 2019 entry. This, together with an initial allocation of 15 places which was announced last year, represents a 69% increase in places – from 130 available in 2017 to 220 in 2019.

This is fantastic news for HYMS and it is vital that we continue to work closely with them to train, recruit and retain our future medical workforce. We are starting to recruit consultants who are HYMS graduates, and I hope we can expand on the number of people we are able to recruit into the organisation that have studied and trained locally.



Board of Directors – 28 March 2018 Quality and Safety Committee Minutes – 20 March 2018

Recommendation

For information	<input checked="" type="checkbox"/>
For discussion	<input checked="" type="checkbox"/>
For assurance	<input checked="" type="checkbox"/>
For approval	<input type="checkbox"/>
A regulatory requirement	<input checked="" type="checkbox"/>

Current approval route of report

The minutes are approved by the Quality and Safety Committee.

Purpose of report

The purpose of the Quality and Safety 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.

Key points for discussion

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

1. Operational Pressures – JT
2. Medical Staffing and agency spend - JT
3. Safeguarding Adults and DoLs - BG
4. Enhanced Supervision – BG
5. Clinical Effectiveness – process and assurance JT
6. Isolation Facilities - JA

Trust Ambitions and Board Assurance Framework

(https://www.yorkhospitals.nhs.uk/about_us/our_values/)

The Board Assurance Framework is structured around the four ambitions of the Trust. How does the report relate to the following ambitions:

- Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.
 - Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.
 - People and Capability** - The quality of our services is wholly dependent on our teams of staff.
 - Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.
-

Reference to CQC Regulations

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

Version number: Version 1

Author: Liz Jackson, Patient Safety Project Support Officer

Executive sponsor: Jennie Adams, Non-Executive Director

Date: 20 March 2018



Quality & Safety Committee Minutes – 20 March 2018

Attendance: Jennie Adams, Libby Raper, James Taylor, Beverley Geary, Fiona Jamieson, Donald Richardson, Lynda Provins and Liz Jackson

Minutes of the meeting held on the 20 February 2018

The notes from the meeting held on the 20 February were approved as a true and accurate record. The Committee noted that due to the Strategic Timeout the minutes are yet to be reviewed by Board.

Matters Arising

CRR Ref: MD3, MD2a, MD2b & Action Log Item 72 - The Committee revisited the discussion around appropriate risk registers for specific risks. It was questioned whether Information Governance should sit on the Finance Risk Register; however as JT is the Caldicott Guardian, patient information risks should sit on the Medical Directors Risk Register. FJ confirmed that the Senior Information Risk Owner (SIRO) report includes an overview of all information governance issues. The level of each breach is assessed and escalated appropriately. The SIRO reports to the Finance and Performance Committee but the annual SIRO report could come to both Committees for assurance. JT has met with Polly McMeekin regarding medical staffing risks sitting on the Workforce or Medical Directors Risk Register, these will be aligned formally. BG felt that there were no risks on the Chief Operating Officer (COO) Risk Register that should be realigned to the Chief Nurse and questioned areas in which the Committee required assurance. The COO risks include emergency planning, 12 hour breaches, patient flow and cancer targets which all impact on safety. The Committee agreed it would be useful to triangulate these with the Safety agenda and asked if the COO Risk Register could come for information. JT explained that Directorate Risk Registers are reviewed at Quality and Safety PAMs and are cross referenced during the meeting.

Action: Patient specific risks in the SIRO report to be discussed at Quality and Safety Committee, terms of reference and work plan to be adjusted accordingly.

Action: COO Risk Register to come to Committee for information.

Falls and Pressure Ulcers - The Committee previously raised concern around the number of falls and pressure ulcers in January and February and noted that these numbers are now beginning to settle. BG advised that themes have been reviewed and there has been some focused work on enhanced supervision. JT added that the interviews for the Deputy Director of Patient Safety and the Head of Patient Safety posts are imminent and there has been a good response to each post. These posts will lead on the falls and pressure ulcer work.

Visiting Times - BG confirmed that the review of visiting times is yet to be discussed at the Senior Nurses Group and will be prioritized at the next meeting.

Action: BG - Visiting times for discussion at the next Senior Nurses Group.



Operational Pressures – CRR Ref: MD6a, MD6b - There are still significant pressure in the system and the Committee was assured that the risk ratings, alerts and concerns raised at the Committee reflect these pressures. There has been a significant increase in 12 hour breaches in Scarborough ED and JT has met with Wendy Scott to discuss ED performance. The Trust average performance doesn't reflect the greater difficulties in Scarborough as the York and Scarborough performance indicators are aggregated. The Committee requested assurance that patients are being kept safe. BG confirmed that Corporate Directors have discussed the breaches and what is being offered to those patients, which now includes hot meals. Patients are kept safe; however cannot receive the expected quality of care when on an ED trolley for a long period of time. Mitigations are being put in place to improve delayed transfers of care. There has been recourse to boarding on occasions where an extra bed is being added to each ward and implementation is assessed on a shift by shift basis. JT added that the low number of discharges is a contributing factor to the pressures and there needs to be a sustainable, systematic approach which includes acceptance of the risk of readmissions. Elective activity will be cancelled if it will have an impact on acute and urgent care. The Committee queried if harm events were being reported. BG confirmed that the 12 hour breaches have been recorded and will be investigated under the SI process. A plan is being put in place for the Easter weekend in the light of the poor response to Christmas staffing requests, however there has been little uptake from staff.

Board – JT to raise at Board

Action Log Items

Item 36 – The Committee noted that Internal Audit have re-audited Patient Consent which has provided limited assurance. The focused work has moved from the Governance Team to the Patient Safety Team and the Committee expressed a desire to see improvement now that there was more clarity around outstanding actions.

Item 68 – The Patient Safety Strategy was discussed at the Strategic Timeout and the Committee queried when the final version would be complete. JT confirmed that the proposals need to be discussed in further detail to ensure that they align with other strategies. JT agreed to send the presentation from the strategic timeout to colleagues and LP will liaise with Non-executives. Patient Safety work is being piloted in some directorates where there is good leadership in place. Four Clinical Directors are standing down in the next month and JT will engage the new Clinical Directors in the patient safety agenda. The thrust of the strategy is to develop a safety culture driven by staff delivering the service.

Action: JT to bring final version to the May meeting, dependent on recruitment and winter pressures.

Item 73 – BG explained that the data around compliance with nursing appraisals is similar to that of statutory and mandatory training, in that the rate of compliance is adversely affected by inclusion in the denominator of staff on maternity or sick leave, workforce and ESR data are also not up to date. Helen Hey is working with ODIL to cleanse the data. The

Committee raised concern around this system issue as CQC have requested percentage compliance.

Item 74 – CRR Ref: CN8 - Update from the last Board meeting was that Isolation Facilities Proposal has been discussed at the Environment and Estates Committee; however, requires further work. The Committee expressed their frustration in the delayed development of the proposal.

Board: JA to raise at board.

All other Actions on the log were included in the agenda items.

Risk Register for the Medical Director and Chief Nurse

The Committee noted that the Chief Nurse risk Register had been reviewed in March.

CRR Ref: CN2 – BG highlighted that the Nurse Staffing risk score has increased as the vacancies have increased in AMU and Elderly Medicine at York. The Chief Nurse Officer for England has advised that it will get worse before it gets better.

CRR Ref: CN15 – A risk around flu outbreak had been added over the winter; however BG explained that this may be de-escalated or removed. The numbers have significantly reduced and patients are now being managed in cubicles. A look back exercise has begun and will be discussed at the DIPC meeting. JT confirmed that the impact of the flu epidemic on mortality will also be reviewed in detail.

The Committee queried if there was anything in the CQC report that was not included on the risk registers. In particular they raised the issue of deprivation of liberty and mental capacity Act and ED children's nursing/safeguarding. There has been a significant work stream since September but a recent internal audit has given limited assurance, BG and FJ will conduct a risk assessment. The Paediatric Consultants are providing safeguarding training in both Emergency Departments and there is some funding for specialist in ED. BG will include Children's Safeguarding in the April Chief Nurse report. The lack of a Paediatric area in the Emergency Departments has been raised at the Estates and Environment Committee; however would require a significant capital expenditure. LR suggested holding a charitable campaign and agreed to liaise with Dianne Willcocks.

Action: BG and FJ to add DoLs to the Chief Nurse Risk Register

Action: BG to include Children's safeguarding update in the April Chief Nurse Report

Board: BG to raise Safeguarding Adults and DoLs at Board.

CRR Ref: MD2a, MD2b and MD10 – JT advised that the Trust continues to employ locums to fill gaps in the medical rotas and agency spend caps have been breached where necessary. The Committee highlighted that medical agency spend has reduced since September and JT confirmed that this is due to rate reduction, a cap on per hour pricing and moving long term locums on to alternative contracts. The CQC noted large gaps in medical staffing on the East Coast and the Committee queried if there was a long term plan. Medical recruitment remains challenging and non-UK recruitment is being



considered. The terms and conditions for doctors in the UK are more attractive than in many other countries. The Committee noted that there are many gaps in the rotas on the Scarborough site and queried if an alternative model is being considered and if cross site working is being implemented. JT confirmed that there are a huge amount of services that work between York and Scarborough hospitals and the issue is delivering acute and urgent care and OOH. DR highlighted that rates for Junior Doctors are different on the Scarborough site to encourage people to work there; this has caused some animosity with the juniors on the York site. JT advised that Hull and York Medical School have been allocated 75 additional places, recruitment fairs are being held for Physicians Assistants and flexible approaches to workforce retention are being explored. DR highlighted that 40% of Junior Doctors are now leaving training after their F2 year.

Board – JT to raise at Board

Patient Safety

Nurse Staffing

CRR Ref: CN2 and CN13

BG confirmed that the Safe Care model should be rolled out by June, staffing rates will be more accurate and reports will look different. A recruitment market place is scheduled to take place in April, which usually attracts a number of new recruits. The Committee raised concern over the 28% unfilled shift rate. BG explained that Ward 24 has now been opened to full capacity and staffing has been challenging. There has been some improvement in the staffing of Chestnut and Beech Ward; however the Acute Medical Units on both sites remain an issue. The Committee noted that they would like to be able to see staffing data for ED nurses if possible.

Focussed work is being undertaken around enhanced supervision, this was piloted in July with work commencing in September. Changes to practice have been implemented and learning will be shared across the organisation. Ward 37 have seen a significant reduction in falls with harm, trained dementia volunteers are in place and the dementia café is being utilised. The decrease in the number of additional staff required for enhanced supervision has led to a £100,000 a month cost saving.

Board – BG to raise at Board

Infection Prevention and Control

CRR REF: CN7 AND CN8

The Committee noted that the Trust has seen no incidences of MRSA for 154 days. Although the Trust is over trajectory for the year, two incidents were contained and two were the same patient. There is a reduction in the number of MSSA and ECOLI incidents compared to the same time last year. BG advised that the Trust is joining a national ECOLI programme and the Infection prevention team will work with the Improvement Academy to lead on the improvement work, linking with ODIL and the isolation facility work.

Maternity Services



The Committee reviewed the results of the National Maternity Survey and BG explained that there has been much improvement work around quality and safety in this area. The Trust has been chosen to be in the third wave of the National Maternal and Neonatal Health and Safety Collaborative, which is a supported quality improvement programme and work in Maternity will also feature in the Quality Priorities.

Assurance: The Committee were assured by the focused work in Maternity and the positive responses from the patient survey.

Patient Safety Walk Rounds

The Committee showed concern around the patient safety walk round on ward G1. BG explained that the Head and Neck and Gynaecology Ward has had many medical outliers over winter and this should improve as operational pressures reduce.

Clinical Effectiveness

Serious Incidents and Never Events

CRR Ref: MD8

The Committee reviewed the charts showing the breakdown of SIs and queried if there was still a back log. FJ confirmed that many sit with the commissioners for sign off; however, learning is shared within the organisation prior to this. JT added that processes are being reviewed and culture embedded as there is currently a lack of ownership and focus of the recommendations, which should flow from a clear RCA. JT advised that all cancer breaches, outside of the 62 day system, are analysed but harm is not currently captured. Psychological harm is not always reported. The Committee highlighted that although there are many medication errors, there have only been five with serious harm out of around 1800 per annum. DR explained that, due to the introduction of EPMA, errors are now picked up at the dispensing stage; therefore do not reach the patient.

Duty of Candour

The Committee highlighted that the Duty of Candour data in the Medical Directors Report does not match the data included in the Board pack. The Committee showed concern that compliance with DoC was poor in February and that the Trust do not report much moderate harm compared to the national average. FJ was confident in the measures of harm used and all SIs are reviewed at SI Committee.

Action: FJ to review DoC data in the Board pack for accuracy

National Bowel and Lung Cancer Audits

The Committee noted the interesting content of the two audits. JT highlighted the improved data quality between 2013/14 and 2014/15 for the Bowel Cancer audit, which provides a better comparator of performance. There is further work to be done around laparoscopic surgery rates and 90 day mortality. The Bowel Cancer Lead has an action



plan that addresses all of the identified issues. FJ confirmed that an action plan is put in place for every clinical audit and monitored by clinical effectiveness. The Committee requested to review the bowel cancer and sepsis action plans and the briefcases to gain assurance that the clinical audit process plan is working effectively.

Action: Bowel Cancer and Sepsis action plans to come to the April meeting.

Assurance: The Committee took assurance from the robust audit process.

Board – JT to raise at Board

Clinical Effectiveness Group

FJ advised that Clinical Effectiveness Group met to discuss terms of reference and broaden the membership, therefore there were no minutes submitted to the Committee. The new enlarged Group is scheduled to meet in April and it is hoped that this will improve the level of clinical engagement.

Anti-biotic prescription audit

The Committee reviewed the Anti-biotic Prescription Audit data and highlighted that the compliance with the recording of duration has decreased. DR advised that this is part of the reduction in anti-biotic usage work. York are recording medications on EPMA and duration is no longer required as review date is now included. The outcome measure of reduced volume of Abs prescribed still shows an improvement.

Patient Experience

The Patient Experience Team

BG advised that the Patient Experience team is now falling in to place. One member is acting up to one of the band 7 roles and the band 7 volunteer role is currently out to advert.

Additional Items

Quality Priorities

BG confirmed that the Maternity quality priorities have been agreed as; a 20% reduction in still births by 2020 and a 20% increase in continuity of care by 2019. BG is meeting to finalise the Infection Prevention priorities today. The Committee were pleased to see that the Governors had chosen dementia as a priority and highlighted that, where possible, a measurement needs to be included by which to assess performance.

Terms of Reference

The Committee thanked LP for the changes made to the terms of reference and asked to include the SIRO annual report in to the work plan and add the Deputy Director of Patient Safety in to the membership. The document was approved pending these amendments.

Action: LP to make amendments.

Time and Date of the next meeting

To be a valued and trusted partner within our care system delivering safe effective care to the population we serve.



Next meeting of the Quality and Safety Committee: 17 April 2018, Boardroom, York Hospital

Quality & Safety Committee – Action Plan – April 2018

No.	Month	Action	Responsible Officer	Due date	Completed
36	Mar 17	Foundation Trust Secretary to liaise with Medical Director for the Patient Consent Audit report	Helen Noble	May 17, Jun 17, Jul 17, Aug 17, Sept 17, Jan 18, Feb 18, July 2018	
68	Dec 17	JT to bring amended Patient Safety Strategy	Medical Director	Feb 18 March 2018 May 2018	
69	Dec 17	Quality Priorities to come for sign off.	Chief Nurse / Foundation Trust Secretary	March 18	Completed
70	Feb 18	Amended TOR to be represented	LP	March 2018	Completed
71	Feb 18	Sepsis Audit to be added to work programme for Feb 2019	LP/FJ	Feb 2019	Completed
72	Feb 18	MD to check with exec colleagues risk register items on IG and Medical Staffing	JT	Mar 18	Completed
73	Feb 18	Nursing appraisal item to be added to March agenda	BG	Mar 18, April 18	
74	Feb 18	Review isolation facility proposals from Estates Director	BG	Mar 18, April 18	
75	Mar 18	SIRO report to be added to the Q&S work plan	LP	April 18	
76	Mar 18	COO Risk Register to come to Committee for information	LP	April 18	
77	Mar 18	Proposed visiting times to be discussed at Senior Nurse Meeting	BG	April 18	
78	Mar 18	To include Childrens Safeguarding update in the April Chief Nurse Report	BG	April 18	
79	Mar 18	To review accuracy of the DoC data in the Board pack	FJ	April 18	
80	Mar 18	Bowel Cancer and Sepsis Action Plans to be reviewed by the Committee	FJ	April 18	



Blank page

Patient Safety and Quality Performance Report

March 2018

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
	Duty of Candour
	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	
Quantitative Information Report	

Quality and Safety Summary: Trust

	Target/Threshold 2017/18	Monthly Target/Threshold	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Patient Experience														
Litigation - Clinical Claims Settled	-	-	5	1	10	7	6	2	5	2	5	2	2	3
Complaints	-	-	38	34	46	36	51	43	50	38	37	27	28	30
Duty of Candour														
Incident Graded Moderate or Above	-	-	n/a	18	7	15	13	11	16	8	22	16	14	7
Verbal Apology Given	-	-	n/a	16	5	13	12	7	11	7	15	6	5	1
Written Apology Required	-	-	n/a	17	7	13	11	11	14	7	18	15	10	7
Written Apology Given	-	-	n/a	12	5	11	7	7	8	5	4	2	2	1
Care of the Deteriorating Patient														
14 hour Post Take - York	90%	Q1 82% Q2 82% Q3 85% Q4 90%	89%	90%	91%	91%	91%	89%	91%	92%	89%	92%	94%	90%
14 hour Post Take - Scarborough	80%	Q1 52% Q2 60% Q3 70% Q4 80%	75%	72%	63%	79%	80%	74%	74%	73%	73%	72%	77%	75%
Acute Admissions seen within 4 hours	80%	80%	87%	85%	83%	86%	93%	86%	92%	86%	90%	87%	89%	87%
NEWS within 1 hour of prescribed time	90%	90%	87.9%	89.4%	87.2%	89.2%	89.0%	88.8%	88.2%	90.2%	90.3%	89.0%	88.3%	89.1%
All Elective patients to have an Expected Discharge Date (EDD) recorded within 24 hours of admission	93%	93%	87%	87%	86%	86%	84%	88%	84%	87%	84%	84%	90%	87%
Measures of Harm														
Serious Incidents	-	-	10	9	20	19	14	12	8	16	10	12	22	21
Incidents Reported	-	-	1383	1236	1196	1243	1323	1210	1268	1258	1248	1323	1430	1205
Incidents Awaiting Sign Off	-	-	1129	828	698	746	868	832	766	733	684	892	900	883
Patient Falls	-	-	222	225	228	231	218	216	268	223	258	293	302	265
Pressure Ulcers - Newly Developed	-	-	137	131	134	109	113	97	107	101	104	131	160	143
Pressure Ulcers - Transferred into our care	-	-	88	74	67	77	82	60	77	68	52	71	71	60
Degree of harm: serious or death	-	-	11	5	1	9	2	1	7	2	6	7	10	1
Degree of harm: medication related	-	-	174	151	128	158	160	128	128	161	172	191	165	125
VTE risk assessments	95%	95%	98.6%	98.5%	97.9%	98.3%	97.6%	97.9%	97.7%	98.3%	98.7%	98.0%	98.2%	97.7%
Never Events	0	0	0	0	1	0	1	1	0	1	0	0	0	0
Drug Administration														
Insulin Errors	-	-	6	12	11	10	12	9	11	11	9	15	9	11
Prescribing Errors	-	-	36	28	33	34	40	24	32	44	66	95	60	23
Preparation and Dispensing Errors	-	-	13	20	14	27	24	7	13	17	19	6	11	9
Administrating and Supply Errors	-	-	75	66	50	58	58	62	54	70	53	61	52	60

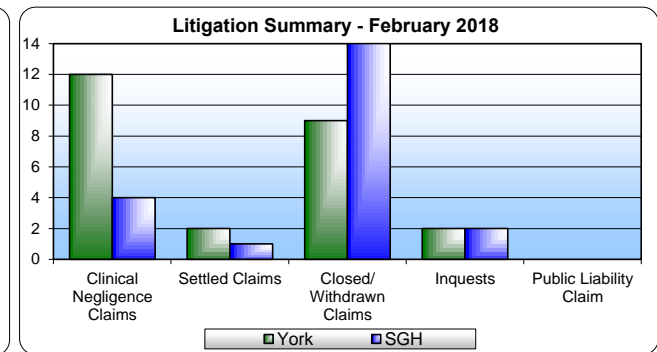
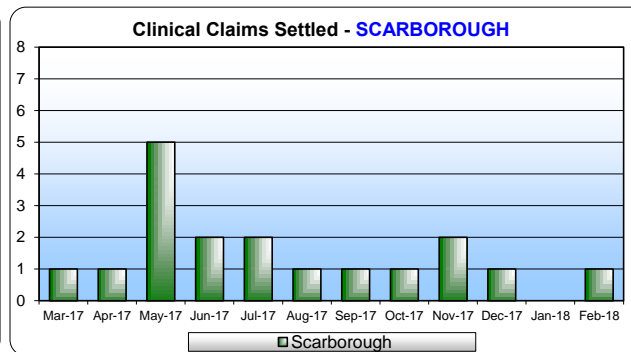
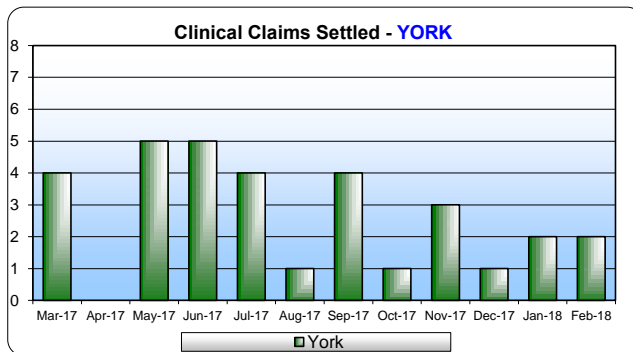
Mortality Information	Target/ Threshold 2017/18	Monthly Target/ Threshold	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15	Jan 15 - Dec 15	Apr 15 - Mar 16	Jul 15 - Jun 16	Oct 15 - Sep 16	Jan 16 - Dec 16	Apr 16 - Mar 17	Jul 16 - Jun 17	Oct 16 - Sep 17
Summary Hospital Level Mortality Indicator (SHMI)	100	100	101	101	99	99	99	100	99	98	97	97	98	100
DoLS	Target/ Threshold 2017/18	Monthly Target/ Threshold	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Standard Authorisation Status Unknown: Local Authority not informed the Trust of outcome	-	-	n/a	17	25	29	16	20	7	4	5	6	11	5
Standard Authorisation Not Required: Patient no longer in Trust's care and within 7 day self-authorisation	-	-	n/a	14	12	5	7	11	9	11	8	11	13	9
Under Enquiry: Safeguarding Adults team reviewing progress of application with Local Authority or progress with ward	-	-	n/a	0	0	0	0	0	0	0	0	0	3	7
Standard Authorisation Granted: Local Authority granted application	-	-	n/a	1	0	0	0	0	2	0	0	0	1	0
Application Not Granted: Local Authority not granted application	-	-	n/a	0	0	1	0	0	0	1	0	0	1	0
Application Unallocated as Given Local Authority Prioritisation: Local Authority confirmed receipt but not yet actioned application	-	-	n/a	0	0	0	0	0	0	2	4	1	0	0
Safeguarding Adults concerns reported to the Local Authority against the Trust	-	-	n/a	1	1	3	4	4	5	1	1	3	6	2
Infection Prevention	Target/ Threshold 2017/18	Monthly Target/ Threshold	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Clostridium Difficile - meeting the C.Diff objective			5	2	2	5	2	3	5	7	4	3	5	4
CDIFF Cumulative Threshold	48 (year)	48 (year)	48	4	8	12	16	20	24	28	32	36	40	44
Clostridium Difficile -meeting the C.Diff objective - cumulative			46	2	4	9	11	14	19	26	30	33	38	42
MRSA - meeting the MRSA objective	0	0	0	0	1	0	0	3	1	0	0	0	0	0
MSSA	30	2	5	3	3	7	5	6	3	3	3	4	2	0
MSSA - cumulative			52	3	6	13	18	24	27	30	33	37	39	39
ECOLI			5	6	8	9	4	7	3	8	8	13	12	2
ECOLI - cumulative			85	6	14	23	27	34	37	45	53	66	78	80
MRSA Screening - Elective	95%	95%	88.1%	89.1%	84.7%	88.3%	85.2%	87.9%	81.7%	87.8%	89.6%	85.4%	87.7%	85.4%
MRSA Screening - Non Elective	95%	95%	87.4%	87.4%	84.3%	85.9%	88.2%	89.5%	88.3%	89.6%	90.2%	87.5%	85.6%	85.9%
Stroke (one month behind due to coding)	Target/ Threshold 2017/18	Monthly Target/ Threshold	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Proportion of patients who experience a TIA who are assessed & treated within 24 hrs	75%	75%	100.0%	87.5%	83.3%	100.0%	62.5%	62.5%	73.7%	94.7%	92.3%	78.3%	93.8%	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%	91.7%	100.0%	100.0%	100.0%	1 month behind
SSNAP Scores			Aug 16 - Nov 16	Dec 16 - Mar 17	Mar 17 - Apr 17	May 17 - Aug 17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18		
Proportion of patients spending >90% on their time on stroke unit	85%	85%	87.1% (B)	87.5% (B)	83.4% (C)	90.5% (A)	90.1% (A)	88.9% (B)	96.4% (A)	89.1% (B)	86.2% (B)	91.7% (A)		
Scanned within 1 hour of arrival	43%	43%	44.4% (B)	44% (B)	44.2% (B)	51.8% (A)	55.4% (A)	60.0% (A)	46.0% (B)	56.3% (A)	42.4% (C)	50.7% (A)		
Scanned within 12 hours of hospital arrival	90%	90%	93.8% (A)	88.7% (B)	92.1% (B)	92.6% (B)	89.1% (C)	94.3% (B)	95.2% (A)	95.8% (A)	89.4% (C)	92.8% (B)		
AMTS	Target/ Threshold 2017/18	Monthly Target/ Threshold	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
AMTS Screening	90.0%	90.0%	88.9%	86.7%	79.3%	85.1%	81.7%	80.5%	82.0%	82.8%	83.4%	80.3%	78.4%	81.7%



Patient Experience (Patient Experience Team)	Measures of Harm	Infection Prevention	Quality and Safety - Miscellaneous
<p>Friend and Family Test (FFT) Latest Results – January 2018</p> <p>The inpatient satisfaction rate for January 2018 was 97.6%, the highest for 12 months. The ED satisfaction rate was 87.3%, York ED remained above average at 88%, Scarborough ED was down 4% at 83%. The inpatient response rate was 27.3%, similar to previous months (national average 22.1%). The ED response rate was 14.2% (national average 11.6%)</p> <p>Complaints and PALS Management</p> <p>27% of cases closed in February met the Trust's 30 day response target.</p>	<p>No Never Events were declared in February 2018.</p> <p>21 Serious Incidents were declared; 14 at York, 5 at Scarborough and 2 in Community. 11 of the SIs were attributed to Clinical Incidents, 7 were attributed to Slips, Trips and Falls and 3 were attributed to Pressure Ulcers.</p>	<p>The Trust reported no cases of MRSA in February. This remains a zero tolerance measure in 2017/18.</p> <p>In February 2018 the Trust reported 4 cases of CDI/F, 3 at York and 1 in Scarborough. The yearly threshold for 2017/18 remains at 48, monthly allocation allows for 4 cases.</p> <p>No cases of MSSA were reported in February.</p> <p>2 cases of ECOLI were reported in February, both at York.</p>	<p>Stroke (reported 1 month behind due to coding) In January the Trust achieved a 'C' rating for the proportion of patients scanned within 1 hour of arrival and 12 hours of hospital arrival, the percentage narrowly below each target. The Trust achieved a 'B' rating for patients spending > 90% of their time on a stroke unit. The 75% target was met for TIA patients assessed within 24 hours (93.8%).</p> <p>Cancelled Operations 129 operations were cancelled within 48 hours of the TCI date due to lack of beds in February. This is an increase on February 2017 when 117 operations were cancelled.</p> <p>Cancelled Clinics/Outpatient Appointments 150 clinics were cancelled with less than 14 days notice; this figure is a 14.3% decrease on February 2017 and is below the monthly threshold of 180. 757 outpatient hospital appointments were cancelled for non clinical reasons which is a 13.7% decrease on February 2017.</p> <p>Ward Transfers between 10pm and 6am 106 ward transfers between 10pm and 6am were reported in February (Scarborough - 34, York - 72), the threshold is 100 threshold per month. In February 2017 there were 98 transfers.</p> <p>AMTS The Trust failed to achieve the 90% target for AMTS screening in February, performance was 81.7%. The Trust has failed to</p>
Care of the Deteriorating Patient	Drug Administration	Mortality	CQUINS update (Operations Team)
<p>The target was achieved for York for the proportion of Medicine and Elderly patients receiving a senior review within 14 hours in February. York achieved 90% against the 90% target for Q4. Scarborough achieved 75% and therefore failed the 80% target for Q4.</p> <p>89.1% of patients had their NEWS scores completed within 1 hour in February against the Trust's internal target of 90%, failing its target for the third consecutive month. Scarborough continue to consistently achieve target with performance of 92.2% in February, York achieved 87.3%.</p> <p>87.3% of Elective patients had their Expected Date of Discharge recorded within 24 hours of admission across the Trust in February. The target of 93% has not been achieved, and this remains consistent with previous months. The last time this target was achieved was March 2016.</p>	<p>11 insulin errors were reported in February, including 4 for York, 5 for Scarborough and 2 for Community.</p> <p>23 prescribing errors were reported across the Trust in February, with 16 for York, 5 for Scarborough and 2 for Community.</p> <p>9 dispensing errors were reported across the Trust in February. The number of dispensing errors has reduced following the peak in November 2017, with 8 at York, 1 at Scarborough and none in Community. However, numbers remain higher than the reduction seen in August and December 2017.</p>	<p>The latest SHMI report indicates the Trust to be in the 'as expected' range. The October 2016 - September 2017 SHMI saw a 2 point increase for York, a 2 point increase for Scarborough and a 2 point increase for the Trust. Trust - 100, York 95 and Scarborough 108.</p> <p>195 inpatient deaths were reported across the Trust in February; 122 were reported at York and 64 were reported at Scarborough.</p> <p>20 deaths in ED were reported in February; 12 at York and 8 at Scarborough.</p>	<p>The Trust is currently collating evidence reports to show compliance against 2017/18 Q3 CQUINS, please refer to CQUINS page 4 for details.</p>

Litigation

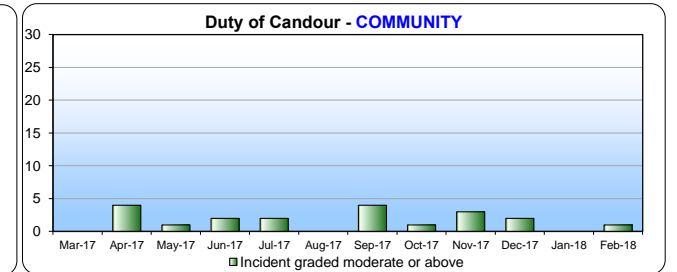
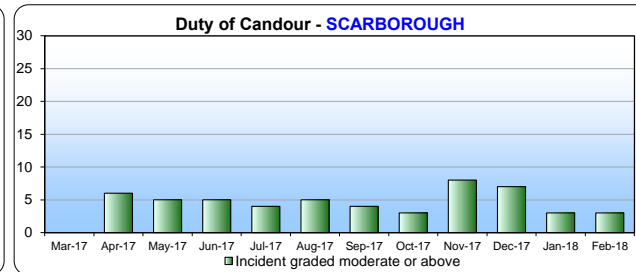
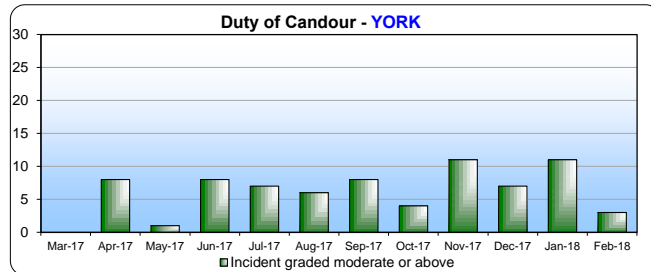
Indicator	Site	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Clinical Negligence Claims Received	York	7	12	7	10	8	10	7	6	7	6	10	12
	Scarborough	2	2	8	7	5	6	3	6	5	4	4	4
Clinical Claims Settled	York	4	0	5	5	4	1	4	1	3	1	2	2
	Scarborough	1	1	5	2	2	1	1	1	2	1	0	1
Closed/ Withdrawn Claims	York	7	0	1	5	4	5	4	3	6	6	5	9
	Scarborough	3	2	1	4	7	1	3	7	6	4	0	14
Coroners Inquests Heard	York	3	3	2	3	6	3	4	1	3	9	3	2
	Scarborough	1	2	1	4	1	1	1	1	3	1	1	2



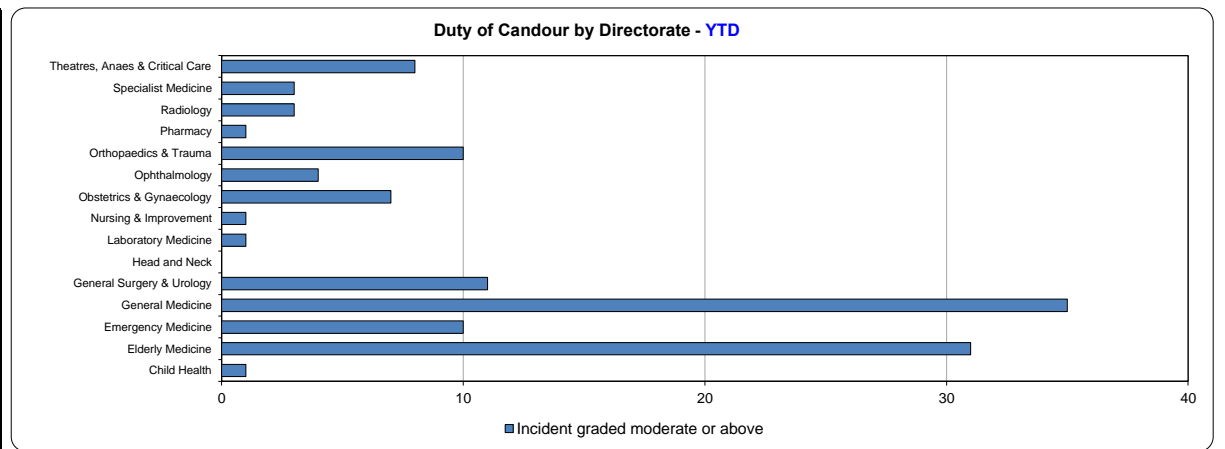
Duty of Candour

Indicator	Site	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Incident graded moderate or above	York	n/a	8	1	8	7	6	8	4	11	7	11	3
Verbal apology given		n/a	6	1	6	7	3	6	3	8	3	3	0
Written apology required		n/a	8	1	8	6	6	7	4	10	6	7	3
Written apology given		n/a	4	1	6	3	3	4	3	2	1	1	1
Incident graded moderate or above	Scarborough	n/a	6	5	5	4	5	4	3	8	7	3	3
Verbal apology given		n/a	6	3	5	3	4	1	3	6	3	2	1
Written apology required		n/a	5	5	4	3	5	4	3	6	7	3	3
Written apology given		n/a	4	3	3	3	4	1	2	1	1	1	0
Incident graded moderate or above	Community	n/a	4	1	2	2	0	4	1	3	2	0	1
Verbal apology given		n/a	4	1	2	2	0	4	1	1	0	0	0
Written apology required		n/a	4	1	1	2	0	3	0	2	2	0	1
Written apology given		n/a	4	1	2	1	0	3	0	1	0	0	0

Note: data from April 2017 onwards all subject to ongoing validation.



Specialty	Indicator - YTD		
	Verbal apology given	Written apology required	Written apology given
Child Health	1	1	1
Elderly Medicine	23	26	14
Emergency Medicine	5	10	3
General Medicine	18	31	9
General Surgery & Urology	9	10	4
Head and Neck	0	0	0
Laboratory Medicine	1	1	0
Nursing & Improvement	1	0	0
Obstetrics & Gynaecology	7	7	7
Ophthalmology	4	4	2
Orthopaedics & Trauma	3	9	4
Pharmacy	1	1	1
Radiology	2	2	2
Specialist Medicine	2	3	1
Theatres, Anaesthetics & Critical Care	6	8	3



Patient Experience

PALS Contacts

There were 215 PALS contacts in February

Complaints

There were 30 complaints in February

New Ombudsman Cases

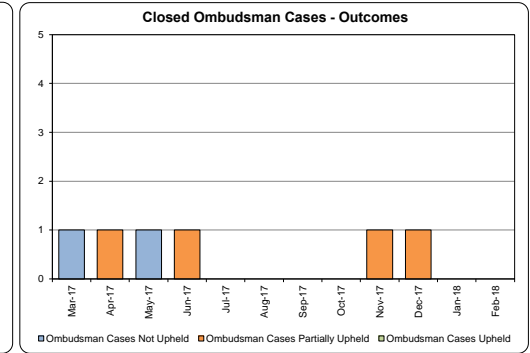
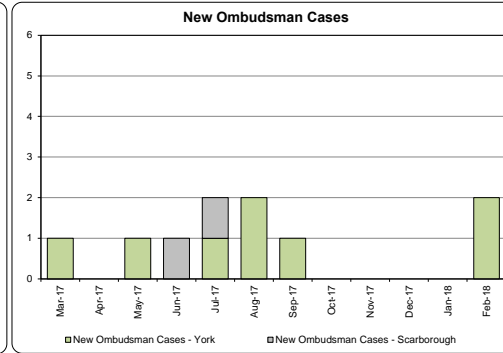
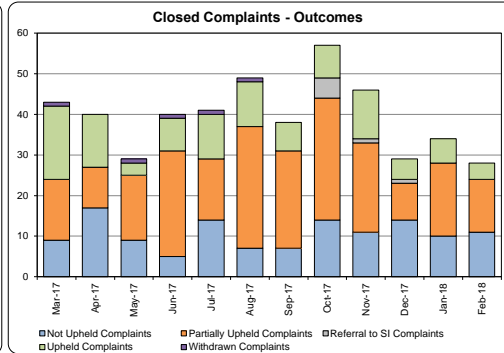
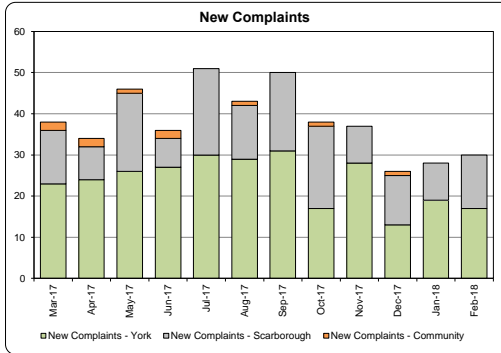
There were 2 new Ombudsman Cases in February, both for York.

Compliments

509 compliments were received in February 2018. The number of compliments per month peaked in September 2017 with 1,519 being received. In recent months there have been over 3,550 compliments received between October 2017 and February 2018.

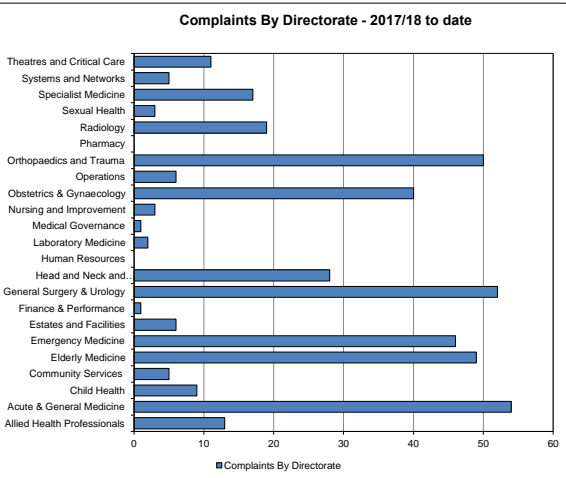
Patient Experience

Mar-18



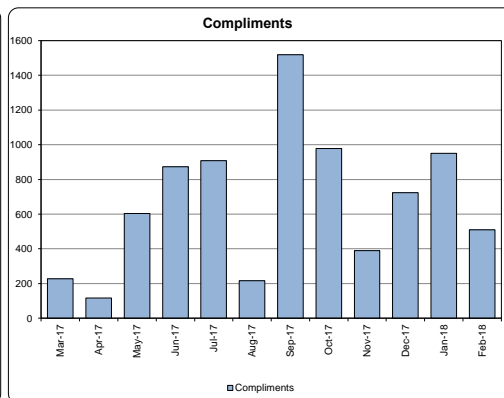
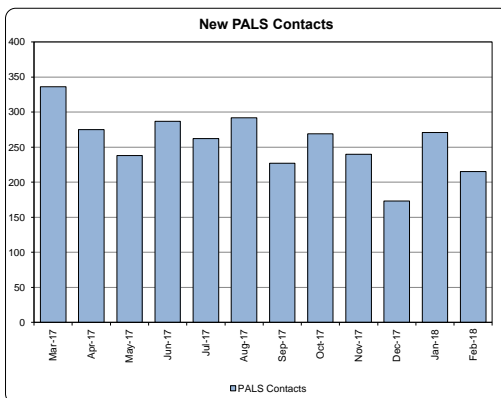
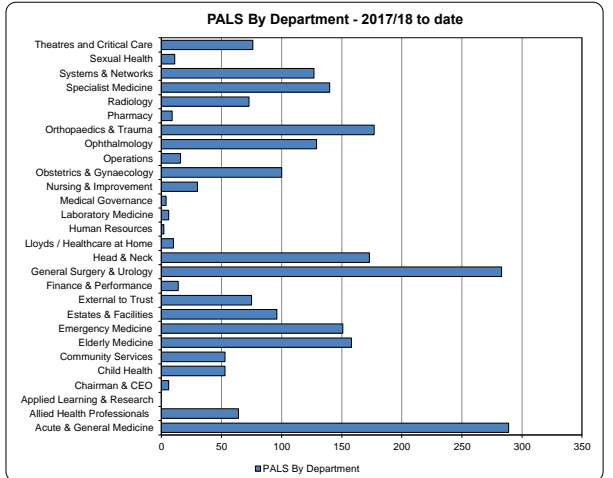
Complaints By Subject	Feb-18	YTD
Access to treatment or drugs	1	9
Admissions, Discharge and Transfer Arrangements	6	69
All aspects of Clinical Treatment	25	281
Appointments, Delay/Cancellation	1	55
Commissioning	0	0
Comms/info to patients (written and oral)	9	121
Complaints Handling	0	0
Consent	0	4
End of Life Care	0	3
Facilities	0	14
Mortuary	0	0
Others	0	0
Patient Care	5	146
Patient Concerns	1	3
Prescribing	0	29
Privacy and Dignity	0	30
Restraint	0	1
Staff Numbers	0	3
Transport	0	0
Trust Admin/Policies/Procedures	2	32
Values and Behaviours (Staff)	6	114
Waiting times	3	15
TOTAL	59	929

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



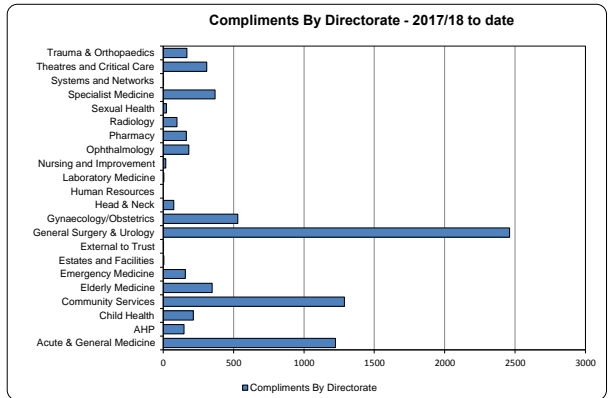
PALS By Subject	Feb-18	YTD
Access to Treatment or Drugs	22	169
Admissions and Discharges (Excluding Delayed Discharge due to absence of care package)	15	160
Appointments	23	473
Clinical Treatment	24	237
Commissioning	0	6
Communication	32	642
Consent	0	5
End of Life Care	0	19
Facilities	7	95
Integrated Care (including Delayed Discharge Due to Absence of a Care Package)	0	0
Mortuary	1	2
Patient Care	18	170
Patient Concerns	9	96
Prescribing	5	38
Privacy, Dignity & Respect	1	33
Staff Numbers	0	4
Transport	0	11
Trust Admin/Policies/Procedures Inc. pt. record management	10	123
Values and Behaviours (Staff)	43	358
Waiting Times	5	108
Total	215	2749

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.



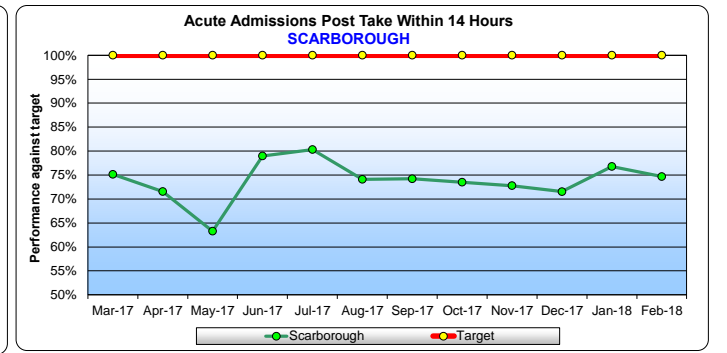
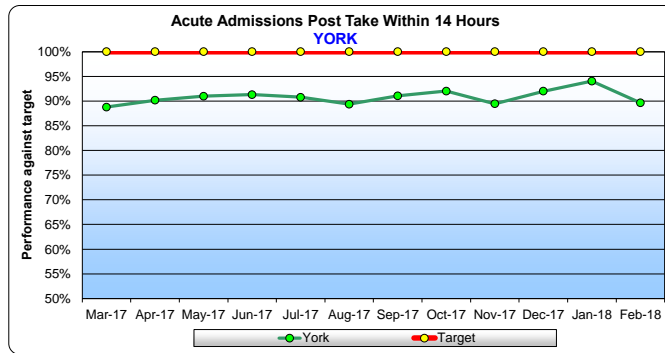
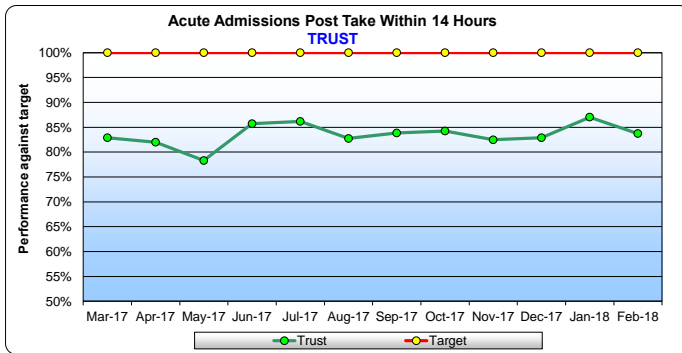
Compliments By Directorate	Feb-18	YTD
Acute & General Medicine	22	1223
AHP	62	147
Child Health	28	213
Community Services	149	1288
Elderly Medicine	19	348
Emergency Medicine	30	156
Estates and Facilities	0	4
External to Trust	0	2
General Surgery & Urology	37	2462
Gynaecology/Obstetrics	26	530
Head & Neck	10	75
Human Resources	0	0
Laboratory Medicine	2	4
Nursing and Improvement	0	19
Ophthalmology	9	182
Pharmacy	0	165
Radiology	13	99
Specialist Medicine	33	369
Systems and Networks	0	2
Theatres and Critical Care	30	310
Trauma & Orthopaedics	30	168
Total	509	7788

Up until December 2016 compliments reported were only those received directly by the Chief Executive and PALS. From January 2017 numbers from wards and departments are included.

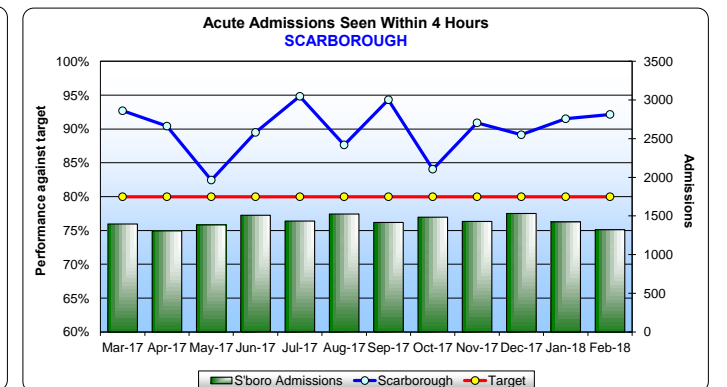
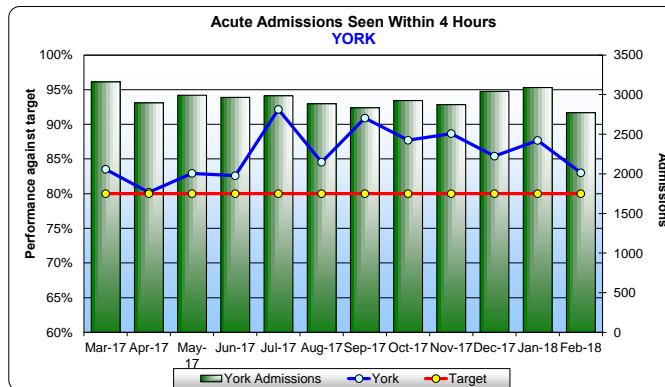
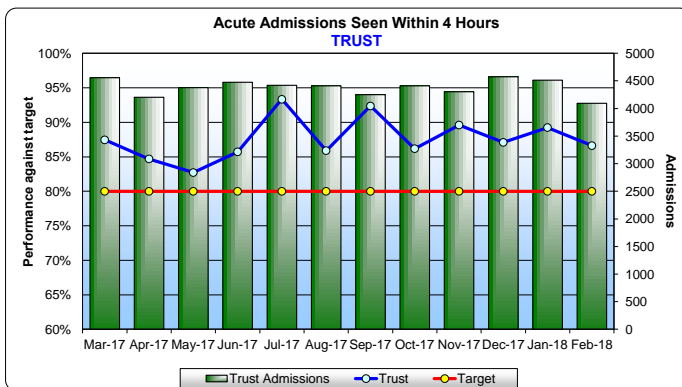


Quality and Safety: Care of the Deteriorating Patient

Indicator	Consequence of Breach (Monthly unless specified)	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Dec	Jan	Feb
Care of the Deteriorating Patient on Acute Medical Assessment Units. Admissions - senior review within 14 hours of arrival (YORK) - Royal College Standard - 100%	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI	90%	91%	90%	91%	92%	94%	90%
Care of the Deteriorating Patient on Acute Medical Assessment Units. Admissions - senior review within 14 hours of arrival (SCARBOROUGH) - Royal College Standard - 100%	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI	76%	71%	76%	73%	72%	77%	75%

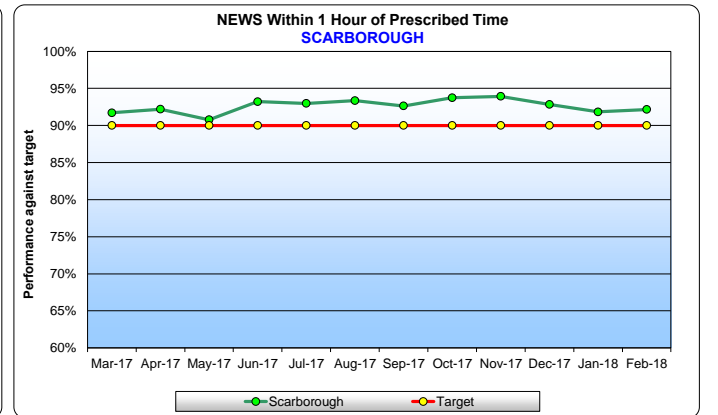
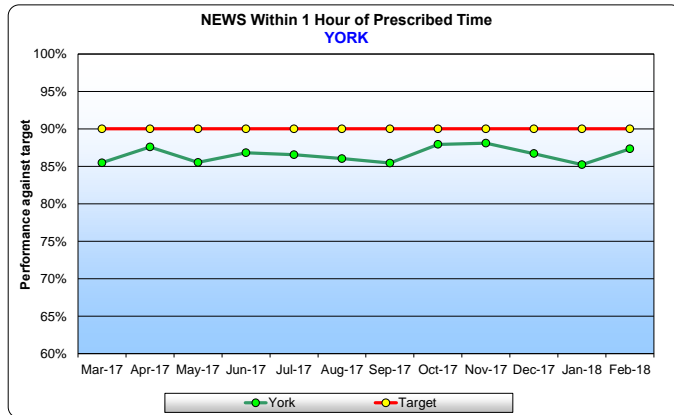
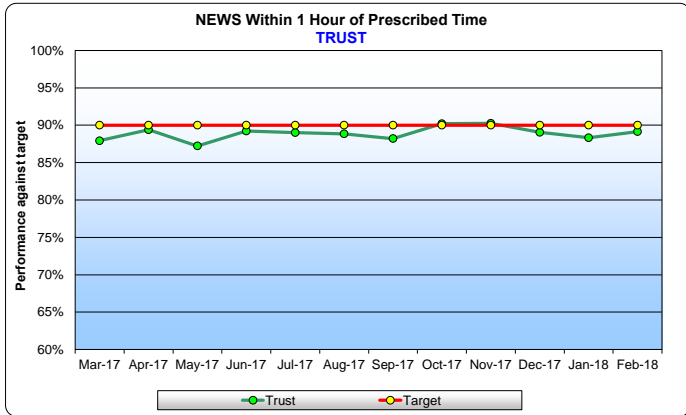


Care of the Deteriorating Patient: All acute medical, elderly medical and orthogeriatric (FNoF) admissions through AMU to be seen by a senior decision maker (registrar or nurse)	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI	80% by site	88.7%	84.4%	90.5%	87.6%	87.1%	89.2%	86.6%
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------	--------------------	-------	-------	-------	-------	-------	-------	-------



Quality and Safety: Care of the Deteriorating Patient

Indicator	Consequence of Breach (Monthly unless specified)	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Dec	Jan	Feb
NEWS within 1 hour of prescribed time	None - Monitoring Only	87.2%	88.7%	88.7%	89.8%	89.0%	88.3%	89.1%



Measures of Harm

Serious Incidents (SIs) declared (source: Datix)

There were 21 SIs reported in February; York 14, Scarborough 5, Community 2.

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 February there were 152 reports of patients falling at York Hospital, 82 patients at Scarborough and 31 patients within the Community Services (265 in total).

Number of Incidents Reported (source: Datix)

The total number of incidents reported in the Trust during February was 1,205; 674 incidents were reported on the York site, 344 on the Scarborough site and 187 from Community Services.

Number of Incidents Awaiting Sign Off at Directorate Level (source: Datix)

At the time of reporting there were 883 incidents awaiting sign-off by the Directorate Management Teams.

Pressure Ulcers (source: Datix)

During February 66 pressure ulcers were reported to have developed on patients since admission to York Hospital, 23 pressure ulcers were reported to have developed on patients since admission to Scarborough and 54 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 February 1 patient incident was 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.

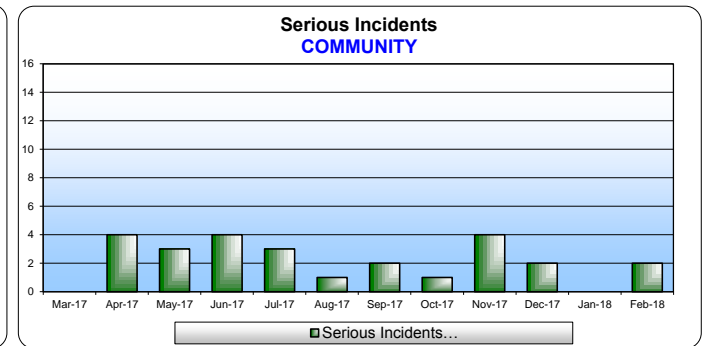
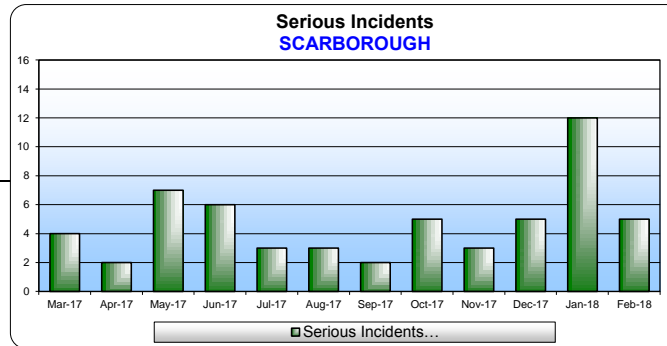
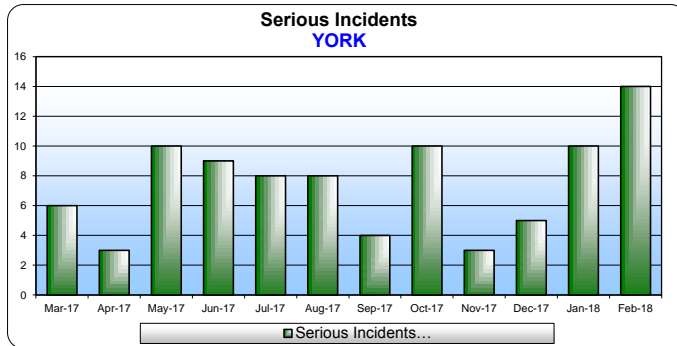
Medication Related Issues (source: Datix)

During February there were a total of 125 medication related incidents reported although this figure may change following validation.

Never Events – No Never Events were declared during February.

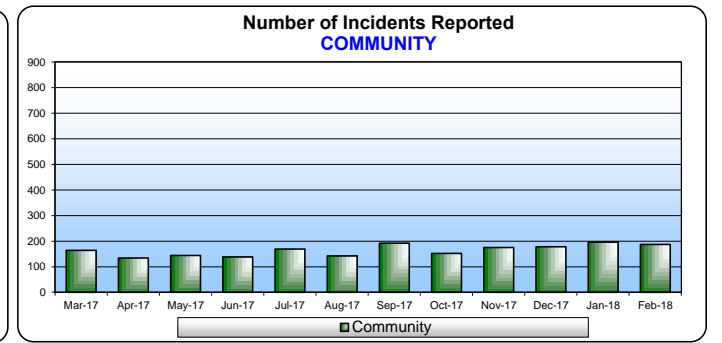
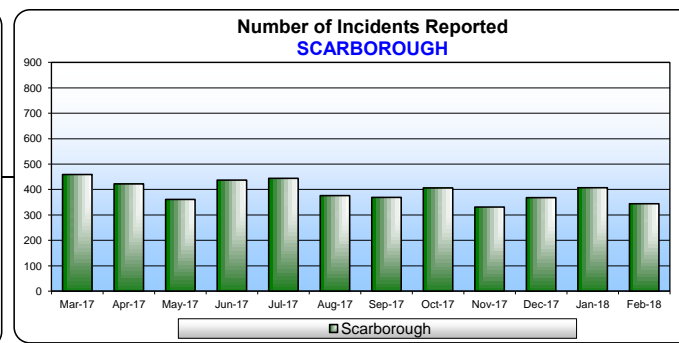
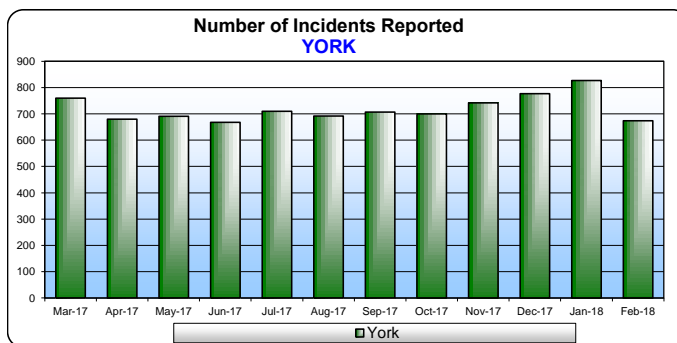
Measures of Harm

Indicator		Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18
Serious Incidents source: Risk and Legal	York	6	3	10	9	8	8	4	10	3	5	10	14
	Scarborough	4	2	7	6	3	3	2	5	3	5	12	5
	Community	0	4	3	4	3	1	2	1	4	2	0	2
Serious Incidents Delogged source: Risk and Legal (Trust)		0	0	0	0	2	1	0	2	0	0	0	3



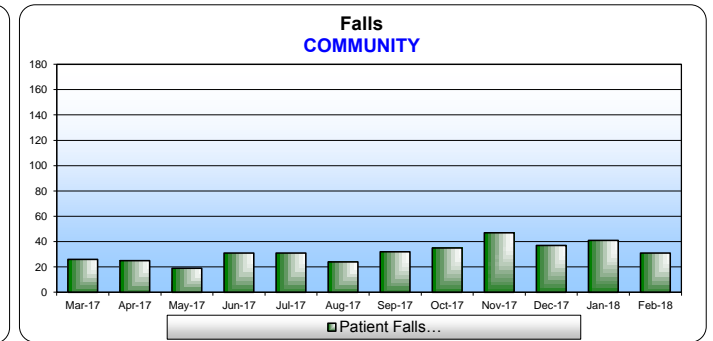
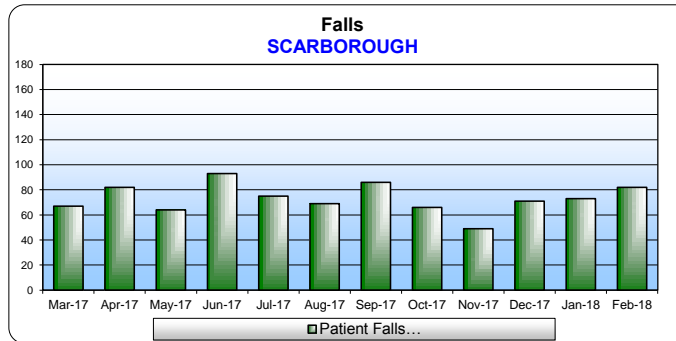
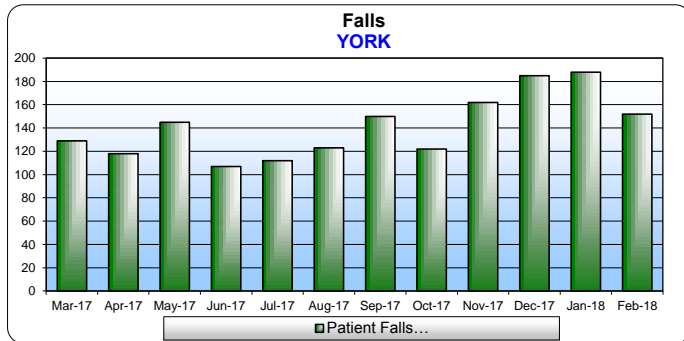
Note - 12 Hour breaches are listed as Operations for the Directorate Investigating (although the location is ED).

Indicator		Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18
Number of Incidents Reported source: Risk and Legal	York	760	680	691	668	710	692	707	700	742	777	827	674
	Scarborough	459	422	361	437	444	376	369	406	331	368	407	344
	Community	164	134	144	138	169	142	192	152	175	178	196	187
Number of Incidents Awaiting sign off at Directorate level		1129	828	698	746	868	832	766	733	684	892	900	883



Measures of Harm

Indicator		Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18
Patient Falls source: DATIX	York	129	118	145	107	112	123	150	122	162	185	188	152
	Scarborough	67	82	64	93	75	69	86	66	49	71	73	82
	Community	26	25	19	31	31	24	32	35	47	37	41	31

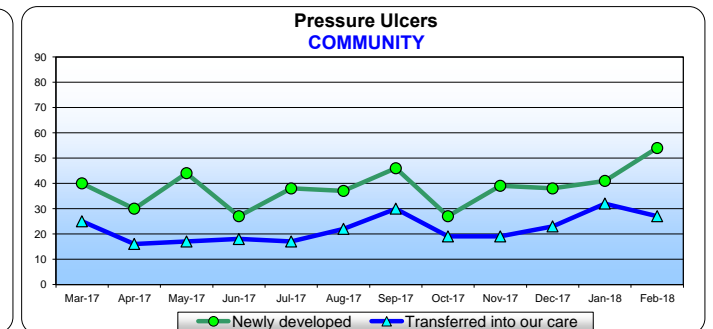
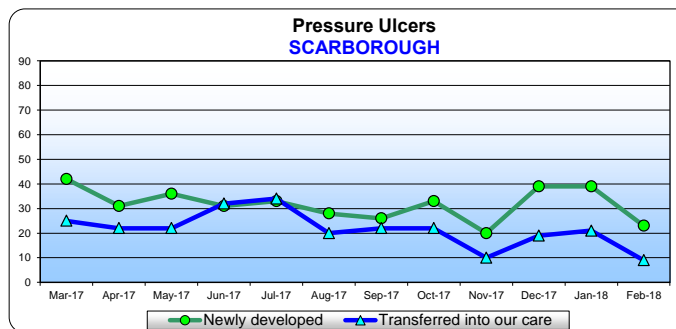
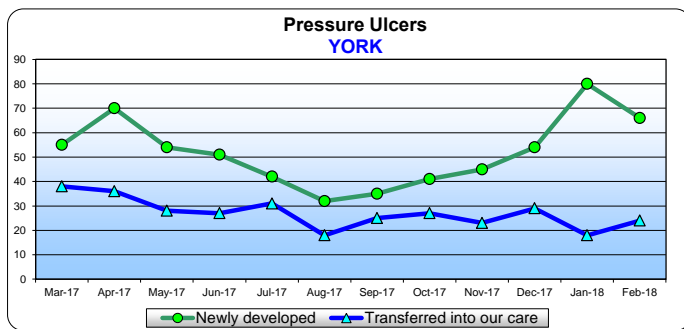


Note - Falls are reviewed retrospectively therefore totals will change month on month. Monthly figures will be refreshed each time the report is updated.

Totals include all degrees of harm, and incidents which have been 'Rejected' are excluded.

Increases in the number of falls in January 17 and December 18 reflect the increase in the number of frail and elderly patients in hospital.

Indicator		Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	
Pressure Ulcers source: DATIX	York	Newly developed	55	70	54	51	42	32	35	41	45	54	80	66
		Transferred into our care	38	36	28	27	31	18	25	27	23	29	18	24
	Scarborough	Newly developed	42	31	36	31	33	28	26	33	20	39	39	23
		Transferred into our care	25	22	22	32	34	20	22	22	10	19	21	9
	Community	Newly developed	40	30	44	27	38	37	46	27	39	38	41	54
		Transferred into our care	25	16	17	18	17	22	30	19	19	23	32	27



Note - Pressure Ulcers are reviewed retrospectively therefore totals will change month on month. Monthly figures will be refreshed each time the report is updated.

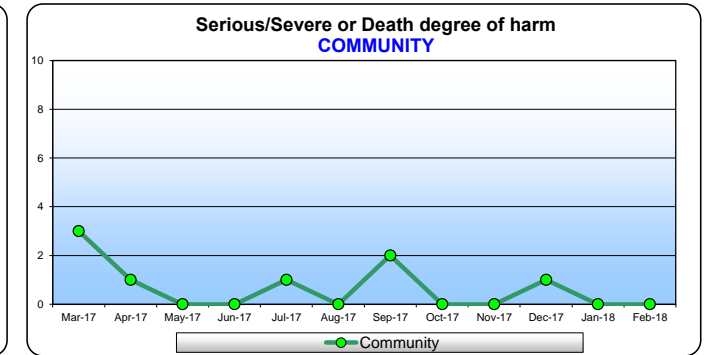
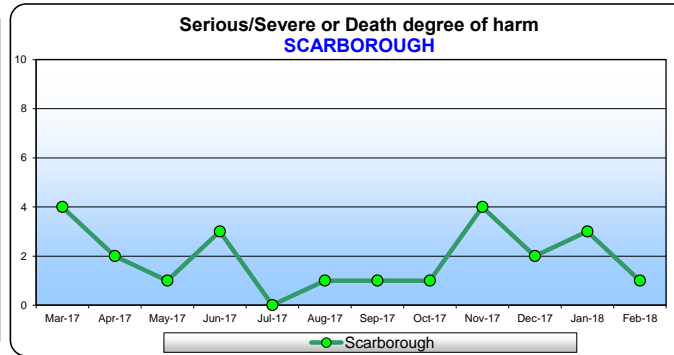
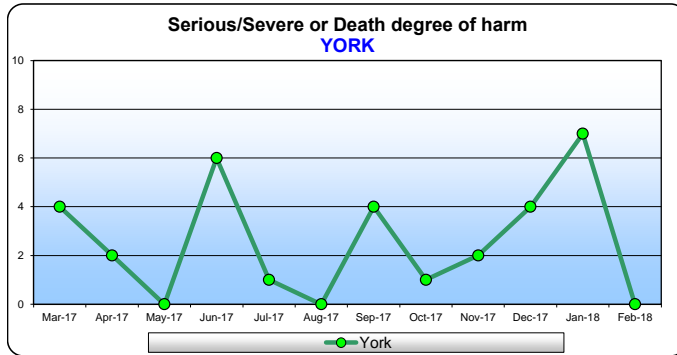
Totals include all degrees of harm, incidents which have been 'Rejected' are excluded as are pressure ulcers which have been categorised as a 'Deterioration of a previously reported ulcer'.

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.

Increases in December 17 and January 18 reflect the increase in the number of frail and elderly patients in acute hospitals.

Measures of Harm

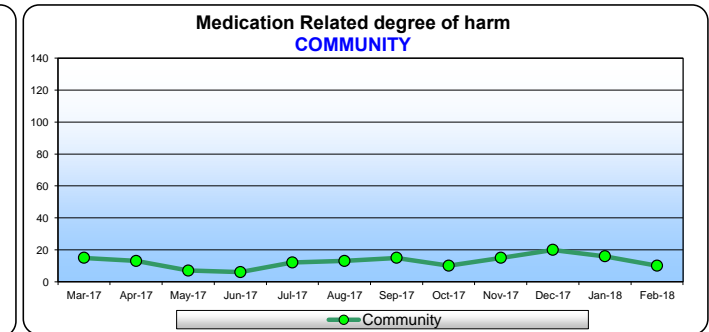
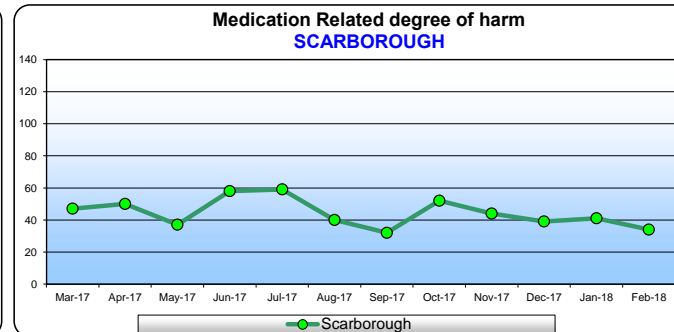
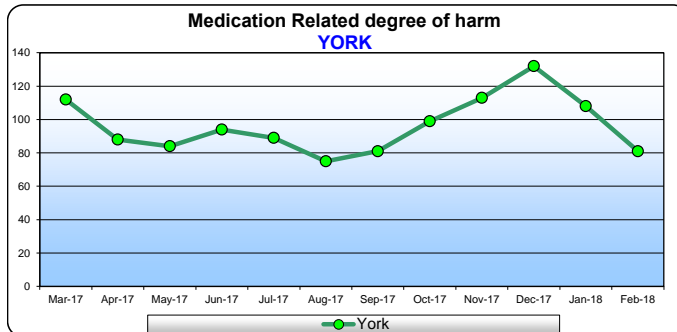
Indicator		Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18
Degree of harm: serious/severe or death source: Datix	York	4	2	0	6	1	0	4	1	2	4	7	0
	Scarborough	4	2	1	3	0	1	1	1	4	2	3	1
	Community	3	1	0	0	1	0	2	0	0	1	0	0



Note: data from October 2016 onwards all subject to ongoing validation

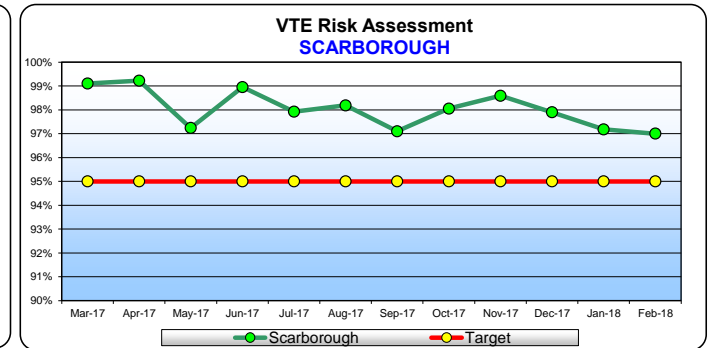
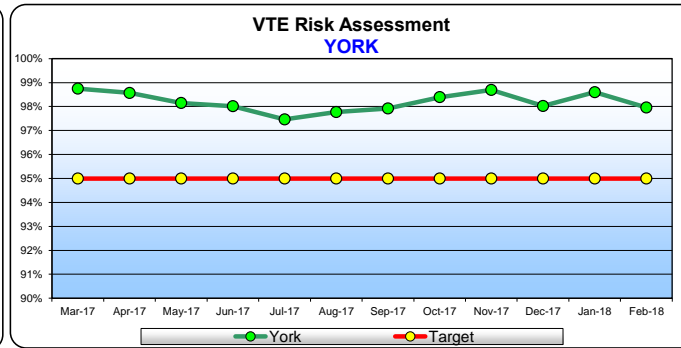
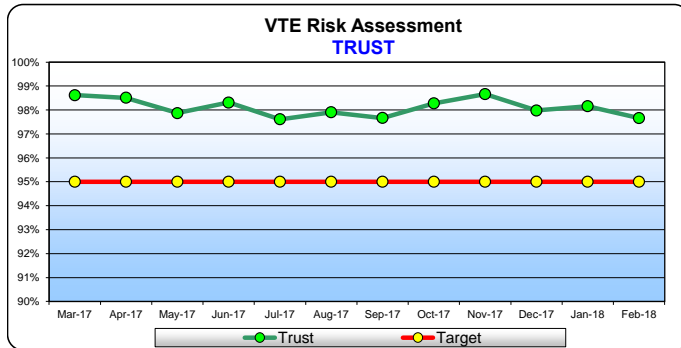
Indicator		Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18
Degree of harm: Medication Related Issues source: Datix	York	112	88	84	94	89	75	81	99	113	132	108	81
	Scarborough	47	50	37	58	59	40	32	52	44	39	41	34
	Community	15	13	7	6	12	13	15	10	15	20	16	10

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



Measures of Harm

Indicator	Consequence of Breach	Site	Threshold	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Dec	Jan	Feb
VTE risk assessment: all inpatient undergoing risk assessment for VTE, as defined in Contract Technical Guidance source: CPD	Issue of Contract Performance Notice and subsequent process in accordance with GC9	Trust	95%	98.5%	98.2%	97.7%	98.4%	98.0%	98.2%	97.7%
		York	95%	98.5%	98.2%	97.7%	98.4%	98.0%	98.6%	98.0%
		Scarborough	95%	99.1%	98.1%	97.7%	98.3%	97.9%	97.2%	97.0%



Never Events

Indicator	Consequence of Breach	Threshold	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Dec	Jan	Feb
SURGICAL									
Wrong site surgery	As below	>0	0	0	2	0	0	0	0
Wrong implant/prosthesis		>0	0	1	0	0	0	0	0
Retained foreign object post-operation		>0	0	0	0	0	0	0	0
MEDICATION									
Wrongly prepared high-risk injectable medication	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure or episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	>0	0	0	0	0	0	0	0
Maladministration of potassium-containing solutions		>0	0	0	0	0	0	0	0
Wrong route administration of chemotherapy		>0	0	0	0	0	0	0	0
Wrong route administration of oral/enteral treatment		>0	0	0	0	0	0	0	0
Intravenous administration of epidural medication		>0	0	0	0	0	0	0	0
Maladministration of insulin		>0	0	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	1	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

Prescribing Errors

There were 23 prescribing related errors in February; 16 from York, 5 from Scarborough and 2 from Community.

Preparation and Dispensing Errors

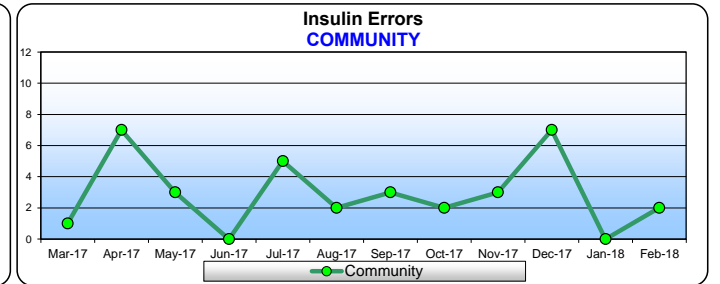
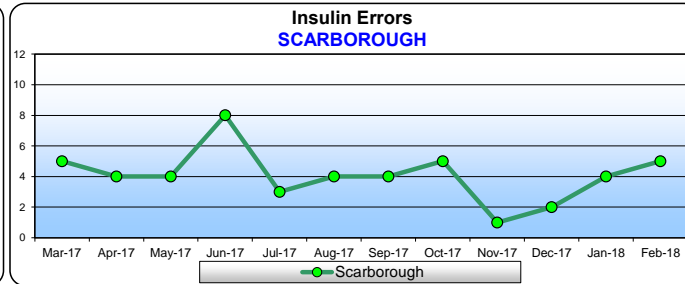
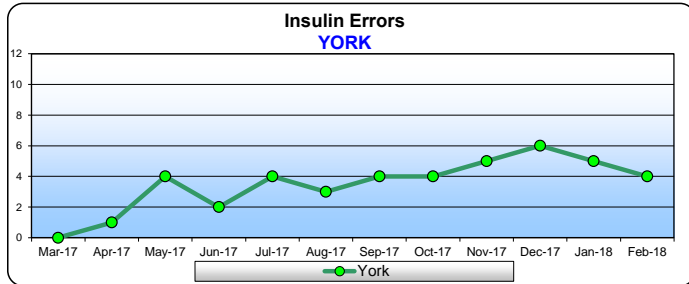
There were 9 preparation/dispensing errors in February; 8 from York, 1 from Scarborough.

Administrating and Supply Errors

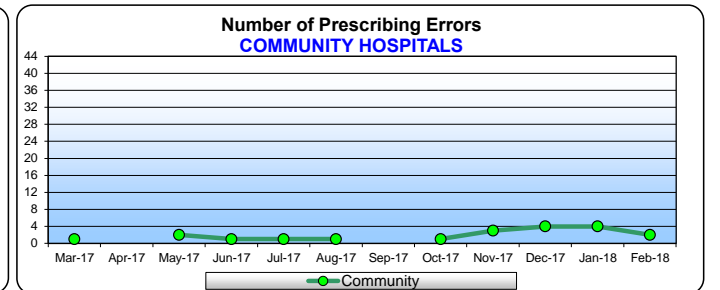
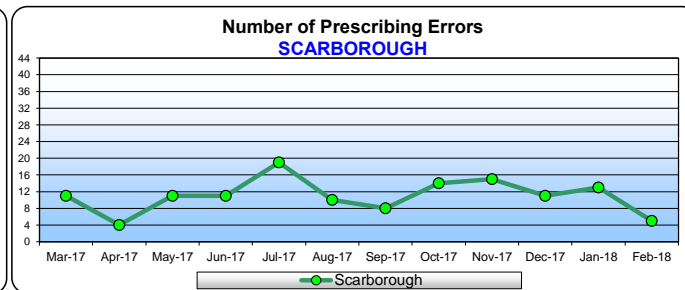
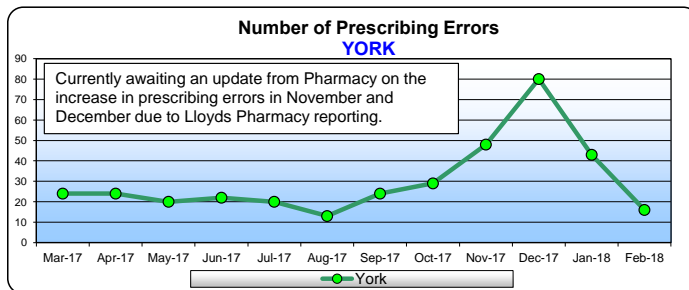
There were 60 administrating/supplying errors in February; 40 were from York, 14 from Scarborough and 6 from Community.

Drug Administration

Indicator		Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18
Insulin Errors source: Datix	York	0	1	4	2	4	3	4	4	5	6	5	4
	Scarborough	5	4	4	8	3	4	4	5	1	2	4	5
	Community	1	7	3	0	5	2	3	2	3	7	0	2

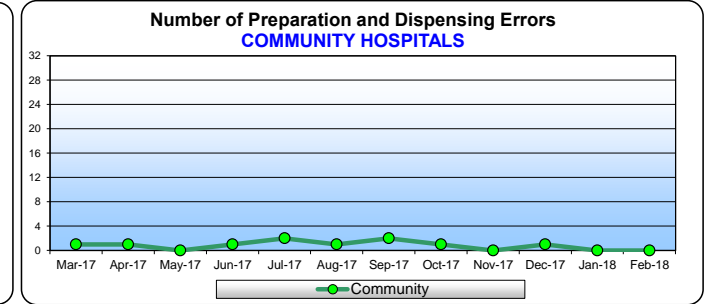
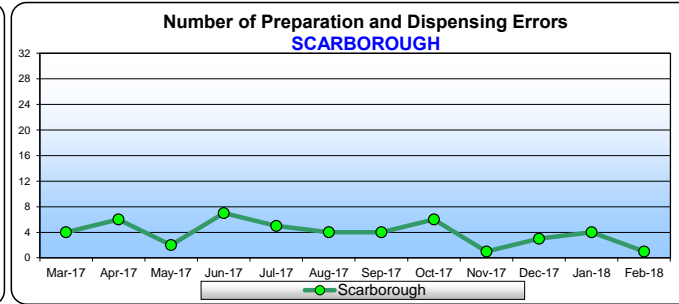
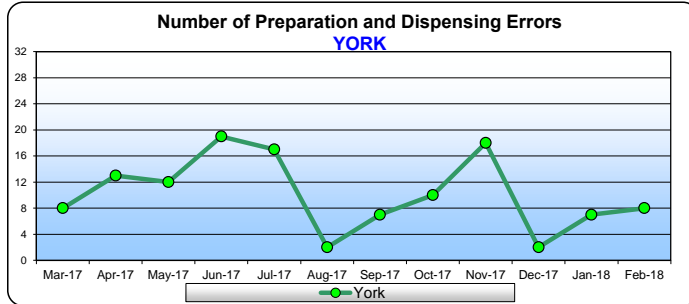


Indicator		Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18
Number of Prescribing Errors source: Datix	York	24	24	20	22	20	13	24	29	48	80	43	16
	Scarborough	11	4	11	11	19	10	8	14	15	11	13	5
	Community Hospitals	1	0	2	1	1	1	0	1	3	4	4	2



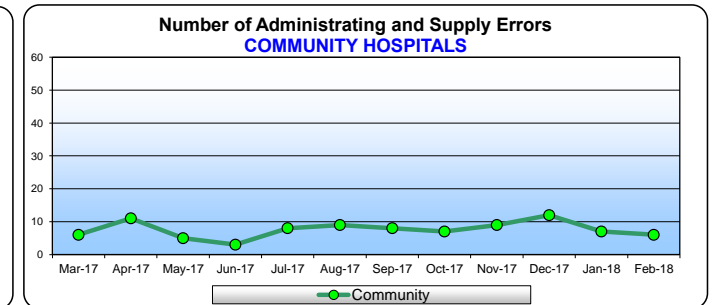
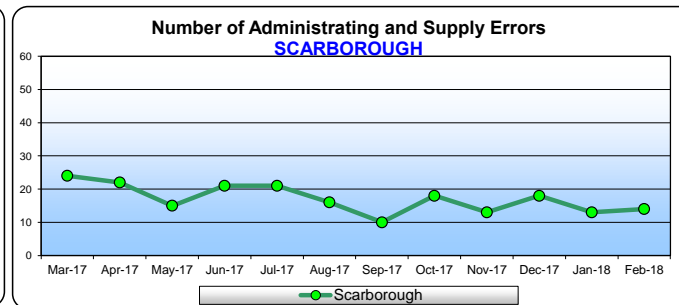
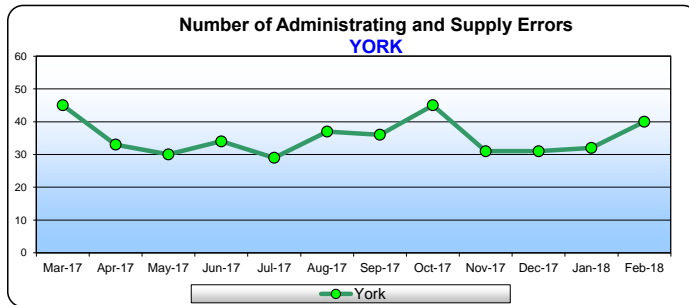
Drug Administration

Indicator		Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18
Number of Preparation and Dispensing Errors source: Datix	York	8	13	12	19	17	2	7	10	18	2	7	8
	Scarborough	4	6	2	7	5	4	4	6	1	3	4	1
	Community Hospitals	1	1	0	1	2	1	2	1	0	1	0	0



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		Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18
Administering and Supply Errors source: Datix	York	45	33	30	34	29	37	36	45	31	31	32	40
	Scarborough	24	22	15	21	21	16	10	18	13	18	13	14
	Community Hospitals	6	11	5	3	8	9	8	7	9	12	7	6



Note re increase in medication error reporting - audit work on missed doses has raised the awareness of the importance of reporting medication errors, and this is thought to have contributed to the increase in administration errors from December onwards.

Mortality

Indicator	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	Oct 15 - Sep 16	Jan 16 - Dec 16	Apr 16 - Mar -17	Jul 16 - Jun 17	Oct 16 - Sep 17
SHMI – York locality	97	96	95	93	94	95	96	94	94	93	93	95
SHMI – Scarborough locality	107	108	107	107	108	107	106	106	104	105	106	108
SHMI – Trust	101	101	99	99	99	100	99	98	97	97	98	100

Definition

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

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

Analysis of Performance

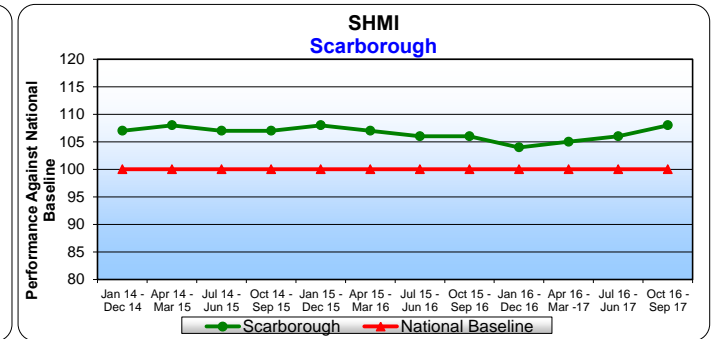
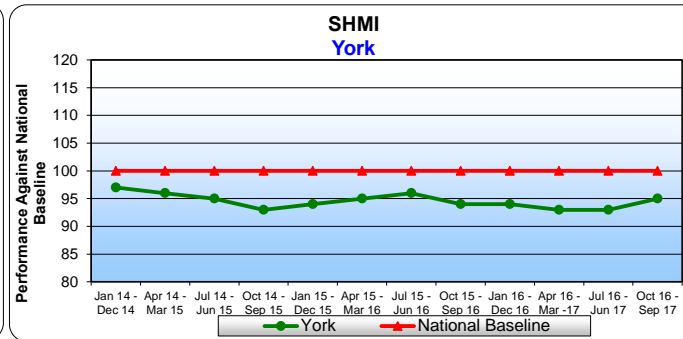
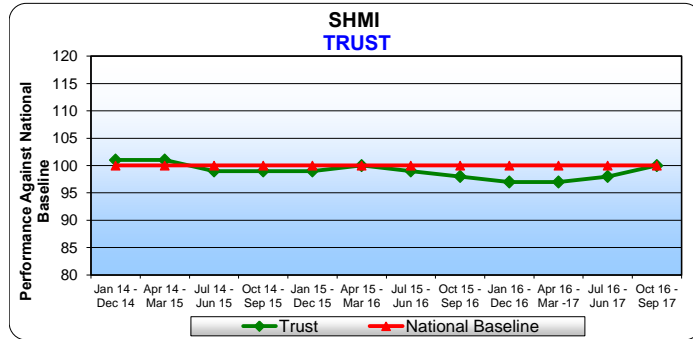
The latest SHMI report indicates the Trust to be in the 'as expected' range. The October 2016 - September 2017 SHMI saw a 2 point increase for York, a 2 point increase for Scarborough and a 2 point increase for the Trust. Trust - 100, York 95 and Scarborough 108.

195 inpatient deaths were reported across the Trust in February. 122 deaths were reported at York Hospital, this is higher than February 2017 (14% increase). 64 deaths were reported at Scarborough, a 7% increase on February 2017. The Trust saw a total of 9 deaths across the Community sites in February 2018, an increase on the 7 recorded in February 2017.

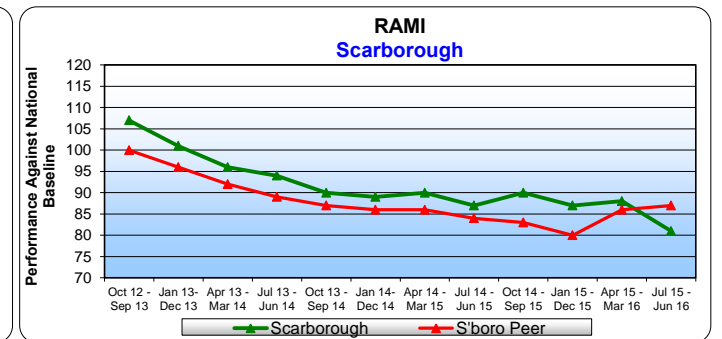
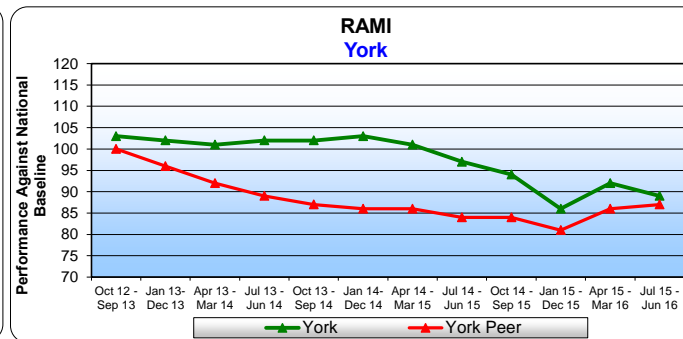
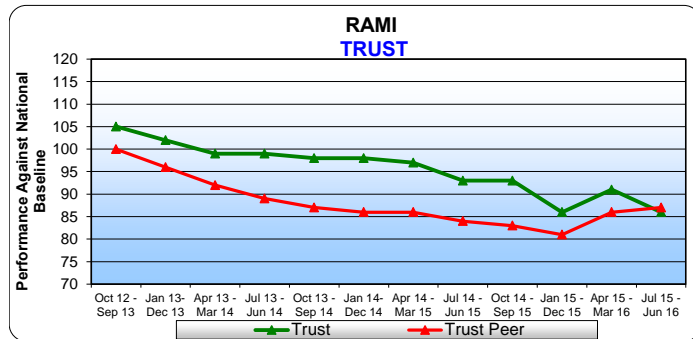
20 deaths in ED were reported in February; 12 at York and 8 at Scarborough. This is an increase on February 2017 (16 deaths in total; 11 at York and 5 at Scarborough).

Mortality

Indicator	Consequence of Breach (Monthly unless specified)	Apr 15 - Mar 16	Jul 15 - Jun 16	Oct 15 - Sep 16	Jan 16 - Dec 16	Apr 16 - Mar -17	Jul 16 - Jun 17	Oct 16 - Sep 17
Mortality – SHMI (TRUST)	Quarterly: General Condition 9	100	99	98	97	97	98	100
Mortality – SHMI (YORK)	Quarterly: General Condition 9	95	96	94	94	93	93	95
Mortality – SHMI (SCARBOROUGH)	Quarterly: General Condition 9	107	106	106	104	105	106	108

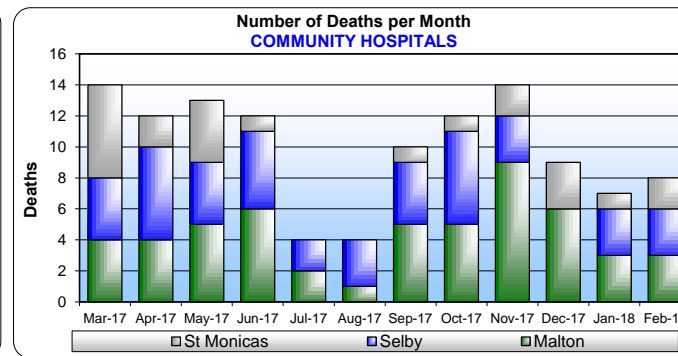
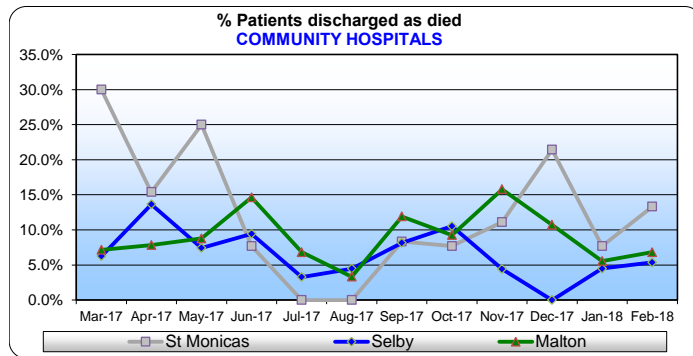
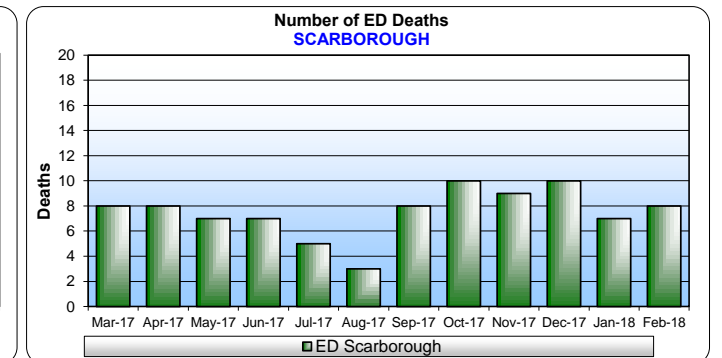
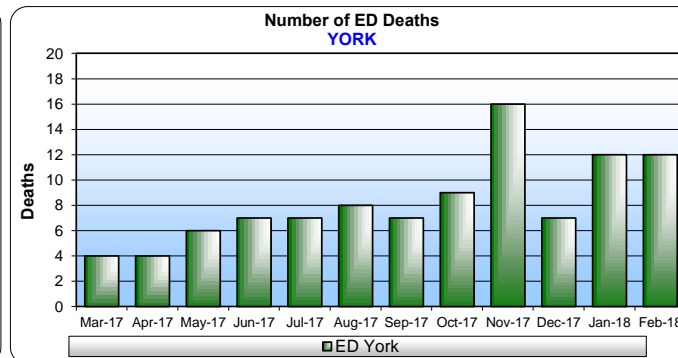
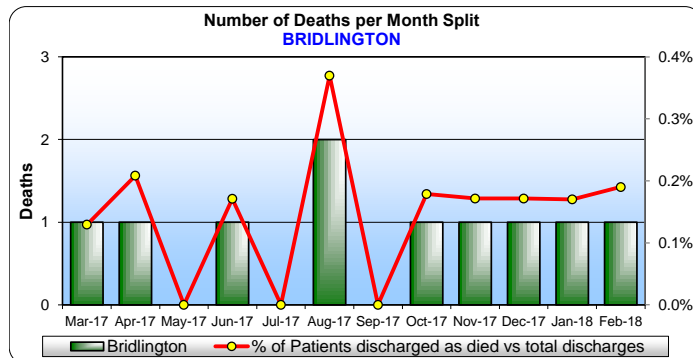
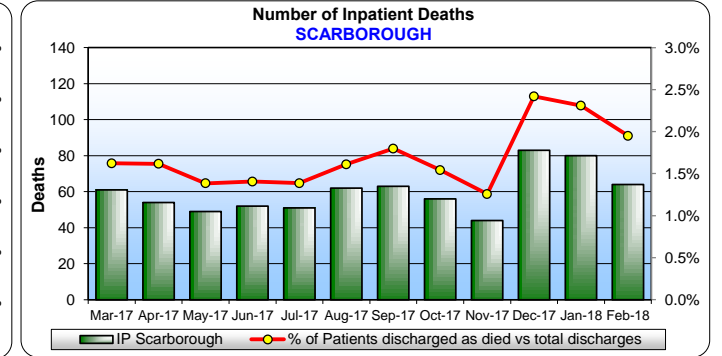
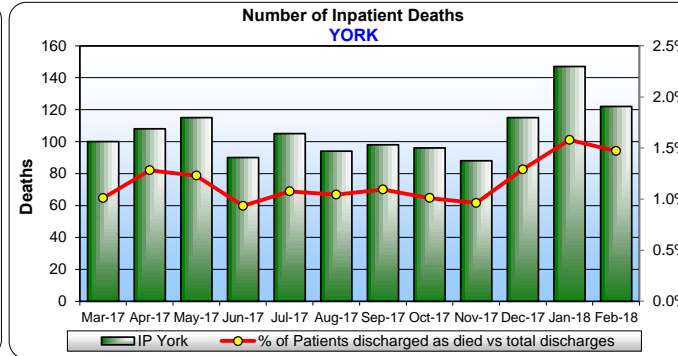
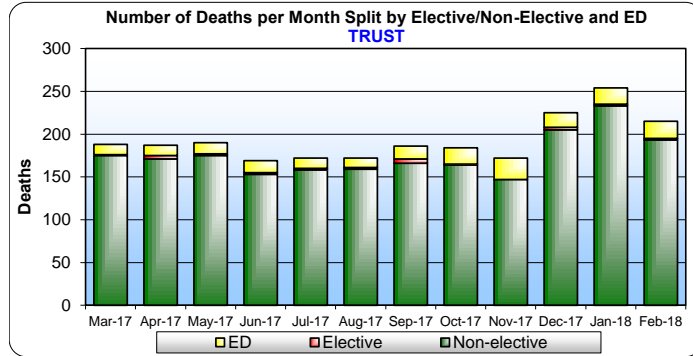


Indicator	Consequence of Breach (Monthly unless specified)	Apr 15 - Mar 16	Jul 15 - Jun 16	Oct 15 - Sep 16	Jan 16 - Dec 16	Apr 16 - Mar -17	Jul 16 - Jun 17	Oct 16 - Sep 17
Mortality – RAMI (TRUST)	none - monitoring only	91	86	94	93	90	84	86
Mortality – RAMI (YORK)	none - monitoring only	92	89	97	96	93	85	86
Mortality – RAMI (SCARBOROUGH)	none - monitoring only	88	81	86	84	84	82	86



Mortality

Indicator	Consequence of Breach (Monthly unless specified)	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Dec	Jan	Feb
Number of Inpatient Deaths	None - Monitoring Only	525	507	482	446	208	235	195
Number of ED Deaths	None - Monitoring Only	46	39	38	56	17	19	20



Month	Malton	Selby	St Monicas	Brid
Mar-17	4	4	6	1
Apr-17	4	6	2	1
May-17	5	4	4	0
Jun-17	6	5	1	1
Jul-17	2	2	0	0
Aug-17	1	3	0	2
Sep-17	5	4	1	0
Oct-17	5	6	1	1
Nov-17	9	3	2	1
Dec-17	6	0	3	1
Jan-18	3	3	1	1
Feb-18	3	3	2	1

Date	Location	Participants	Actions & Recommendations
07/02/2018	Women's Unit, York	Andy Bertram - Director of Finance Michael Sweet - Non-Executive Director Liz Ross - Head of Midwifery Nicola Dean - Clinical Director Chris Foster - Matron Kristen Bourne - Deputy Directorate Manager Helen Hope - Deputy Sister Nurse Tracey Clarke (observing) Doctor Sarah Pearson (observing)	<p>Quality of Care to Gynae/early miscarriage women on G1 (mixed sex ward) Quality – Gynaecology patients particularly those experiencing miscarriage on G1 which is a mixed sex ward and predominantly Head & Neck is compromised; this is in spite of skilled Gynaecology nurses on G1 and training from Women's unit senior staff for G1 nurses to improve the care/experience of women experiencing miscarriage. Action: Further training and development for nursing staff on G1 from Gynae Senior staff to be arranged. Action: Costs for the redesign of the Women's Unit to be put into a business case to address adequate environment and space to provide the best service for our women.</p> <p>Senior clinician review The most common complaint from women attending Gynaecology Assessment Unit is they are kept in the department longer than they would like, waiting for senior doctor review. Action: This will be improved with the successful recruitment to the 2 new Consultant posts.</p> <p>Development of Roles. Consider: Nurses/Midwives to be trained to perform ultrasound scan – the prohibitive factors may be radiology support needed for the training in practise and availability of scanning equipment. The courses are external and available and there are nurses who would undertake the training. Nurse sonographers would allow an extension of the EPAU (Early pregnancy assessment unit) service from mornings 7 days per week to full days.</p> <p>Positive: use of space/cleanliness/organisation. The women's unit delivers EPAU/GAU (Gynae assessment unit)/Colposcopy /Hysteroscopy and pre-operative assessment (for all Gynae patients). This constitutes high activity in a small area which has limited storage facility for equipment and service delivery. Despite these constraints the area is clean /tidy and scores 98% and above for Matron Environment audits monthly.</p> <p>Positive: Respecting the sensitivity of the reasons women are attending the women's unit. There are separate waiting rooms for EPAU women to those women waiting for colposcopy/Hysteroscopy/Pre-operative assessment in order to maintain privacy and the awareness of the sensitivity of client groups visiting the Women's unit i.e. women with early pregnancy loss.</p> <p>Confidentiality: The reception desk for EPAU is adjacent to the main reception desk and is part of the thorough fare to GAU/G1/Colposcopy etc. Although staff take all measures possible to optimise confidentiality the lay out due to the available space does pose a risk to patient confidentiality at times. Action: The proposed new women's unit expansion currently with capital planning would eliminate this risk.</p>
21/02/2018	Lilac and Maple Wards, Scarborough	Mike Proctor – Deputy Chief Executive Harriet Lynch – Matron Mike Keane – Non – Executive Director	<p>High proportion of medical outliers leading to difficulties getting patients reviewed. Action – Reduce outliers. Implement patient slow improvement measures (SAFER etc.) Consider permanently changing use of Lilac or Maple to medical ward.</p> <p>Staffing levels. Action – All actions to maintain safety in place – new patient dependency score will assist decision making.</p> <p>Treatment room sometime used as an inpatient bed area. Fixed wall nurse call needs modification for use by a patient in bed. Action – Fixed wall nurse call needs modification for use by a patient in bed.</p>
21/02/2018	ED, Scarborough	Mike Proctor – Deputy Chief Executive Ed Smith – Deputy Director Sally Alexander – Operational Manager Sarah Freer – Matron Amy Dailey - Sister Mike Keane - Non – Executive Director	<p>Overcrowding with patients – failure of patient flow. Action – Implementation of SAFER.</p> <p>Lack of space. Action – Capital schemes in planning to expand space available.</p> <p>Staff wastage high – particularly newly qualified nurse. Action – Consider new creative solutions, e.g.; use of ODP's, physicians, assistants, nurse associates etc to supplement existing staff and reduce stress.</p>

YORK - MATERNITY DASHBOARD			Measure	Data source	No Concerns (Green)	Of Concern (Amber)	Concerns (Red)	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Activity	Births	Bookings	1st m/w visit	CPD	≤302	303-329	≥330	366	248	288	301	287	294	295	301	294	186	315	248
		Bookings <13 weeks	No. of mothers	CPD	≥90%	76%-89%	≤75%	91.8%	90.9%	88.9%	88.0%	87.5%	87.1%	85.1%	91.4%	92.2%	82.3%	90.8%	89.9%
		Bookings ≥13 weeks (exc transfers etc)	No. of mothers	CPD	< 10%	10.1%-19.9%	>20%	4.1%	4.3%	5.9%	7.3%	5.9%	4.8%	7.1%	5.3%	4.4%	5.9%	7.3%	5.2%
		Bookings ≥ 13wks seen within 2 wks	No. of mothers	CPD	≥90%	76%-89%	≤75%	86.70%	54.50%	64.70%	81.80%	70.60%	71.40%	81.00%	68.80%	76.90%	54.50%	87.00%	92.30%
		Births	No. of babies	CPD	≤295	296-309	≥310	264	244	267	259	273	269	302	272	264	253	250	244
	Closures	No. of women delivered	No. of mothers	CPD	≤295	296-310	≥311	261	237	263	253	269	262	297	269	261	250	248	242
		Homebirth service suspended	No. of suspensions	Comm. Manager	0-3	4-6	7 or more	0	0	0	0	0	1	0	0	0	0	0	
		Women affected by suspension	No. of women	Comm. Manager	0	1	2 or more	0	0	0	0	0	1	0	0	0	0	0	
		Community midwife called in to unit	No. of times	Comm. Manager	3	4-5	6 or more	3	0	0	3	2	1	4	0	0	0	0	
		Maternity Unit Closure	No. of closures	Matron	0		1 or more	0	0	0	0	0	1	0	0	0	0	0	
		SCBU at capacity (since May 2017)	No. of times	SCBU						0	0	0	2	0	0	0	0	0	
		SCBU at capacity of intensive cots	No. of times	SCBU				7	2	2	0	1	3	0	2	1	0	0	
		SCBU no of babies affected	No. of babies affected	SCBU	0	1	2 or more	6	0	0	0	0	0	0	0	0	1	0	

Workforce	Staffing	MW to birth ratio	Ratio	Matron	≤29.5	29.6 - 30.9	>31	28	35	35	34	34	30	30	32	34	31	30	31
		1 to 1 care in Labour	CPD	CPD	100%	80% - 99.9%	≤79.9%	78.9%	71.7%	76.0%	77.5%	72.5%	73.7%	68.0%	72.1%	73.1%	86.4%	80.2%	82.6%
		LW Co-ordinator supernumary %	Shift Handover Sheets	Risk Team	100%	80% - 99.9%	≤79.9%	74.0%	63.0%	69.0%	65.0%	62.0%	51.0%	50.0%	62.0%	68.0%	84.0%	89.0%	60.7%
		Consultant cover on L/W	av. hours/week	DM / CD	40		≤39	76	76	76	76	76							
		Anaesthetic cover on L/W	av.sessions/week	DM / CD	10	4-9	≤3	10	10	10	10	10	10	10	10	10	10	10	10

Clinical Indicators	Neonatal/ Maternal	Normal Births	No. of svd - %	CPD	≥60.6%	60.5-55%	<55%	62.6%	58.7%	61.9%	58.9%	63.2%	59.6%	62.9%	49.1%	61.4%	59.2%	58.9%	57.5%
		Assisted Vaginal Births	No. of instr. Births - %	CPD	≤13.2	13.3-17.9%	≥18%	11.9%	11.4%	9.9%	14.6%	11.2%	10.7%	10.1%	15.2%	14.6%	15.2%	11.7%	14.5%
		C/S Births	Em & elect - %	CPD	≤26%	26.1-27.9%	>28%	25.7%	30.4%	28.1%	26.1%	25.3%	29.8%	27.6%	35.3%	23.8%	24.4%	29.0%	27.7%
		Eclampsia	No. of women	CPD	0		1 or more	0	2	0	0	0	0	0	0	0	0	0	0
		Undiagnosed Breech in Labour	No. of women	CPD	2 or less	3-4	5 or more	1	0	1	1	1	1	2	1	1	1	2	1
		HDU on L/W	No. of women	LW Activity Sheet	3 or less	4	5 or more	4	21	11	23	12	14	23	18	9	11	11	17
		BBA	No. of women	Risk Team - Datix	2 or less	3-4	5 or more	1	5	1	5	4	3	4	1	3	6	2	2
		Diagnosis of HIE	No. of babies	SCBU Paed	0	1	2 or more	0	0	2	0	0	0	2	1	0	0	1	0
		NHS Resolution cases	No of cases		0	1	2 or more			2	0	0	0	2	0	0	0	0	
		Morbidity	Neonatal Death	No of babies	Risk team- EBC	0		1 or more	0	2	1	0	0	0	0	0	0	0	0
	Antepartum Stillbirth		No. of babies	Risk Team	0	1	2 or more	0	0	1	0	3	1	0	2	0	1	0	
	Intrapartum Stillbirths		No. of babies	Risk Team	0		1 or more	0	0	1	0	0	0	0	0	0	0	0	
	Risk Management	Breastfeeding Initiation rate	% of babies feeding at birth	CPD	>74.4%	74.3-70.1%	<70%	73.6%	71.7%	77.6%	75.5%	73.6%	77.1%	75.8%	77.7%	80.8%	76.4%	73.0%	77.3%
		Smoking at time of delivery	% of women smoking at del.	CPD	<11%	12-14%	>15%	14.6%	11.0%	9.1%	6.7%	12.6%	11.5%	9.8%	7.1%	6.5%	8.8%	11.3%	12.4%
		SI's	No. of SI's declared	Risk Team	0		1 or more	0	2	4	1	0	1	0	1	0	0	0	
		PPH > 1.5L	No. of women	CPD	2 or less	3-4	5 or more	3	8	4	8	9	9	9	9	7	5	10	9
		PPH > 1.5L as % of all women	% of births	CPD				0.8%	3.4%	1.5%	3.6%	3.3%	3.4%	3.0%	3.3%	2.7%	2.0%	4.0%	3.7%
	New Complaints	Shoulder Dystocia	No. of women	CPD	2 or less	3-4	5 or more	3	6	2	2	3	6	1	1	3	4	0	1
		3rd/4th Degree Tear	% of tears (vaginal births)	CPD	≤2.5%	2.6- 3.9%	≥4%	5.1%	1.2%	1.6%	4.2%	2.9%	2.6%	2.7%	1.1%	2.5%	5.7%	2.2%	1.7%
		Informal	No. of Informal complaints	Risk Matrix	0	1-4	5 or more	1	1	3	2	0	3	0	2	0	1	1	1
Formal	No. of Formal complaints	Risk Matrix	0	1-4	5 or more	2	3	2	2	2	1	2	0	0	2	0	1		

Maternity Dashboard metrics were reviewed on 01.08.2017

SCARBOROUGH - MATERNITY DASHBOARD			Measure	Data source	No Concerns (Green)	Of Concern (Amber)	Concerns (Red)	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	
Activity	Births	Bookings	1st m/w visit	CPD	≤210	211-259	≥260	217	154	206	171	177	188	185	163	196	135	199	129	
		Bookings <13 weeks	No. of mothers	CPD	≥90%	76%-89%	≤75%	91.2%	92.2%	90.8%	89.5%	91.5%	90.4%	90.3%	88.3%	87.8%	88.9%	90.5%	90.7%	
		Bookings ≥13 weeks (exc transfers etc)	No. of mothers	CPD	< 10%	10%-20%	>20%	4.6%	7.8%	8.3%	9.9%	6.8%	6.4%	8.1%	9.8%	9.7%	5.2%	5.5%	7.0%	
		Bookings ≥ 13wks seen within 2 wks	No. of mothers	CPD	≥90%	76%-89%	≤75%	100%	100%	82%	82%	75%	92%	100%	94%	89%	86%	91%	89%	
		Births	No. of babies	CPD	≤170	171-189	≥190	128	112	121	108	127	118	145	117	114	125	127	116	
	Closures	No. of women delivered	No. of mothers	CPD	≤170	171-189	≥190	127	111	120	108	127	116	145	115	110	124	126	114	
		Homebirth service suspended	No. of suspensions	Comm. Manager	0-3	4-6	7 or more	0	0	0	0	0	0	0	0	0	0	2	0	
		Women affected by suspension	No. of women	Comm. Manager	0	1	2 or more	0	0	0	0	0	0	0	0	0	0	0	0	
		Community midwife called in to unit	No. of times	Comm. Manager	3	4-5	6 or more	0	0	0	0	0	0	0	0	0	0	1	1	
		Maternity Unit Closure	No. of closures	Matron	0		1 or more	0	0	0	0	0	0	0	0	0	0	0	0	
		SCBU at capacity (since May 2017)	No. of times	SCBU							1	0	0	0	0	2	6	2	5	2
		SCBU at capacity of intensive care cots	No. of times	SCBU				0	1	4	1	5	2	0	0	2	1	2	3	
		SCBU no of babies affected	No. of babies affected	SCBU	0	1	2 or more	0	3	0	0	0	1	0	2	3	3	0	0	

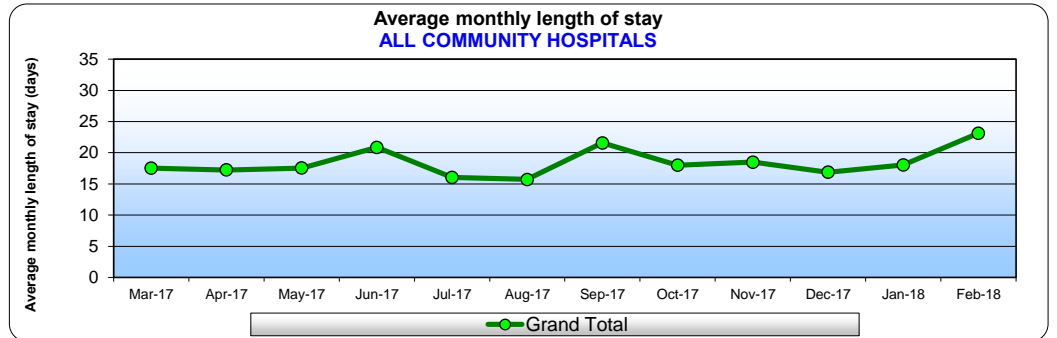
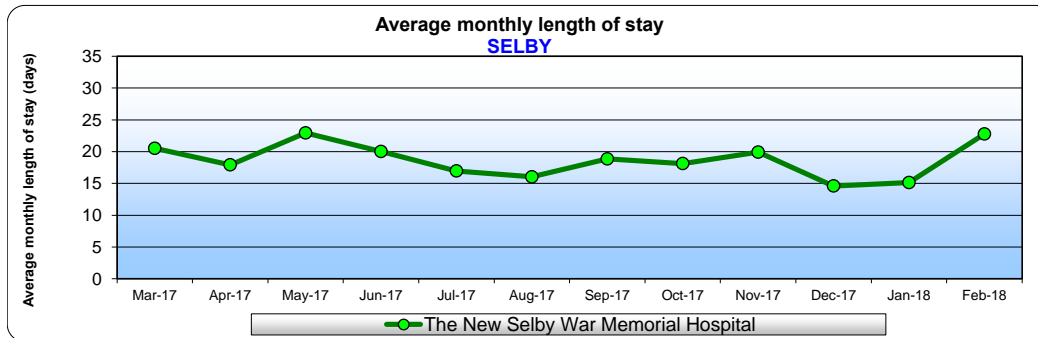
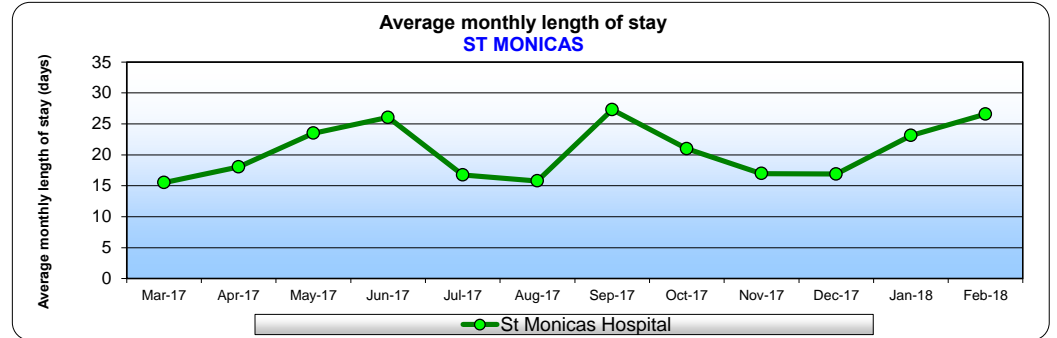
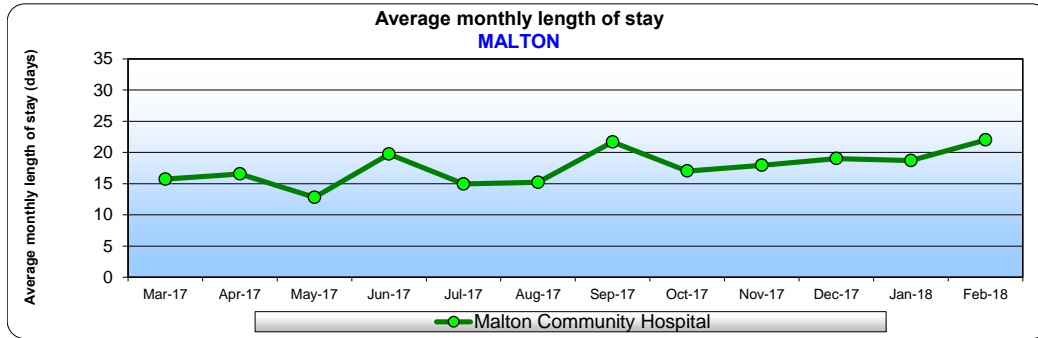
Workforce	Staffing	M/W to birth ratio	Ratio	Matron	≤29.5	29.6-30.9	>31	40.2	23.2	24	24	24	24	26	25	25	26	25	25
		1 to 1 care in Labour	CPD	CPD	≥100%	80% - 99.9%	≤79.9%	89.8%	86.5%	80.8%	88.8%	82.7%	90.5%	91.0%	87.0%	88.2%	87.9%	86.5%	83.5%
		L/W Co-ordinator supernumary %	Shift Handover Sheets	Risk Team	≥100%	80% - 99.9%	≤79.9%	85.5%	91.6%	88.3%	80.0%	75.8%	80.6%	55.0%	82.0%	73.3%	68.0%	87.0%	71.0%
		Consultant cover on L/W	av. hours/week	DM / CD	40		≤39	40	40	40	40								
		Anaesthetic cover on L/W	av.sessions/week	DM / CD	≥10	4-9	≤3	3	3	3	3	5	5	5	5	5	5	5	5

Clinical Indicators	Neonatal/ Maternal	Normal Births	No. of svd - %	CPD	≥60.6%	60.5-55%	<55%	66.9%	64.9%	66.9%	63.6%	63.6%	68.9%	68.5%	77.1%	63.2%	72.8%	78.0%	71.6%
		Assisted Vaginal Births	No. of instr. Births - %	CPD	≤13.2	13.3-17.9%	≥18%	5.5%	14.4%	5.8%	12.0%	7.1%	7.8%	8.3%	6.1%	10.9%	8.1%	4.0%	7.0%
		C/S Births	Em & elect - %	CPD	≤26%	26.1-27.9%	>28%	26.8%	19.8%	27.5%	23.1%	27.6%	21.6%	22.8%	15.7%	27.3%	19.4%	18.3%	21.1%
		Eclampsia	No. of women	CPD	0		1 or more	0	0	0	0	0	0	0	0	0	0	0	0
		Undiagnosed Breech in Labour	No. of women	CPD	2 or less	3-4	5 or more	1	1	0	0	1	0	3	1	0	0	0	1
		HDU on L/W	No. of women	LW Activity Sheet	3 or less	4	5 or more	4	7	2	4	5	1	3	1	2	4	0	3
		BBA	No. of women	Risk Team - Datix	2 or less	3-4	5 or more	3	1	5	3	2	1	2	2	0	4	4	0
		Diagnosis of HIE	No. of babies	SCBU Paed	0	1	2 or more	0	0	0	0	1	0	1	0	0	1	0	0
		NHS Resolution cases	No of cases		0	1	2 or more			0	1	0	0	0	0	0	1	0	0
		Morbidity	Neonatal Death	No of babies	Risk team- EBC	0		1 or more	0	0	0	0	0	0	0	0	0	0	0
	Antepartum Stillbirth		No. of babies	Risk Team	0	1	2 or more	0	0	1	0	1	0	0	0	1	1	0	0
	Intrapartum Stillbirths		No. of babies	Risk Team	0		1 or more	0	0	0	0	0	0	0	0	0	0	0	0
	Risk Management	Breastfeeding Initiation rate	% of babies feeding at birth	CPD	>74.4%	74.3-70.1%	<70%	51.2%	56.8%	54.2%	59.3%	57.5%	63.8%	55.2%	59.1%	59.1%	58.1%	65.9%	57.0%
		Smoking at time of delivery	% of women smoking at del.	CPD	<11%	12-14%	>15%	24%	23%	18%	19%	17%	25%	16%	22%	25%	18%	18%	23%
		SI's	No. of SI's declared	Risk Team	0		1 or more	0	0	0	1	0	0	0	0	0	0	0	0
		PPH > 1.5L	No. of women	CPD	2 or less	3-4	5 or more	5	5	2	3	4	0	2	0	2	4	0	2
		PPH > 1.5L as % of all women	% of births	CPD				3.9	4.5	1.7	2.8	3.0	0.0	1.4	0.0	2	3.2	0	2
	New Complaints	Shoulder Dystocia	No. of women	CPD	2 or less	3-4	5 or more	2	1	0	2	1	1	0	1	2	1	0	1
		3rd/4th Degree Tear	% of tears (vaginal births)	CPD	≤2.5%	2.6- 3.9%	≥4%	1.1%	1.1%	0.0%	1.2%	0.0%	1.1%	3.6%	2.0%	1.2%	2.0%	1.0%	1.1%
		Informal	No. of Informal complaints	Risk Matrix	0	1-4	5 or more	0	1	0	0	0	0	0	1	0	0	0	0
Formal	No. of Formal complaints	Risk Matrix	0	1-4	5 or more	2	0	0	0	0	0	1	1	0	2	1	1	0	

Maternity Dashboard metrics were reviewed on 01.08.2017

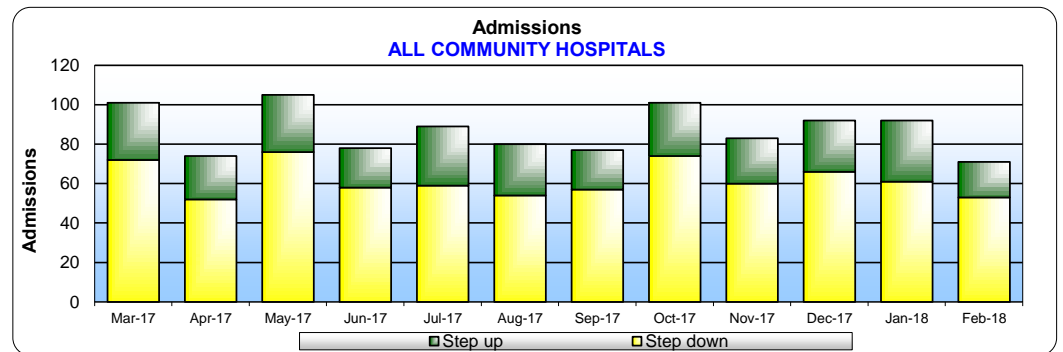
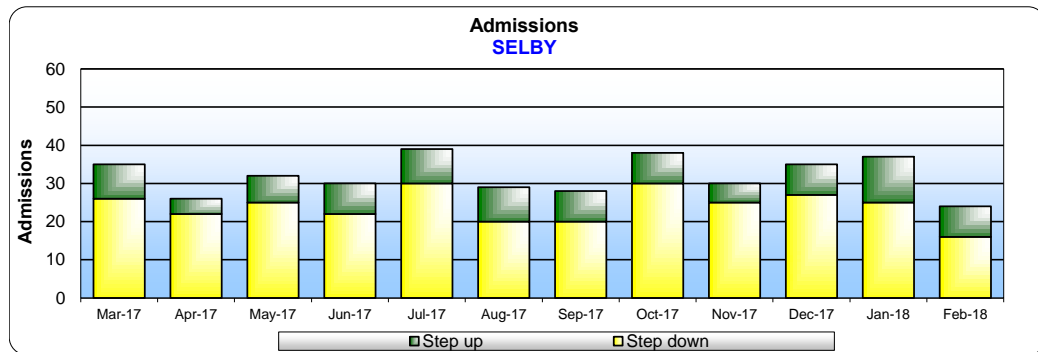
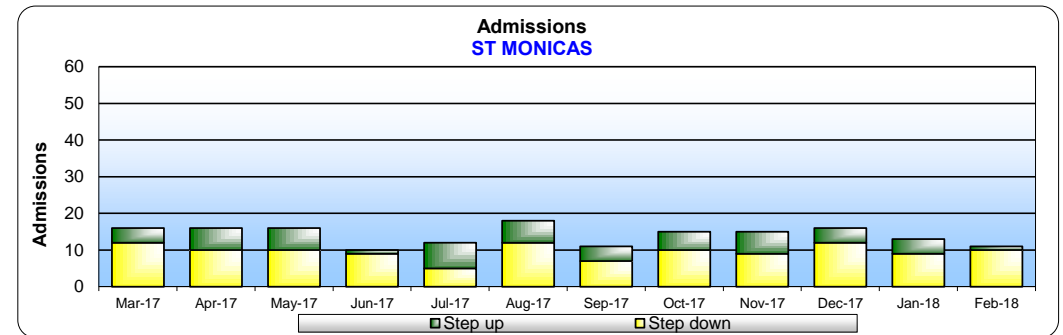
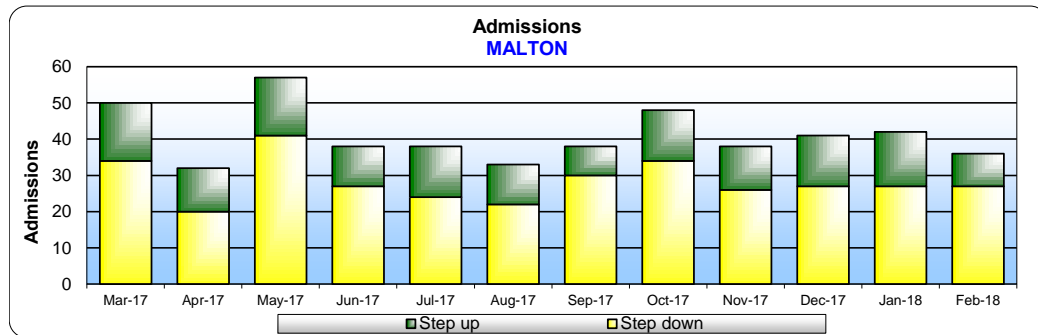
Community Hospitals

Indicator	Hospital	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Dec	Jan	Feb
Community Hospitals average length of stay (days) Excluding Daycases	Malton Community Hospital	17.9	16.0	17.4	18.0	19.0	18.7	22.0
	St Monicas Hospital	14.4	22.6	19.6	18.3	16.9	23.1	26.6
	The New Selby War Memorial Hospital	20.2	20.4	17.2	17.6	14.6	15.2	22.8
	Total	18.0	18.5	17.6	17.8	16.9	18.1	23.1



Community Hospitals

Indicator	Hospital		Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Dec	Jan	Feb
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.	Malton Community Hospital	Step up	37	39	33	40	14	15	9
		Step down	90	88	76	87	27	27	27
	St Monicas Hospital	Step up	22	13	17	15	4	4	1
		Step down	37	29	24	31	12	9	10
	The New Selby War Memorial	Step up	22	19	26	21	8	12	8
		Step down	76	69	70	82	27	25	16
	Total	Step up	81	71	76	76	26	31	18
		Step down	203	186	170	200	66	61	53



Quality and Safety: Misc

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Dec	Jan	Feb
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	18	4	5	5	3	2	10
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	5	0	0	0	0	20	0
% Compliance with WHO safer surgery checklist	No financial penalty	100%	100%	100%	100%	100%	100%	100%	100%
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	99%	99.8%	99.7%	99.6%	99.8%	99.8%	99.8%	To follow
Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	95%	98.2%	97.9%	97.2%	98.0%	98.2%	98.2%	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%	3.9%	7.1%	6.9%	5.6%	7.1%	2.6%	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%	99.0%	72.6%	96.0%	100.0%	96.1%	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%	100.0%	90.5%	88.7%	90.7%	91.1%	90.7%	90.2%
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	0	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	0	CCG to audit for breaches						

Monthly Quantitative Information Report

	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Complaints and PALS												
New complaints this month	38	34	46	36	51	43	50	38	37	27	28	30
Top 3 complaint subjects												
All aspects of Clinical Treatment	39	26	36	22	37	26	29	21	26	18	15	25
Communications/information to patients (written and oral)	16	6	10	18	15	17	6	11	11	6	11	9
Patient Care	23	15	11	19	20	17	18	5	8	9	19	5
Top 3 directorates receiving complaints												
Acute & General Medicine	7	8	7	3	4	11	8	2	3	2	3	3
Emergency Medicine	6	4	4	5	5	5	4	5	4	4	3	3
General Surgery & Urology	4	1	7	3	7	1	6	8	11	2	2	4
Number of Ombudsman complaint reviews (new)	1	0	1	1	2	2	1	0	0	0	0	2
Number of Ombudsman complaint reviews upheld	0	0	0	0	0	0	0	0	0	0	0	0
Number of Ombudsman complaint reviews partly upheld	0	1	0	1	0	0	0	0	1	1	0	0
New PALS queries this month	336	275	238	287	262	292	227	269	240	173	271	215
Top 3 PALS subjects												
Communication issues	62	63	56	90	91	60	54	54	53	43	46	32
Any aspect of clinical care/treatment	30	26	17	18	16	19	18	25	29	24	21	24
Appointments	46	57	53	55	42	48	30	51	43	24	47	23

Serious Incidents												
Number of SI's reported	10	9	20	19	14	12	8	17	10	12	22	21
% SI's notified within 2 working days of SI being identified	100%	100%	100%	100%	100%	100%	100%	94%	100%	100%	100%	95%
* this is currently under discussion via the 'exceptions log'												
Compliance with Duty of Candour for Serious Incidents*:												
-Verbal Apology Given	n/a	7	8	7	8	6	4	6	6	4	3	0
-Written Apology Given *	n/a	4	7	5	6	2	4	5	0	2	0	0
-Invitation to be involved in Investigation	5	1	7	8	5	5	2	4	2	2	0	0
-Given Final Report (If Requested)	2	1	2	3	0	5	5	2	5	1	3	0

Pressure Ulcers**												
Number of Category 2	94	91	79	69	68	60	55	74	72	80	101	83
Number of Category 3	2	5	7	3	5	1	4	3	5	8	4	6
Number of Category 4	2	2	2	2	1	2	1	0	2	2	0	0
Total number developed/deteriorated while in our care (care of the organisation) - acute	97	101	89	82	79	58	68	75	65	93	120	96
Total number developed/deteriorated while in our care (care of the organisation) - community	40	30	45	27	34	39	39	26	39	38	40	47

Falls***												
Number of falls with moderate harm	3	6	2	3	1	1	4	1	3	6	4	2
Number of falls with severe harm	3	1	1	1	2	0	4	0	2	4	7	1
Number of falls resulting in death	0	0	0	0	0	0	0	0	0	0	0	0

Monthly Quantitative Information Report

	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Safeguarding												
% of staff compliant with training (children)	85%	85%	85%	84%	84%	83%	83%	83%	83%	84%	84%	83%
% of staff compliant with training (adult)	86%	86%	86%	86%	86%	85%	85%	85%	85%	85%	85%	84%
% of staff working with children who have review DBS checks												
Prevent Strategy												
Attendance at the HealthWRAP training session												
Number of concerns raised via the incident reporting system												
Claims												
Number of Negligence Claims	9	14	15	17	13	16	10	12	12	10	14	16
Number of Claims settled per Month	5	1	10	9	6	2	5	2	5	2	2	3
Amount paid out per month ****	£3,338,000	£1,200,000	£674,869	£6,382,000	£83,500	£105,000	£1,808,000	£90,000	£243,733	£1,900	£281,500	£29,000
Reasons for the payment	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability

* The Trust has been developing its processes for recording Duty of Candour and reporting since 1 April 2017.

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 & 4 pressure ulcer data excludes Category 3 ulcers which are recorded as having developed within 72 hours of admission to inpatient care. The increase in pressure ulcers in January reflects the number of frail and elderly patients in the acute Trust.

**** 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. One claim settled in March was settled for a £3,000,000 lump sum plus £59,000 per annum for life. Only the lump sum is reflected in the amount paid out. A claim was settled in June for £6m lump sum with annual payments for life which all totals approximately £14,999,999. Only the lump sum is reflected in the amount paid as the the remainder of the payment is approximate. A claim was settled in September for a £1.5m lump sum with a £50,000 periodical payment per annum. Only the lump sum is reflected in the amount paid.

Blank page

Board of Directors – 28 March 2018

Medical Director's Report

Recommendation

For information	<input checked="" type="checkbox"/>
For discussion	<input checked="" type="checkbox"/>
For assurance	<input checked="" type="checkbox"/>
For approval	<input type="checkbox"/>
A regulatory requirement	<input type="checkbox"/>

Current approval route of report

This report is only written for the Board of Director's.

Purpose of report

This report provides an update from the Medical Director.

Key points for discussion

- SI summary report
- Consultants new to the Trust
- Bowel cancer audit
- Lung cancer audit
- Antibiotic prescribing audit

Trust Ambitions and Board Assurance Framework

(<https://www.yorkhospitals.nhs.uk/about-us/our-values/>)

The Board Assurance Framework is structured around the four ambitions of the Trust. How does the report relate to the following ambitions:

- Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.
- Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.
- People and Capability** - The quality of our services is wholly dependent on our teams of staff.
- Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

Reference to CQC Regulations

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

Version number: 1

Author: Dr Ed Smith, Deputy Medical Director

Executive sponsor: Mr Jim Taylor, Medical Director

Date: March 2018



1. Introduction and Background

In the report this month:

Patient Safety-

- SI summary report

Clinical Effectiveness-

- consultants new to the Trust
- bowel cancer audit
- lung cancer audit

Patient Experience-

- antibiotic prescribing audit results

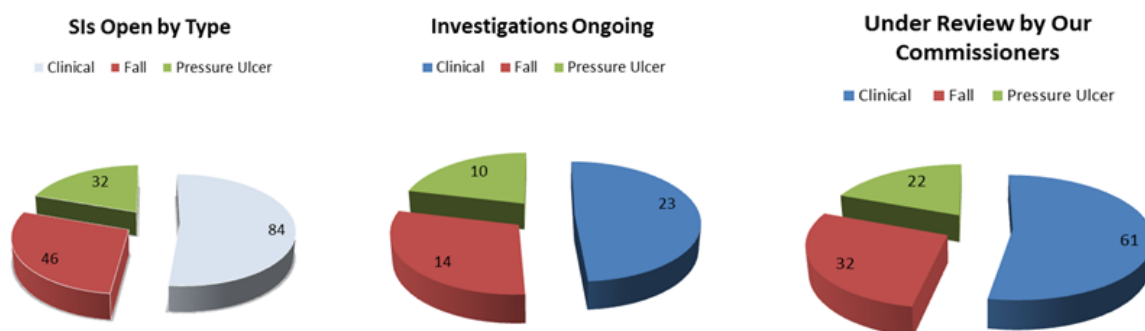
2. Patient Safety

2.1 Serious incident summary report

From 1 March 2017 to 28 February 2018, a total of 174 SIs have been declared for investigation. In total there are currently 47 SIs which are currently under investigation by the Trust and 115 which are under review by our commissioners. There are a further 39 SIs which have been closed by our commissioners but still have actions outstanding to be implemented by the Trust.

This paper aims to set out the numbers by month, the category of incident and trending information.

Open SIs

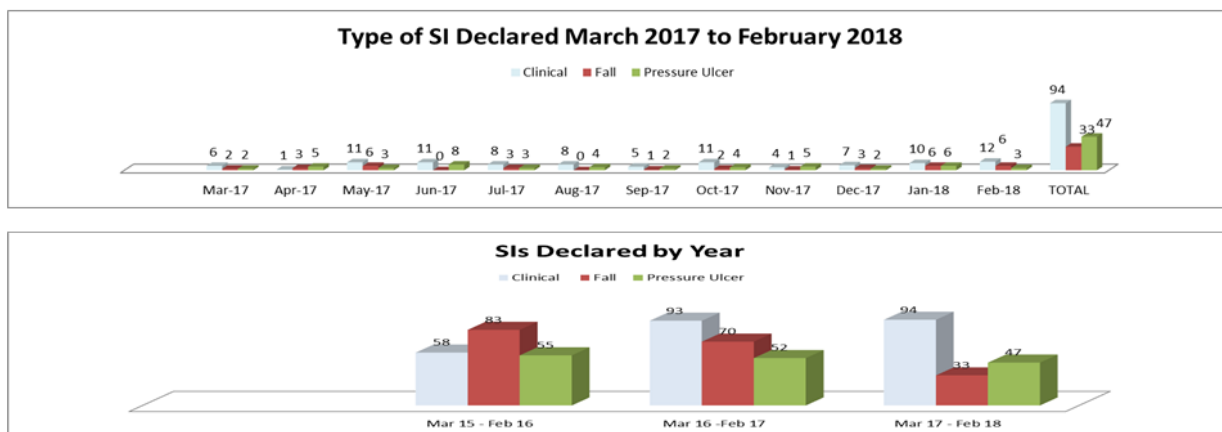


SI's Declared by Month and by Year

The tables below shows the breakdown by month for SI's declared; the SI type; the current status by month and whether or not SIs were declared to the commissioner within the required 48 hours period.



To be a valued and trusted partner within our care system delivering safe effective care to the population we serve.



From March 2017 until February 2018 declaration within 48 hours was at 99%.

Duty of Candour

Since April 2017 the Trust has been updating its processes for ensuring that the Duty of Candour is undertaken.

Duty of Candour - All SIs as recorded on Datix	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	TOTAL
SIs Graded Moderate or Above Requiring Duty of Candour	7	8	11	8	8	5	11	9	7	17	16	107
Confirmed and Documented Verbal Apology	7	8	7	8	6	4	6	6	4	3	0	59
Verbal Apology Not Yet Given	0	0	4	0	2	1	5	3	3	14	16	48
% Confirmed and Documented Verbal Apology	100%	100%	64%	100%	75%	80%	55%	67%	57%	18%	0%	55%
Confirmed and Documented Written Apology	4	7	5	6	2	4	5	0	2	0	0	35
Written Apology Not Required	0	0	3	0	1	0	3	2	0	0	0	10
Written Apology Not Yet Given	3	1	3	2	5	0	6	6	3	17	16	62
% Confirmed and Documented Written Apology (or not required)	57%	88%	73%	75%	38%	100%	45%	33%	57%	0%	0%	42%

Duty of Candour - Clinical SIs as recorded on Datix	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	TOTAL
SIs Graded Moderate or Above Requiring Duty of Candour	0	5	7	4	5	3	6	3	2	5	7	47
Confirmed and Documented Verbal Apology	0	5	5	4	3	2	4	2	1	0	0	26
Verbal Apology Not Yet Given	0	0	2	0	2	1	2	1	1	5	7	21
% Confirmed and Documented Verbal Apology	N/A	100%	71%	100%	60%	67%	67%	67%	50%	0%	0%	55%
Confirmed and Documented Written Apology	0	4	3	4	2	2	4	0	1	0	0	20
Written Apology Not Required	0	0	2	0	1	1	0	0	0	0	0	4
Written Apology Not Yet Given	0	1	2	0	2	0	2	3	1	5	7	23
% Confirmed and Documented Written Apology (or not required)	N/A	80%	71%	100%	60%	100%	67%	0%	50%	0%	0%	51%

Duty of Candour - Falls SIs as recorded on Datix	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	TOTAL
SIs Graded Moderate or Above Requiring Duty of Candour	3	2	0	3	0	1	2	1	3	6	6	27
Confirmed and Documented Verbal Apology	3	2	0	3	0	1	2	1	2	3	0	17
Verbal Apology Not Yet Given	0	0	0	0	0	0	0	0	1	3	6	10
% Confirmed and Documented Verbal Apology	100%	100%	N/A	0%	N/A	0%	100%	100%	67%	50%	0%	63%
Confirmed and Documented Written Apology	1	2	0	1	0	1	0	0	1	0	0	6
Written Apology Not Required	0	0	0	0	0	0	0	0	1	0	0	1
Written Apology Not Yet Given	2	0	0	2	0	0	2	1	1	6	6	20
% Confirmed and Documented Written Apology (or not required)	33%	100%	N/A	33%	N/A	100%	0%	0%	67%	0%	0%	26%

Duty of Candour - Pressure Ulcers as recorded on Datix	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	TOTAL
SIs Graded Moderate or Above Requiring Duty of Candour	4	1	4	1	3	1	3	5	2	6	3	33
Confirmed and Documented Verbal Apology	4	1	2	1	3	1	0	3	1	0	0	16
Verbal Apology Not Yet Given	0	0	2	0	0	0	3	2	1	6	3	17
% Confirmed and Documented Verbal Apology	100%	100%	50%	100%	100%	100%	0%	60%	50%	0%	0%	48%
Confirmed and Documented Written Apology	3	1	2	1	0	1	1	0	0	0	0	9
Written Apology Not Required	0	0	1	0	0	0	0	3	1	0	0	5
Written Apology Not Yet Given	1	0	1	0	3	0	2	2	1	6	3	19
% Confirmed and Documented Written Apology (or not required)	75%	100%	75%	100%	0%	100%	33%	60%	50%	0%	0%	42%

Serious Incidents Declared by Type and Directorate

In terms of categories, the hotspots continue to be pressure ulcers and slip trips and falls with harm. Strategies have been developed and implemented that aim to ensure safer care for patients who may be at risk of pressure ulcers and falls. Whilst the number of falls still looks high, there is a trend of a reduction from the previous year.

The peaks and troughs which occur in both falls and pressure ulcers appear to a result from the pre-investigation work that occurs to establish pressure ulcer categories prior to being declared to CCG. All other categories have very small numbers of incidents.



Serious Incidents Declared by Type		Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	TOTAL
12 Hour Breach	Operations	0	0	1	2	2	1	1	2	0	4	4	5	22
12 Hour Breach x9	Operations	1	0	0	0	0	0	0	0	0	0	0	0	1
Accident meeting SI Criteria	Elderly Medicine	0	0	1	0	0	0	0	0	0	0	0	0	1
Baby complication / hypoglycaemia	Obstetrics and Gynaecology	0	0	0	0	0	0	1	0	0	0	0	0	1
Category 3 Pressure Ulcer	Community Services	0	3	1	3	2	1	0	1	3	0	0	2	16
	Elderly Medicine	1	0	0	1	0	3	1	0	0	0	0	1	7
	General Surgery & Urology	0	0	1	0	0	0	0	0	0	0	0	0	1
	Medicine (General & Acute)	0	0	0	1	0	0	0	1	0	1	2	0	5
	Theatres, Anaesthetics, Critical Care	0	0	0	0	0	0	0	2	0	0	1	0	3
	Trauma and Orthopaedic	0	0	0	0	0	0	0	0	0	0	2	0	2
Category 3 Pressure Ulcers x2	Community Services	0	0	1	0	0	0	0	0	0	0	0	0	1
Category 3 Pressure Ulcers x6	Elderly Medicine	0	1	0	0	0	0	0	0	0	0	0	0	1
Category 4 Pressure Ulcer	Community Services	1	1	0	2	0	0	1	0	1	1	0	0	7
	Medicine (General & Acute)	0	0	0	0	1	0	0	0	1	0	0	0	2
	Theatres, Anaesthetics, Critical Care	0	0	0	1	0	0	0	0	0	0	0	0	1
	Trauma and Orthopaedic	0	0	0	0	0	0	0	0	0	0	1	0	1
Delayed Diagnosis	Elderly Medicine	0	0	0	0	0	0	0	1	0	0	0	0	1
	Emergency Medicine	0	0	0	1	0	0	0	0	0	0	0	0	1
	General Surgery & Urology	0	0	0	0	0	0	0	0	1	0	0	0	1
	Medicine (General & Acute)	0	0	0	0	0	0	0	0	0	1	0	0	1
	Specialist Medicine	0	0	0	0	0	0	0	0	0	0	1	0	1
Diagnostic Incident - Delay/Failure to Act on	(blank)	0	0	0	0	0	0	0	0	0	0	0	1	1
	Emergency Medicine	0	0	0	1	0	0	0	0	0	0	0	0	1
	Medicine (General & Acute)	0	0	0	0	0	0	1	0	0	0	0	0	1
	Radiology	0	0	0	0	0	1	0	0	0	0	0	0	1
Infection Prevention Incident	Theatres, Anaesthetics, Critical Care	1	0	0	0	0	0	0	0	0	0	0	0	1
	Elderly Medicine	0	0	0	1	0	0	0	0	0	0	1	0	2
	Nursing & Improvement	0	0	1	0	0	0	0	0	0	0	0	0	1
Information Governance Breach	Nursing & Improvement	0	0	0	0	0	1	0	0	0	0	0	0	1
Maternity/Obstetrics Incident - Baby Only	Laboratory Medicine	1	0	0	0	0	0	0	0	0	0	0	0	1
	Obstetrics and Gynaecology	0	1	2	3	1	0	0	0	0	0	0	0	7
Maternity/Obstetrics Incident - Mother Only	Obstetrics and Gynaecology	0	0	0	0	0	1	0	0	0	0	0	0	1
Serious Incidents Declared by Type		Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	TOTAL
Medication Incident	Emergency Medicine	0	0	0	0	0	0	0	0	0	0	0	1	1
	Medicine (General & Acute)	0	0	0	0	0	0	0	0	0	0	1	0	1
	Specialist Medicine	1	0	0	0	0	0	1	0	0	0	0	0	2
	Pharmacy	0	0	0	0	0	0	0	1	0	0	0	0	1
Slips, Trips & Falls	Community Services	0	0	0	0	1	0	0	0	0	0	0	0	1
	Elderly Medicine	2	2	6	0	1	0	0	0	0	0	0	2	13
	General Surgery & Urology	0	0	0	0	0	0	0	0	0	0	0	1	1
	Medicine (General & Acute)	0	1	0	0	0	0	0	0	0	0	0	0	1
	Specialist Medicine	0	0	0	0	2	0	0	0	0	0	0	0	2
Slips, Trips and Falls - Clinical	Emergency Medicine	1	0	0	0	0	0	0	0	0	0	0	0	1
Slips, Trips and Falls - Patient Death	Community Services	0	0	1	0	0	0	0	0	0	0	0	0	1
Suboptimal Care	Child Health	1	0	0	0	0	0	0	0	0	0	0	0	1
	Emergency Medicine	0	0	1	0	1	0	0	0	0	0	0	0	2
	Medicine (General & Acute)	0	0	0	1	1	1	1	2	1	0	0	0	7
Surgical Procedure Incident	Trauma and Orthopaedic	0	0	0	0	0	0	0	1	0	0	0	0	1
Surgical/Invasive Procedure Incident	General Surgery & Urology	0	0	0	0	0	0	0	0	0	0	0	1	1
	Theatres, Anaesthetics, Critical Care	0	0	0	0	0	0	0	0	0	0	1	0	1
	Trauma and Orthopaedic	0	0	1	1	0	1	0	0	0	0	0	0	3
Treatment Delay	Elderly Medicine	0	0	0	0	0	0	0	1	0	0	1	0	2
	Emergency Medicine	0	0	1	0	0	0	0	0	0	0	0	0	1
	General Surgery & Urology	0	0	0	0	0	0	0	1	0	0	0	0	1
	Medicine (General & Acute)	0	0	0	0	0	0	0	0	1	1	1	0	2
	Ophthalmology	0	0	1	0	1	1	0	0	0	0	0	0	3
	Theatres, Anaesthetics, Critical Care	0	0	0	0	0	0	0	0	0	0	0	1	1
	Trauma and Orthopaedic	0	0	0	0	0	0	0	0	0	0	0	1	1
VTE Incident meeting SI criteria	Elderly Medicine	0	0	0	1	0	0	0	0	0	0	0	0	1
Wrong Implant / Prosthesis - Never Event	Trauma and Orthopaedic	0	0	1	0	0	0	0	0	0	0	0	0	1
Wrong Site Surgery - Never Event	General Surgery & Urology	0	0	0	0	1	0	0	0	0	0	0	0	1
	Medicine (General & Acute)	0	0	0	0	0	1	0	0	0	0	0	0	1
Slips, trips and falls	Community Services	0	0	0	0	0	0	1	0	0	1	0	0	2
	Elderly Medicine	0	0	0	0	0	0	0	0	0	1	1	2	4
	Emergency Medicine	0	0	0	0	0	0	0	0	1	0	2	1	4
	General Surgery & Urology	0	0	0	0	0	0	0	1	0	0	2	0	3
	Medicine (General & Acute)	0	0	0	0	0	0	0	1	0	1	1	0	3
	Trauma and Orthopaedic	0	0	0	0	0	0	0	0	0	0	0	1	1
Unexpected Death	General Surgery & Urology	0	0	0	0	0	0	0	1	0	0	0	0	1
Wrong Patient/ Never Event	General Surgery & Urology	0	0	0	0	0	0	0	1	0	0	0	0	1
Operation Given Without Valid Consent	Theatres, Anaesthetics, Critical Care	0	0	0	0	0	0	0	0	1	0	0	0	1
System Failure, Unexpected Death	Medicine (General & Acute)	0	0	0	0	0	0	0	0	1	0	0	0	1
Missed Diagnosis	Emergency Medicine	0	0	0	0	0	0	0	0	0	1	0	0	1
Medical Equipment/Devices/Disposables Inc	Medicine (General & Acute)	0	0	0	0	0	0	0	0	0	0	0	1	1
TOTAL		10	9	20	19	14	12	8	17	10	12	22	21	174

Invitation to be involved in the investigation and sharing of the report

Invitation to participate and sharing of report	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	TOTAL
Invitation to be involved in Investigation?	5	1	7	8	5	5	2	4	2	2	0	0	41
% Confirmed Invitation to be Involved in Investigation (Clinical SIs)	83%	100%	64%	73%	63%	63%	40%	36%	50%	29%	0%	0%	44%
Given Final Report (If Requested)? (Clinical SIs)	2	1	2	3	0	5	5	2	5	1	3	0	29
% Clinical SIs Confirmed given Final Report (If Requested)?	67%	50%	50%	75%	0%	83%	83%	67%	83%	25%	38%	0%	54%



To be a valued and trusted partner within our care system delivering safe effective care to the population we serve.

3. Clinical Effectiveness

3.1 Consultants new to the Trust

The following consultants joined the Trust in February:

Dr Narmin Baraheni
 Obstetrics & Gynaecology
 York

Dr Luke McLaughlin
 Paediatrics
 York

3.2 National Bowel Cancer Audit (NBOCA) Annual Report 2016

The National Bowel Cancer Audit (NBOCA) compares the care and outcomes of patients diagnosed with bowel cancer in England and Wales. The NBOCA collects data on items which have been identified and generally accepted as measures of good care within:

- Care pathways
- Surgical care
- Survival rates
- Rectal cancer

The 2016 Annual Report is the seventh report published and includes data on patients nationally, regionally and locally diagnosed with bowel cancer in 2014/2015.

The table below provides details of the audit outcomes from the current 2016 report and the previously published report in 2015

	2013/14				2014/15			
	YTH	SGH	Region	National	YTH	SGH	Region	National
Number of patients reported to the audit	272	10	3,158	30,663	223	115	3008	30,122
Seen by clinical Nurse specialist (%)	98	83	83	93	94	98	82	92
Curative Major Resection Treatment Pathway (%)	68	40	63	63	53	55	60	59
Too Little Treatment Pathway (%)	1	0	5	4	3	0	4	4
Non-Curative Major Resection Treatment Pathway (%)	-	-	-	-	7	8	3	4
Too Much/Too Frail Treatment Pathways (%)	17	0	16	15	17	17	17	16
Not Known/Other Treatment Pathway	60	14	16	17	21	20	16	17
No. patients having major	197	-	1,998	19,445	156	60	1,893	18,808



	2013/14				2014/15			
	YTH	SGH	Region	National	YTH	SGH	Region	National
surgery								
Patients with distant metastases at time of surgery (%)	5	-	11	10	2	3	7	9
Major surgery carried out as urgent or emergency (%)	14	-	13	16	22	8	12	16
Median number of lymph nodes excised	21	-	18	17	22	19	18	17
Laparoscopic surgery Attempted (%)	37	-	52	57	33	45	55	61
Length of hospital stay >5 days (%)	70	-	74	69	73	62	76	69
No. patients having major surgery	194	-	1,851	19,304	156	60	1,877	18,663
Observed 90-day mortality (%)	2.6	-	3.8	3.9	6.4	0	3.7	3.8
Adjusted 90-day mortality (%)	3	-	4.2	3.9	6.6	0	4.4	3.8
No. patients having major surgery linked to HES	182	-	1,728	16,270	147	58	1,752	16,002
Observed 30-day unplanned readmission rate (%)	17	-	20.4	19.9	4.8	15.5	10.2	10.1
Adjusted 30-day unplanned readmission rate (%)	17.3	-	20.1	19.9	4.8	16.3	10.2	10.1
No. patients having major resection	178	74	2,167	19,087	144	50	2,015	19,845
Observed 2-year mortality (%)	22	21.8	22.7	22	19.2	15.1	20.7	20.9
Adjusted 2-year mortality	30.1	26.2	23.9	22	22.2	16.1	22	20.9

This is the 7th report from this National Audit and the comparison against the current report findings and the data reported annually since 2005 evidences that year on year that the Trust is making steady improvement against the audit criteria.

The Trust has maintained contact with a Clinical Nurse Specialist above the National average, and the Trust mortality outcomes are within the normal limits.

The Trust's curative resection rate is less than the National average by approx. 7%. However the Trust has more emergency operations (by 10%) than nationally reported which could account for the higher non –major resection patients being reported in our audit data.

The Trust's rectal cancer rates are equivalent to the National average.



3.3 National Lung Cancer Data Audit

The National Lung Cancer Audit is a Quality Account national audit and mandated under the National Clinical Audit Patient Outcomes Programme (NCAPOP).

NICE guidance underpins this audit criteria with a set of 15 quality standards intended to describe what a high-quality lung cancer service should deliver.

The aim of the audit is to improve patient care and experience on a national level by reducing variation in clinical outcomes.

This report covers the findings from the Annual Report 2016 which details the audit data submitted during 2015.

For the first time, York and Scarborough Hospitals' results have been combined for the reporting period; as a result it not possible to accurately compare the data from previous years, therefore the data for York Trust has been benchmarked against the Regional data available.

Process, Imaging & Nursing Measures

	York Hospitals NHS FT (2015)	Yorkshire and the Humber
Number Submitted	333	4,446
Performance Status (PS) completeness	90.4% ✓	80.4% ✗
Stage completeness	98.2% ✓	96.5% ✓
Discussed at MDT	90.4% ✗	83.3% ✗
Pathological diagnosis	68.5% ✗	70.0% ✗
Pathological diagnosis (odds ratio)	0.69	0.76
NSCLC NOS	15.1% ✗	12.5% ✓
Seen by LCNS	83.8% ✗	46.0% ✗

✓ equal to or exceeds level suggested for this audit year

✗ below level suggested for this audit year

Treatment & Outcome Measures

	York Hospitals NHS FT (2015)	Yorkshire and the Humber
Anticancer	57.7% ✗	59.6% ✗
Anticancer (OR)	0.74	0.91
Surgery	12.0% ✗	14.9% ✗
Surgery (OR)	0.56	0.78
NSCLC chemo	62.7% ✓	67.3% ✓
NSCLC chemo (OR)	1.02	1.19
SCLC chemo	80.0% ✓	71.7% ✓
SCLC chemo (OR)	1.56	1.14
Survival	35.4%	37.6%

✓ equal to or exceeds level suggested for this audit year

✗ below level suggested for this audit year



There are significant demographic differences between the two geographical areas, of York & Scarborough, with Scarborough CCG having the oldest population in England (we have overtaken Eastbourne), and a higher smoking prevalence compared to York which impacts on the audit findings.

The number of surgical cases submitted to this audit is low, but previous analysis indicates high levels of advanced disease and comorbidity existing in patients at presentation.

Similarly the biopsy rates are lower than the national expectation, which is believed to be due to the more elderly demographic in Scarborough, as those patients may not be fit for intervention. Correspondingly the impact of Scarborough's demographic of elderly smokers, is believed to have impacted on the lower general anticancer treatment figure for the Trust.

Although 90% of eligible patients are discussed at the lung Multi-Disciplinary Team Meetings, and despite this being higher than the regional percentage achieved, it is still below the 100% target set within the NICE guidance.

The number of patients seen by the lung Clinical Nurse Specialist is lower than the national expectation. This may reflect the lower numbers seen in Scarborough, which have then been merged.

4. Patient Experience

4.1 Antibiotic prescription audit results

The summary of the antibiotic prescriptions from the February prescription audit are presented below.

The total antibiotic consumption has decreased by 8% up to the end of February which is in contrast to the previous month where there was a 0.1% decrease. This may possibly be attributed to the early commencement of the Flu season. To interrogate this idea we are planning a retrospective audit to examine this.

The pip taz consumption has fallen dramatically in the year to date and this is largely attributable to the hard work of the microbiologists and the pharmacy team in highlighting and reviewing all patients initiated on pip taz.

The carbapenem consumption is showing an 8% increase compared to the previous month of an 11% increase. All patients initiated on carbapenems are reviewed by the microbiologists to ensure that they are on the most appropriate therapy. The challenge is the CQUIN is based on a percentage decrease which is extremely hard for us to achieve given that we are the second lowest users in the SHA. Examining the rolling average going back over the last five years shows a very slight decrease in Trust consumption. This has been presented to the CCG for mitigation against the CQUIN.

The monthly point prevalence audit shows a slight decrease in the recording of indication across medicine, care of the elderly, surgery and urology. In contrast women's health and orthopaedics have achieved 100%. Unfortunately the recently published CQC report noted that the inspectors found some prescription charts at Bridlington and Scarborough where

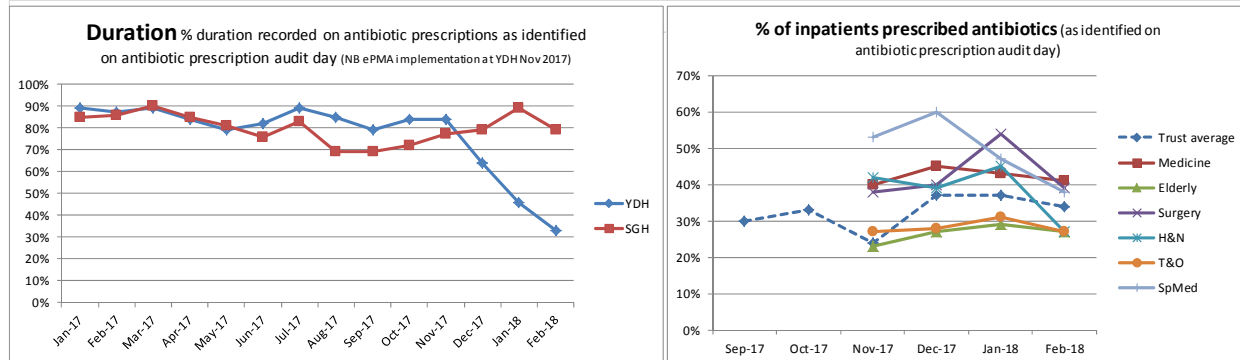


the indication was not recorded. This should be rectified by the implementation of EPMA in Scarborough which is anticipated in May.

There is a decrease in the number of patients with an antibiotic duration recorded and this disappointing. In part this is due to the implementation of EMPA which automatically prompts a review after 72 hours but has no facility to easily add a stop date at the review. This is being reviewed by the EPMA work plan. Next year's CQUIN will require documentation of a detailed review including recording of one of the seven antimicrobial prescribing decisions. Again the EPMA implementation team have been approached to help CPD to support this.

York Teaching Hospitals NHS Foundation Trust																			
Pharmacy Antimicrobial Team Antibiotic Usage Summary Report Feb-17 to Feb-18																			
Antibiotic Consumption data % change of cumulative totals 2016/17 vs 2017/18 as at FEBRUARY 2018																			
better / worse / no change vs same month previous year?	better (less than previous month)			no change (variation of up to 2% on previous)			worse (greater than 2% from previous month)			not recorded	x								
	↑	↔	↓	↔	↔	↔	↔	↔	↔			↔	↔	↔	↔	↔			
DDD's / 1000 admissions	Trust	Medicine	Care of the Elderly	Surgery & urology	Women's Health	Trauma & Orthopaedics	Theatre, Anaesthetic & Critical Care	SpMed	Head and Neck	Paediatrics									
Total Antibiotic consumption	-8%	+0.8%	↔	+15%	↔	+3%	↔	+1%	↑	+22%	↔	-4%	↔	-7%	↔	+28%	↑	+7%	↑
Pip/tazo consumption	-43%	-17%	↓	-16%	↓	-41%	↓			+33%	↔	-8%	↓	-16%	↔	-97%	↓		
carbapenems consumption	+6%	+15%	↔	+16%	↑	+36%	↑			-163%	↔	-24%	↑	+14%	↑	-133%	↑		

Key Antimicrobial indicators (results based on prescriptions identified on audit day)



Indicators December 2017	Trust	Medicine	Care of the Elderly	Surgery & urology	Women's Health	Trauma & Orthopaedics	Theatre, Anaesthetic & Critical Care	SpMed	Head and Neck	Paediatrics									
											↑	↔	↓	↔	↔	↔	↔	↔	↔
% pts Rx Abx	34%	↓	41%	↓	27%	↔	39%	↓	11%		27%	↓	x	x	38%	↓	36%		x
% IV																			
% indication recorded YDH	ePMA mandates that an indication is recorded therefore these results are no longer reported																		
% indication recorded SGH	83%	↓	79%	↓	86%	↓	85%	↓	100%	↑	100%	↑	x	x	x	x	x	x	x
% duration recorded YDH	33%	↓	35%	↓	34%	↓	19%	↓	0%	↓	65%	↑	x		20%	↓	31%	↑	
% duration recorded SGH	79%	↓	77%	↓	89%	↓	76%	↓	0%	↓	100%	↔	x		x		x		
% Rx with duration (Trust)	48%	↓	49%	↓	52%	↓	47%	↑	0%	↓	69%	↑	x	x	20%	↓	31%	↑	x



5. Recommendations

The Board is asked to review and approve the content of the report.



Blank page

Board of Directors – 28 March 2018

Chief Nurse Report – March 2018

Recommendation

For information	<input checked="" type="checkbox"/>
For discussion	<input checked="" type="checkbox"/>
For assurance	<input checked="" type="checkbox"/>
For approval	<input type="checkbox"/>
A regulatory requirement	<input type="checkbox"/>

Current approval route of report

Quality & Safety Committee – 20th March 2018
Board of Directors – 28th March 2018

Purpose of report

The Chief Nurse report provides assurance on progress towards the delivery of our quality priorities, and highlights any risks to delivery of the Nursing & Midwifery and Patient Experience Strategies. The four themes are:

- Experience and Communication
- Workforce
- Safe, quality care
- Partnerships and efficiency

The themes triangulate with the Patient Experience and Patient Safety strategies in order that priorities are aligned to ensure delivery of the key objectives.

Key points for discussion

- Improvement in Friends and Family Test Results
- Infection Prevention Team Update
- Maternity Safety Improvement Plan

Trust Ambitions and Board Assurance Framework
(https://www.yorkhospitals.nhs.uk/about_us/our_values/)

The Board Assurance Framework is structured around the four ambitions of the Trust. How does the report relate to the following ambitions:

- Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.
- Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.
- People and Capability** - The quality of our services is wholly dependent on our teams of staff.
- Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

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

Version number: 1

Author: Beverley Geary, Chief Nurse

Executive sponsor: Beverley Geary, Chief Nurse

Date: March 2018



1. Introduction and Background

The Chief Nurse report provides assurance on progress towards the delivery of our quality priorities, and highlights any risks to delivery of the Nursing & Midwifery and Patient Experience Strategies. The four themes are:

- Experience and Communication
- Workforce
- Safe, quality care
- Partnerships and efficiency

The themes triangulate with the Patient Experience and Patient Safety strategies in order to ensure delivery of the key objectives.

2. Progress on key strategic themes

In line with the Nursing and Midwifery strategy, this report is aligned to the four key themes

2.1 Experience and Communications

2.1.1 Friends and Family Test

The inpatient satisfaction rate for January 2018 was 97.6%, the highest for 12 months. The ED satisfaction rate was 87.3%, York ED remained above average at 88%, and Scarborough ED was down 4% at 83%. The inpatient response rate was 27.3%, similar to previous months (national average 22.1%). The ED response rate was 14.2% (national average 11.6%)

2.1.2 Complaints and PALS Management

27% of cases closed in February met the Trust's 30 day response target. The Patient Experience Team are providing the Chief Nurse and Deputy Chief Nurse with directorate-level performance reports on complaints management which are discussed as part of the operational and executive performance assurance meetings. Where directorates have been consistently falling below the standard they have been asked to present an improvement plan. 80% of PALS in February were closed within 10 days.

2.1.3 Volunteering – Helpforce

Five Trusts commenced their pilots in February 2018. Learning from these pilots will be shared with the 2nd wave of HelpForce Trusts (of which we are one) to support their development of volunteering. Our Trust's approach is to develop a volunteering project which links volunteer and statutory public services across the community (initially in York).



2.2 Workforce

2.2.1 Vacancy Position

Due to continued problems with Oracle reporting it has not been possible to provide an up to date vacancy position on the dashboards as at the end of February 2018.

The Chief Nurse team continues to work with the recruitment team on attracting both experienced and newly qualified nurses into the Trust as well as developing new roles, such as the Associate Practitioner role. The Chief Nurse team has recently attended a careers fair at the Coventry University (Scarborough Campus) to begin to engage with new students who will be commencing their nursing studies from September 2018.

The elderly medical wards on the York site are experiencing a rise in nursing vacancies. Assistant Directors of Nursing are working with the Matrons to develop plans to mitigate risk; including moving of staff in the medium term and block booking of agency staff, however this will continue to be a significant challenge given the current RN vacancy rate across the region. This may have an impact on the Trust's strategic aim to reduce agency spend.

A cohort of 17 Associate Practitioners commenced in post on 29th January 2018 and a further 9 were recruited in February with their anticipated start date being 23rd April 2018. Further recruitment is anticipated later in the year.

The Chief Nurse Team will also be holding a Market Place at York Hospital on Saturday 21st April to promote all the nursing vacancies across the Trust as well as holding information sessions on Healthcare Assistants, Associate Practitioner and apprentice Nursing Associate roles.

2.2.2 SafeCare

The Trust commenced implementation of Safecare at the beginning of February 2018. Four inpatients units were identified as test sites to ensure any issues from implementation were addressed and lessons learned. The roll out is now well under way with the aim of all York inpatients units being operationally live by the end of March 2018. Early indications from staff feedback are that it has been positively received and initial compliance with staff data inputting is high. The roll-out across Scarborough inpatient units will commence in April 2018 followed by community hospitals. It is anticipated all inpatients units will be operationally live by the end of June 2018.

Once full implementation is completed, it will be possible to extract performance data from the system and this will be incorporated into future reporting.



2.2.3 Nurse Roster Project

Since the project begun in August 2016 there has been a total of 33 Deep Dive meetings completed with a further 5 areas having been notified that their meetings are due.

The Project has seen some generalised improvements with regards to 'unfinalised duties' when comparing year on year data. August 2016- July 17 shows a 7% decrease on the monthly average of unlocked duties in comparison to August 2015- July 16. Our current data suggests that this improvement is continuing into 2017-18 with the monthly average being 33 % less than 2016-17 position.

The most recent data relating to Staff with Net Hours owed to the Trust also suggests that improvements are being seen with the position from January 2018 being 26% lower than our starting point in July 2017.

The Nurse Rostering Project is currently on an approximate two month pause. This is to allow for an objective and holistic review of the Deep Dive and Roster Assurance processes currently in place. The review will be based on feedback from relevant stakeholders.

2.3 Safe, Quality Care

2.3.1 Infection Prevention Update

We continue to focus upon the management of Influenza. Whilst we are now seeing a clear reduction in numbers of confirmed influenza, flu rates remain high compared to past years. For this reason Ward 23 remains operating as the Influenza ward until such a time that the side room capacity will be able to absorb these patients. Currently, there are 3 bays on 23 still dedicated to respiratory viruses.

In order to capture the lessons from 2017/18 Flu season (discussed in last month's CN report), the Infection Prevention Team have undertaken a survey of key stakeholders and will be conducting a formal review to plan for future seasons.

Nationally, there has been a rise in gastrointestinal infections. Our Trust has seen a reflection of this and as a result has closed a number of Wards and Bays due to these outbreaks. The predominant organism isolated within the trust has been Norovirus. As ever, we closely manage each and every alert / outbreak situation to aid patient flow as best as possible.

The following table shows the Trust incidence of cases – i.e. those cases attributed to the Trust and not taken on admission.



	Annual Trust threshold	Threshold to end of February	Total Trust attributed to date	February incidence	Days from last case		Community	Critical Care	Elderly Medicine	Emergency Medicine	Medicine	Specialist medicine	Surgery & Urology	Trauma & Orthopaedics
MRSA bacteraemia	Zero tolerance		4	0	154	Incidence to date			1	1	2			
						Incidence per 10000 bed days	0.00	0.00	0.09		0.27	0.00	0.00	0.00
						Days since last case	511		154		216	675	501	
MSSA bacteraemia	30	27.5	39	0	45	Incidence to date		3	9		18	3	3	3
						Incidence per 10000 bed days	0.00	6.00	0.84		2.40	3.64	0.79	1.33
						Days since last case	398	201	93		45	174	104	214
E coli bacteraemia	To be agreed		79	1	18	Incidence to date	8	2	19		23	7	12	8
						Incidence per 10000 bed days	2.81	4.00	1.77		3.06	8.49	3.16	3.56
						Days since last case	47	302	31		18	36	55	84
Clostridium difficile toxin	48	44	42	4	3	Incidence to date	5	3	9		15	5	3	2
						Incidence per 10000 bed days	1.75	6.00	0.84		2.00	6.07	0.79	0.89
						Days since last case	20	170	4		37	3	110	134

• Community

In response to our initial meeting with Community Leads in Dec 17, our community IPN Lead has highlighted the need for Aseptic Non-Touch Technique (ANTT) training for staff. So far, 32 staff members across the community have conducted ANTT training, with the next session planned for 16.03.18.

Low ANTT compliance reports obtained from CLaD have also prompted training for trainers in clinical areas. These are challenging to organise due to staff availability. 14 members of staff have completed this training since 01.01.18.

E-Learning packages have been developed and will go live on 01.04.18. These include the non-clinical, AHP and clinical e-learning packages.

The IP Lead Nurse visited the renal unit at Easingwold on 26.02.18. A number of improvement strategies have been suggested. The IPT recognise the huge efforts that this department are making with infrastructure available to them. This unit remains a significant concern and should be escalated at every opportunity.

2.3.2 Flu Vaccine for Pregnant Women

Working in partnership with Vale or York CCG, Public Health England and the Local Authority, maternity services have commenced a new service to increase the uptake of the flu vaccine in pregnant women. A promotional video was made with the Vale of York CCG with information put out on social media sites too.

From December 2017 the flu vaccine is now available for pregnant women in all out patient hospital antenatal clinics and on the Antenatal wards.

We are pleased to report an 11% increase in uptake in the Vale of York to 72% for women in a clinical risk group. This is the highest uptake in Yorkshire and the



Humber. Scarborough and Ryedale are the highest in Yorkshire and the Humber for pregnant women not in a Clinical Risk group and for all pregnant women.

	Summary of Flu Vaccine Uptake % 2016/17			Summary of Flu Vaccine Uptake 2017/18		
	Pregnant and NOT IN a clinical risk group	Pregnant and IN a clinical risk group	All Pregnant Women	Pregnant and NOT IN a clinical risk group	Pregnant and IN a clinical risk group	All Pregnant Women
ERY CCG	46.0	62.8	47.8	45.7	59.4	47.1
HRW CCG	54.1	67.3	55.6	56.6	70.2	57.8
HaRD CCG	49.3	53.7	49.8	52.9	65.5	54.1
HULL CCG	43.0	50.8	43.7	45.5	49.1	45.8
NE LINGS CCG	33.4	58.6	35.9	39.1	56.4	40.7
N LINGS CCG	27.7	50.7	29.8	39.3	57.1	40.8
SR CCG	53.1	61.6	54.1	57.1	69.2	58.5
VoY CCG	52.2	61.1	53.1	55.9	72.0	57.5
Total	43.4	57.8	44.8	47.9	61.4	49.2

2.3.3. York Maternity services Safety Improvement Plan

The publication of 'Better Births' in 2016 has seen the Trust consider and review its Maternity with the view to meeting the key aim of the new national maternity strategy to make the NHS the safest place in the world to give birth.

Attached at appendix 1 is the Trust's improvement plan with an update on the progress that has been made.

2.4 Partnerships & Efficiency

2.4.1 National Maternal & Neonatal Health Safety Collaborative

National Maternal & Neonatal Health Safety Collaborative supported quality improvement work will contribute to the national ambition to reduce maternal deaths and rates of stillbirths, neonatal deaths and brain injuries that occur during or soon after birth by 20% by 2020 and 50% by 2025.

York Trust have been chosen to be in wave three of the Collaborative (one of forty five trusts in wave three) commencing in April 2019.

A maternity safety improvement plan (see appendix) has been developed structured around the five key drivers for delivering safer maternity care, set out in 'Spotlight on Maternity' DOH 2016;

- Leadership
- Learning and best practice
- Teams
- Data
- Innovation



To be a valued and trusted partner within our care system delivering safe effective care to the population we serve.

3 Recommendation

The Board is asked to note the Chief Nurse Report for March 2018



Board of Directors – 28 March 2018

Use of Enhanced Supervision within Elderly Medicine (York)

Recommendation

- | | |
|--------------------------|-------------------------------------|
| For information | <input checked="" type="checkbox"/> |
| For discussion | <input checked="" type="checkbox"/> |
| For assurance | <input type="checkbox"/> |
| For approval | <input type="checkbox"/> |
| A regulatory requirement | <input type="checkbox"/> |

Current approval route of report

Quality & Safety Committee – 20th March 2018
Board of Directors – 28th March 2018

Purpose of report

The purpose of this report is to provide the Board of Directors with an update and overview of enhanced supervision care across Wards 25 and 37 at York Hospital.

The report describes a review of the enhanced supervision model of care and relates this to patient safety data in relation to falls on Wards 25 and 37.

Key points for discussion

Information relating to the incidence of falls, including falls with harm, data relating to the associated cost of 1:1 supervision showing a reducing reliance on this type of enhanced supervision with alternatives, and the alternative interventions undertaken to safeguard patients.

Trust Ambitions and Board Assurance Framework

(https://www.yorkhospitals.nhs.uk/about_us/our_values/)

The Board Assurance Framework is structured around the four ambitions of the Trust. How does the report relate to the following ambitions:

- Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.
- Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.

- ☒ **People and Capability** - The quality of our services is wholly dependent on our teams of staff.
- ☒ **Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

Reference to CQC Regulations

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

Regulation 9 – Person Centered Care
Regulation 10 – Dignity & Respect
Regulation 12 – Safe Care & Treatment

Version number: Version 1

Author: Virginia Russell, Assistant Director of Nursing & Lee Fry, Matron - Elderly Medicine

Executive sponsor: Beverley Geary, Chief Nurse

Date: March 2018



1. Introduction and Background

Enhanced supervision is an integral part of a therapeutic plan for patients at high risk of harm and aims to ensure the safe and sensitive monitoring of a patients' condition, including their conduct and mental health. Although enhanced supervision is used to support patients with a range of needs the majority of patients requiring this level of care in an acute setting are those at risk of falls.

Across in-patient areas a falls risk assessment is undertaken on admission or transfer of the patient and routine re assessment happens every 7 days thereafter or following a patient fall.

Within the assessment, consideration is given to a range of interventions to reduce the risk of the patient falling; enhanced supervision can be considered within this, and as part of the care plan.

Traditionally nursing staff have implemented enhanced supervision most frequently as a 1:1 relationship with the patient, where continuous observation is undertaken. This may be across a 24 hour period or for a particular time of the day or night and has been organised shift by shift through the allocation of additional staff usually above establishment.

As significant numbers of patients with frailty are cared for across our ward areas the demand for enhanced supervision has increased significantly and a reliance on the 1:1 observation of patients has led to an increasing number of care hours.

A local project designed to develop new models for delivering enhanced supervision has been undertaken, latterly across wards 25 and 37 at York Hospital; with the aim of developing alternatives to the 1:1 enhanced supervision approach and safely manage falls risk.

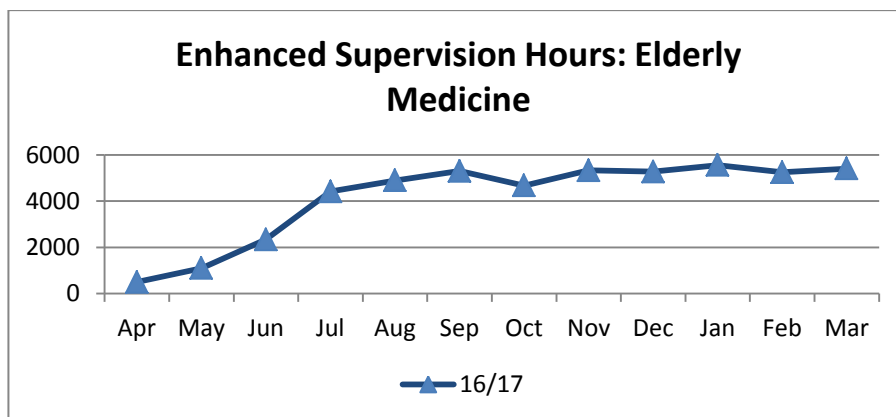
2. Use of Enhanced Supervision 2016-17

Increasing demand for additional staff to provide 1:1 enhanced supervision for patients across elderly medicine 2016-17 led to a year end position of 50,074 additional care hours being provided at a cost of £1,051,048.

The forecast trend for 2017-18 indicated a potential requirement of 52,467 additional care hours with a projected cost of £1,067,612.



The below graph shows the increasing enhanced supervision hours for 2016-17.



2.1 Testing Change- The Doncaster Model

Oversight of work undertaken by colleagues at Doncaster Royal Infirmary demonstrated the outcomes of delivering enhanced supervision using a model with several tiers of risk assessment and associated actions.

Patients are assessed for enhanced supervision requirements as follows:

- Interim- patient requiring additional supervision for a period or part of a shift or requiring frequent visual checks
- Cohort- patient nursed within a group in a bay or area with a nurse present at all times
- Continuous- individual 1:1 care with visual contact at all times

The 'Doncaster' model was piloted across 4 wards at York Hospital including paediatrics using a PDSA cycle.

There was an evident lack of clarity and consistency about what was managed within establishment and when a team requested additional staff in order to provide enhanced supervision.

Results showed a more complex assessment process resulting in small decrease or maintenance in the number of care hours required for 1:1 enhanced supervision.

The Doncaster model did not include the use of distraction therapy as a technique to manage risk of harm.



The Doncaster model was not easily applied in child health and the ward requested a number of changes to ensure they could use the assessment.

Ward	Length of pilot	Additional shifts req.	Previous shifts req.	Comments
17	4 weeks	14	Not available	Assessment tool difficult to use in child health
26	2 weeks	14	5	5 beds closed during pilot reducing requirement for additional staff
28	4 weeks	4	0	1 shift per week differential
39	2 weeks	14	14	

2.2 PDSA Cycles on ward 25 and 37

Following the pilot it was agreed, in July 2017 to implement elements of the Doncaster model across wards 25 and 37, the aim being also to develop and test a 'tool kit' of options for nurses to implement in addition to the option of 1:1 enhanced supervision care.

Staff on the wards were keen to use the process to improve the quality of care delivered and reported finding it difficult to manage the demands 1:1 care for long periods with complex patients, particularly if allocated for a whole shift.

Staff members were encouraged to view enhanced supervision requirements as:

- Interim- patient requiring additional supervision for a period or part of a shift or requiring frequent visual checks
- Cohort- patient nursed within a group in a bay or area with a nurse present at all times
- Continuous- individual 1:1 care with visual contact at all times

Daily review of individual patients continued with an emphasis on the patient and their pattern of needing enhanced supervision and consideration of family or volunteer support to meet some of this need.

A process of 15 minute 'sweeps' was introduced to support interim supervision and the principle of 'sweeps' is now being used across all elderly medicine in York and Scarborough Hospitals.

Cohorting of a bay of patients at risk of falls was already in use but the delegation of staff to remain with the group was alternated throughout the shift so each nurse had a time limited period with the cohort.



2.3 Distraction Therapy

Distraction therapy and greater socialisation of patients was developed further on Ward 37 to support enhanced supervision requirements and improve the quality of experience for patients.

The Ward 37 dementia café has enabled patients to meet and engage in activity either individually or within a group (usually led by our volunteers) and has been of real benefit. Non-pharmacological interventions such as music therapy, reminiscence, animal-assisted therapy are all now in use and recognised to be of benefit in particular for patients with dementia.

A supportive prompt sheet for bank and agency staff has also been developed on the ward to ensure all staff has understanding of engagement and distraction within 1:1 care.

Other actions to improve the environment for patients has supported the wards to develop distraction therapy, for example, the introduction of self-locking ward doors has supported easier and safer mobility around the ward for patients with confusion or capacity issues.

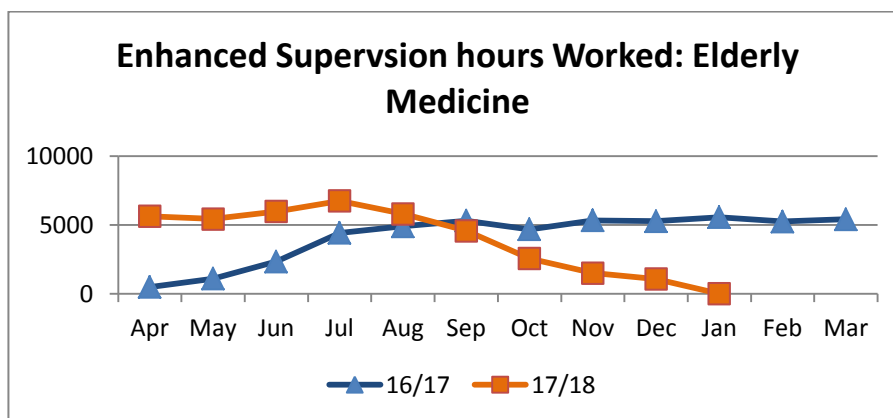
2.4 Use of Enhanced Supervision Care Hours 2017-18

Since the introduction of 'sweeps' and the development of distraction therapy and cohorting techniques, the requirement for additional hours to provide enhanced supervision across the elderly medicine wards has shown a sharp downward trend (Q2 and Q3 2017-18).

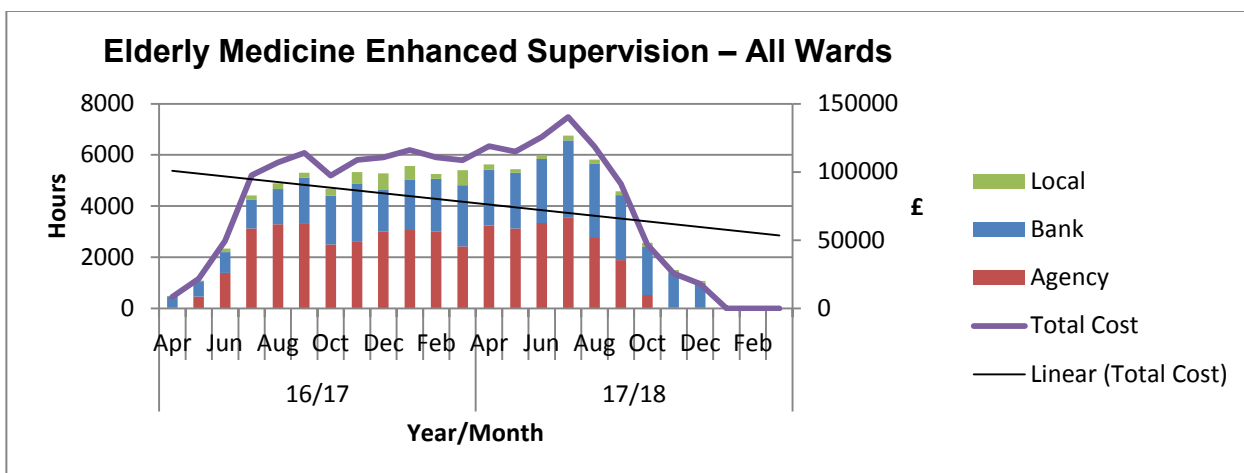
This reduction is also attributable to the revision of the enhanced supervision assessment process within nursing, which includes Matron oversight of all patients considered for 1:1 supervision combined with Assistant Director of Nursing approval for all these requests.

The graphs below show the current use of enhanced supervision, and include both 1:1 supervision and also additional staff required to supervise some groups of cohorted patients who are not able to be managed with establishment.

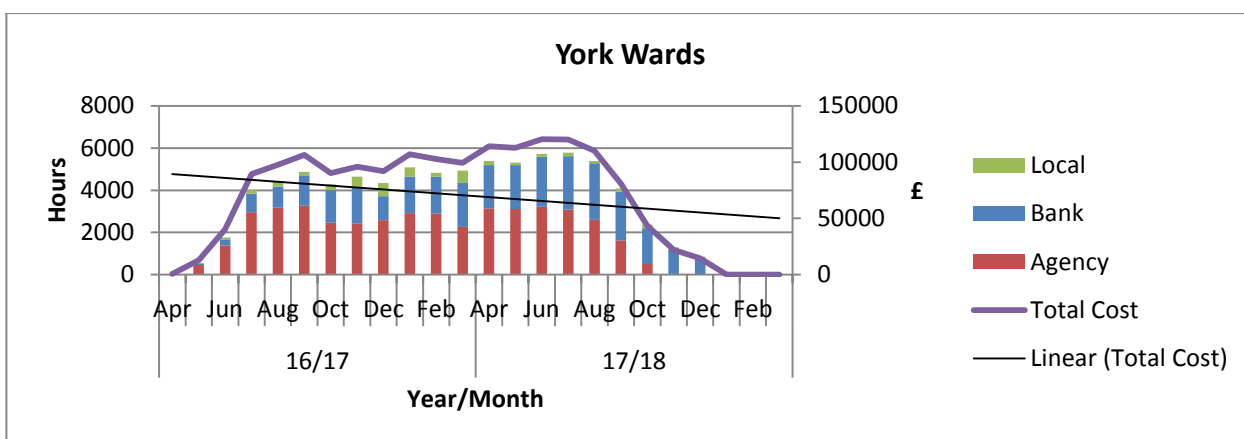
The graph below shows the downward trend in enhanced supervision care hours 2016-18.



The graph below shows the associated reduction in enhanced supervision costs alongside a breakdown of staff 2016-18



Historically the use of 1:1 enhanced supervision has been greater across the York wards and this remains the case although the differential is now reducing and the trend across York wards shows a marked decline.



Using the December 2017 forecast trend, the projected year end position 2017-18 is 42,567 care hours with a projected trend cost of £855,208.

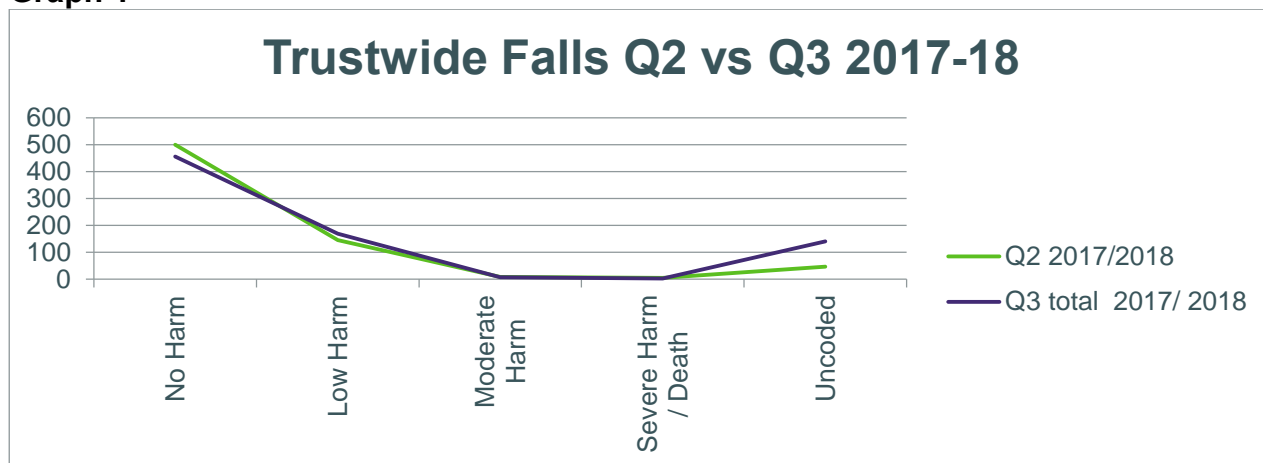
The initial forecast for 2017-18 was 52,467 care hours at a cost of £1,067,612.



2.5 Patient Safety

Across the Trust, in Q3 there has been a 9% increase in overall falls in comparison to Q2, but a small reduction in falls which have resulted in moderate, severe harm or death. See Graph 1.

Graph 1

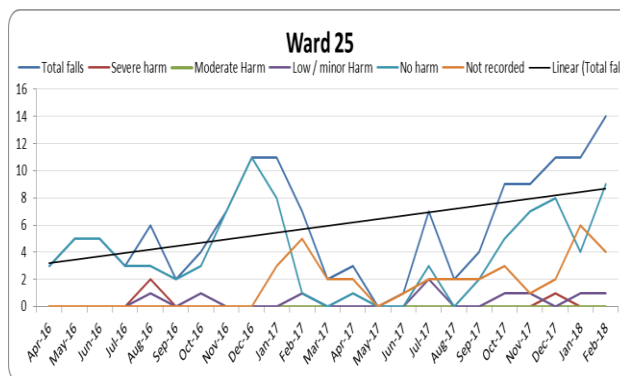
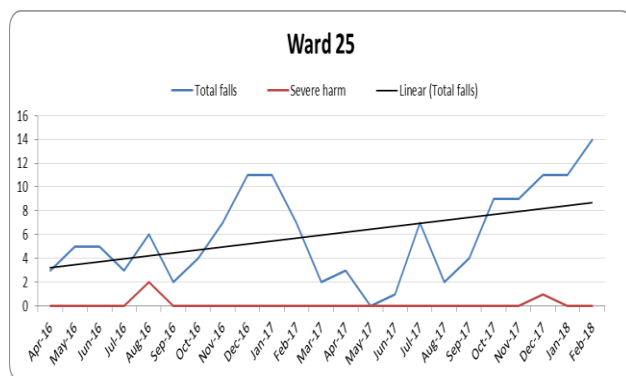


The graphs below show the number of falls on Ward 25 since April 2016.

Since July 2017 it can be seen that total numbers of falls on Ward 25 have increased but it is worth noting that falls with moderate or severe harm have not increased.

This may be attributable to the limited use of distraction therapy on the Ward where the environment does not easily support group activities and socialisation. Development of space within the Ward would support greater use of distraction therapy and it is recommended that this be explored further with the aspiration to include this aspect of environmental upgrading of Ward 25 in the Ward refurbishment programme.

It is also recognised that Ward 25 has a challenging vacancy position, with its workforce being supplemented by both bank and agency staffing. Despite commitment from the substantive team it may be that our temporary workforce are not as familiar or engaged in the initiatives being introduced on the Ward.



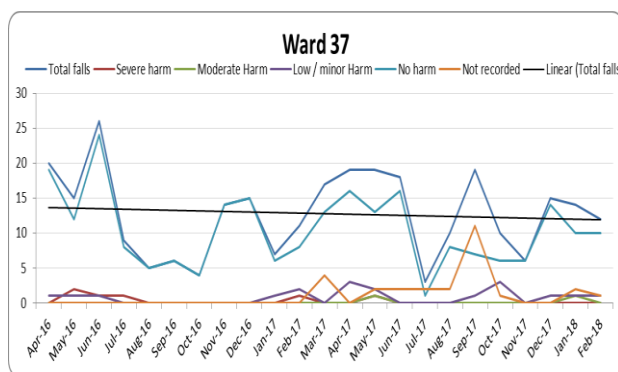
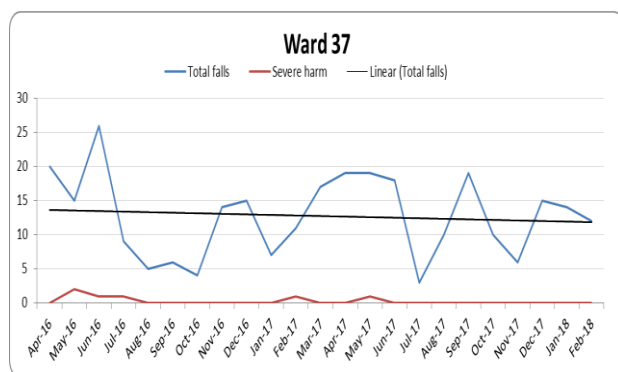
The graphs below show the numbers of falls on Ward 37 since April 2016.

There has also been an increase in the number of falls since July 2017 when the new model of care for enhanced supervision was implemented, however July 2017 would appear to be an outlier month with the lowest number of falls recorded since April 2016.

It is of note that comparing the position at Q2-Q3 there has been a reduction in the total number of falls on the Ward.

Falls with severe harm have remained at zero since July 2017.

It is likely that the increase in the use of distraction therapy, a vibrant volunteer programme and utilisation of the dementia café, has contributed to this Q2-Q3 reduction, which is against Trust trend.



3. Next Steps

It is recommended that both Ward 25 and Ward 37 continue to implement the models of care for enhanced supervision to ensure that these are embedded and the full impact of the change can be evaluated. The remaining elderly wards will continue to implement aspects of the enhanced supervision model including 'sweeps', cohorting and the new process for requesting 1:1 enhanced supervision, and monitor their patient safety data in response.

The implementation of SafeCare, will also enable Ward leaders to have in the moment data on the acuity and dependency of their patients to be able to respond to patient need.

This will include patient's requiring interim enhanced supervision where staff can be quickly deployed as required. It is anticipated that the SafeCare system will be operationally live by June 2018 and that the responsiveness of the system will enable safe deployment of staff to meet the acuity and dependency of enhanced supervision patients more flexibly.

Further analysis of the impact of both the enhanced supervision model and how it works in tandem with SafeCare will be required during 2018-19.



4. Detailed Recommendation

The Board is asked to note the information provided in respect of enhanced supervision models and patient safety within the report.



Appendix 1

York Maternity services Safety Improvement Plan July 2017 (updated February 2018)

Introduction

Maternity transformation is moving forward following the publication of the national maternity review 'Better Births' 2016. The national maternity transformation board are driving forward implementation of the recommendations from Better Births and aim to achieve the Secretary of State for Health ambition in the new maternity strategy to make the NHS the safest place in the world to give birth.

On 13 November 2015 the Secretary of State for Health announced a national ambition to half the rates of stillbirths, neonatal and maternal deaths and intrapartum brain injuries by 2030, with a 20% reduction by 2020. In November 2017 the Secretary of State for Health announced a new maternity strategy and brought forward the date to half rates of stillbirth from 2030 to 2025. The government plans to offer independent investigations and coroner involvement.

The Healthcare Safety Investigation Branch (HSIB) will standardise investigations of cases so that the NHS learns as quickly as possible from what went wrong and shares the learning to prevent future tragedies.

York maternity service are part of the national, regional and local work to achieve the ambition working with the Humber, Coast and Vale Local Maternity System (LMS) and Yorkshire and the Humber Clinical Network. York are due to commence a service improvement programme with the National maternal and neonatal health safety collaborative in April 2019 (Wave 3 of the programme).

The LMS have submitted plans to achieve recommendations in Better Births. York are part of the 5 work streams to implement the plan. Increasing service user involvement is a priority with the newly formed Maternity Voices Partnership (MVP) in the LMS.

This document is the York Maternity services plan, structured around the five key drivers for delivering safer maternity care, set out in 'Spotlight on Maternity' 2016.

Authors: Liz Ross, Head of Midwifery Nicola Dean, Clinical Director

Date: (version 1) July 2017 **Updated version 2 February 2018**

Leadership <i>Create strong leadership for maternity systems at every level</i>			
Action	Lead	Update/ Action	Date completed/update
Board level maternity champion appointed	Chief nurse	In place	January 2017
Midwifery and Obstetric safety champions appointed	Head of Midwifery Clinical Director	Appointed	January 2017
	Matron (additional safety champion)	Appointed	February 2018
Safety Improvement plan agreed and made public	Head of Midwifery Clinical Director	July 2017 plan completed however this was not submitted to Board (Maternity annual report to Board summarises actions and update from the safety plan)	Plan completed July 2017
		<ul style="list-style-type: none"> To submit to Chief Nurse for Q&S committee 	March 2018
Leadership development for senior midwifery and obstetric staff	Head of Midwifery Clinical Director	<ul style="list-style-type: none"> CD development HoM development Senior leaders programme Band 6 to 7 development 	Complete and ongoing
Develop a culture of learning not blaming	Head of Midwifery Clinical Director	<ul style="list-style-type: none"> Promote the role of the Trust 'freedom to speak up' guardian Address workforce behaviours and develop a supportive culture (RCM workshop, Occ Health tools, restorative practice training with ODIL) 	December 2017
		<ul style="list-style-type: none"> Support 'fairness champion' roles in maternity Named Obstetrician workplace behaviour champion 	January 2018

Learning and best practice			
<i>Identify and share best practice, and learn from investigations</i>			
Action	Lead	Action	Date completed/update
Implement Saving Babies Lives care bundles	Matron (Scarborough)	<ul style="list-style-type: none"> • Pilot site for care bundles • Fully implement care bundles • Commence Baby clear project Scarborough 	Complete 2017
Reduce unnecessary separation of mother and baby (Atain project)	Matron (York) SCBU Manager (York)	<ul style="list-style-type: none"> • Commence transitional care on postnatal wards • Reduce term admissions due to 'cold babies' 	Complete December 2017
Improve learning from incidents	Head of Midwifery Clinical Director	<ul style="list-style-type: none"> • Share learning from SIs with staff • Contribute to Regional safety learning group • MDT case review for NHSR and Each baby Counts cases 	January 2018 and ongoing
Improve learning following stillbirth	Clinical Governance leads Matrons Bereavement midwife	<ul style="list-style-type: none"> • Identify themes from SCOR database • Perinatal mortality MDT meetings • Implement Y&H stillbirth review process 	January 2018
		<ul style="list-style-type: none"> • Implement national perinatal mortality review tool when available (information received regarding this tool February 2018) • To review cases from January 2018 onwards 	February 2018 sent request for access April 2018
Improve bereavement pathway following stillbirth and early neonatal death	Matrons Bereavement midwife	<ul style="list-style-type: none"> • Develop training • Implement national bereavement pathway • Share learning locally using Y&H Clinical network presentation 	Complete and ongoing January 2018
Improve breast feeding rates	Infant feeding co-ordinators	<ul style="list-style-type: none"> • Maintain BFI standards • Audit of BFI standards • Education and development of staff (Maternity and paed) 	October 2017
		<ul style="list-style-type: none"> • Support Child health in working towards BFI accreditation 	Update September 2018

Reduce major PPH	Labour Ward Clinical leads	<ul style="list-style-type: none"> • Implement Risk assessment checklist in labour • Case review of all PPH > 1.5 litres 	January 2018 and ongoing
Implement recommendations from the national maternity review report 'Better Births'	Head of Midwifery Clinical Director	<ul style="list-style-type: none"> • Work with LMS to produce an action plan by October 2017 • Benchmark and local action plan 	Complete December 2017
		<ul style="list-style-type: none"> • Implementation of actions through LMS work streams • Service user involvement in Maternity Voices Partnership (MVP) 	Update September 2018

Teams			
<i>Prioritise and invest in the capability and skills of the maternity workforce and promote effective multi-professional team working</i>			
Action	Lead	Action	Date completed/update
Ensure training needs analysis annually for MDT in maternity	Risk Management Midwife	<ul style="list-style-type: none"> • Annual review of training needs • Annual training arranged 	December 2017
Achieve 80% compliance for mandatory training. Update Feb 2018 CNST evidence require 90% compliance for emergency training including CTG	Deputy Clinical Directors Matrons	<ul style="list-style-type: none"> • Use of learning hub to monitor mandatory training. • Summary compliance report to directorate management meetings 	Update April 2018
Review and update MDT emergency training (Safety funding received to improve emergency training in 2017)	Head of Midwifery Clinical Director	<ul style="list-style-type: none"> • PROMT train the trainers • Human factors training • NLS (paeds and midwives) • Childbirth emergencies in the community 	Complete January 2018
		<ul style="list-style-type: none"> • Roll out PROMPT in 2018 to all staff working in Maternity 	Commenced January 2018 to Update July 2018
Improve midwives and Obstetricians knowledge of perinatal mental health	Head of Midwifery Clinical Director	<ul style="list-style-type: none"> • Develop training (following successful bid for training funds 2017) 	Complete January 2018 (Training

		<ul style="list-style-type: none"> • Develop leads for PNMH • Guidelines for PNMH • Early identification of PNMH issues and referral 	ongoing)
--	--	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------

Data
Improve data collection and linkages between maternity and other clinical data sets, to enable benchmarking and drive a continuous focus on prevention and quality

Action	Lead	Action	Date completed/update
Submit data to Yorkshire and Humber regional dashboard	Risk Management midwife	<ul style="list-style-type: none"> • Submit quarterly data • Verification of data 	December 2017
Representation at Yorkshire and Humber dashboard development group	Head of Midwifery	Continue to attend and contribute to the development of the regional dashboard	December 2017
Submit data to; <ul style="list-style-type: none"> • NHS Maternity services data set • National Maternity and perinatal audit • MBRRACE-UK • RCOG; Each Baby Counts • NHS Resolution • National Screening Committee NHSE (KPIs) 	Head of Midwifery Clinical Director Risk Management Midwives Clinical Governance leads Screening co-ordinator	<ul style="list-style-type: none"> • Verify data submitted • Review reports and develop response and actions as appropriate 	Complete February 2018 and ongoing

Innovation
Create space for accelerated improvement and innovation at local level

Action	Lead	Action	Date completed/update
Undertake the national Maternity and neonatal collaborative health quality improvement programme		<ul style="list-style-type: none"> • In wave 3 of the rollout to commence in April 2019 	Due to commence April 2019

Head of Midwifery Clinical Director		<ul style="list-style-type: none"> Learn from Waves 1 and 2 (attend events for shared learning) Engage with the Communities of Practice to share learning 	Update July 2018
		<ul style="list-style-type: none"> Safety champions to meet bi monthly with board level safety champion 	Commenced February 2018. Update August 2018
Reduce perineal trauma	Labour Ward Clinical leads	<ul style="list-style-type: none"> Use of episcissors (following successful bid for funding) Individual reflection of each case Risk review discussion 	Complete December 2017
		<ul style="list-style-type: none"> Audit following 1 year of use of episcissors' (April 2018) 	Update July 2018
Improve uptake of flu and pertussis vaccinations in pregnancy	Community Team Leader	<ul style="list-style-type: none"> Commence flu vaccinations in outpatients and antenatal inpatient areas 	Commenced December 2017
		<ul style="list-style-type: none"> Commence pertussis vaccinations 	2018/19

References:

Spotlight on Maternity. Contributing to the Governments national ambition to halve the rates of stillbirth, neonatal and maternal death and intrapartum brain injuries by 2030. DOH March 2016

Safer Maternity Care. Next steps towards the national maternity ambition. DOH October 2016

Better Births, National Maternity review 2016

Each baby Counts RCOG and NHS Resolution

MBRRACE-UK Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries in the UK

Board of Directors – 28 March 2018 Out of Hospital Care Board Quarterly Strategy Report

Recommendation

- | | |
|--------------------------|-------------------------------------|
| For information | <input checked="" type="checkbox"/> |
| For discussion | <input checked="" type="checkbox"/> |
| For assurance | <input type="checkbox"/> |
| For approval | <input type="checkbox"/> |
| A regulatory requirement | <input type="checkbox"/> |

Current approval route of report

This report is presented for the first time to the Board of Directors.

Purpose of report

The purpose of this quarterly report is to provide the Board of Directors with a strategic update relating to out of hospital services.

Key points for discussion

This report provides the Board of Directors with a progress report against each of the key themes and developments from the Out of Hospital Care Strategy.

Two years on from the publication of the strategy it offers an opportunity to reflect on the successes in moving towards our vision of 'Community First'.

It also describes the plan to refresh the strategy in line with the new five year strategy for the organisation, the new clinical strategy and updated local commissioning intentions.

Trust Ambitions and Board Assurance Framework

(https://www.yorkhospitals.nhs.uk/about_us/our_values/)

The Board Assurance Framework is structured around the four ambitions of the Trust. How does the report relate to the following ambitions:

- Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.
- Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.

- People and Capability** - The quality of our services is wholly dependent on our teams of staff.
- Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

Reference to CQC Regulations

There are no references to CQC regulations.

Version number: Version 1

Author: Steve Reed, Joint Head of Strategy

Executive sponsor: Wendy Scott, Chief Operating Officer

Date: March 2018



1. Introduction and Background

The purpose of this quarterly report is to provide the Board of Directors with a strategic update relating to out of hospital services.

The Out of Hospital Care Strategy (2016-21) described three key themes to implement our vision of 'Community First'. The 'plan on a page' summarising the strategy is included at appendix 1 for reference. The key themes from the strategy are:

1. Developing integrated community services for localities;
2. Developing the interface between acute and community services;
3. Moving services from acute to community settings.

Within each of these themes, the strategy described a number of developments that would be implemented to deliver the strategy. Two years on from the publication of the strategy, this report provides the Board of Directors with a review on the success of delivering these developments.

It should be noted that the procurement of a new community services model for the Scarborough and Ryedale populations through the duration of the period under review has limited the opportunities to develop more innovative approaches for those communities. The Trust will look to work closely with Humber Foundation Trust as they become the new community services provider to deliver against the second and third themes of the strategy.

Internal audit recently completed a review of the strategy and its implementation with a finding of significant assurance.

The paper also proposes an approach to refresh the strategy in line with the new five year organisational strategy, clinical strategy and updated commissioning intentions.

2. Success in delivering the Out of Hospital Care Strategy

The following sections provide an update on some of the notable progress against each of the strategy themes and the development areas within these.

2.1 Developing integrated community services

Progress towards **new integrated care models** can be seen in the work undertaken in the North Locality (Easingwold and North Ryedale) where plans are progressing for closer working between primary care, community and social care teams across the locality. To support this, local leaders have developed a bid for primary care transformation funds to establish joint, non-registered posts that would work between primary care and community teams. Within the City of York, the Trust is an active member of the Primary Care Home model which brings together multi-agency teams to focus on the key health challenges for local communities.

The December 2017 Board update described the work to develop a new workforce model for community nursing. With a focus on holistic and preventative care this delivers on the

ambitions for **self-management and peer support**. The Organisational Development and Improvement Learning team have developed a programme of health coaching training which is being delivered to health and social care staff. The Trust is also working as part of the Self-Care workstream (led by York Centre for Voluntary Services).

The Trust charity has supported the pilot of a **care co-ordinator** based in general practice in South Hambleton. The co-ordinator supports a cohort of frail and vulnerable local people making connections between services and with the local community infrastructure. Following the success of the pilot, local practices have agreed to invest primary care sustainability funds to continue the role. We also continue to work closely with the development of services such as the North Yorkshire County Council (NYCC) Living Well service that works with individuals to understand what is important to them in their lives and supports them to access alternatives to statutory services.

Through the Selby and Ryedale Community Hubs the Trust has developed a service in partnership with primary care to **support care homes** through inreach reviews delivered by consultant geriatricians and local GPs. Over the three years that the scheme has been running, admissions from care home residents in Selby has grown by 11% which compares favourably to the 34% growth seen in a comparator group over the same period. In York, community therapy and nursing teams are joining a 'virtual team' established to support homes identified as having higher admission rates to hospital.

2.2 Developing the interface between acute and community services

Throughout 2016, both York and Scarborough Hospital sites undertook a series of rapid tests of change of a **discharge to assess** approach in partnership with City of York Council (CYC) and NYCC. The learning from these tests has been incorporated into our Home First approach. Both sites are now using a discharge to assess approach for patients who require assessment of their longer term needs under Continuing HealthCare (CHC).

The recent Care Quality Commission (CQC) review of the health and social care interface in the City of York highlighted the development of the 'One Team' an **integrated intermediate care and reablement service** bringing together the Trust provided Community Response Team, CYC reablement services, primary care led York Integrated Care Team and voluntary sector services. The project has worked closely with a public reference group who have improved the information provided to people being supported by the service and informed the emerging service model.

In re-providing the intermediate care services from Archways Intermediate Care Unit as home-based support, the Trust introduced a community **advanced clinical practitioner role** providing assessment, diagnosis and treatment for patients in community settings. Discussions have taken place between the Care of the Elderly directorate and local primary care regarding the development of **community geriatrician** models following the success of the care home inreach service described in section 2.1.

December 2017 saw the launch of an **integrated discharge hub** bringing together Trust discharge liaison nurses, hospital social workers (from all three local authorities) and CHC assessment nurses. The hub has already seen reductions in duplication and improved

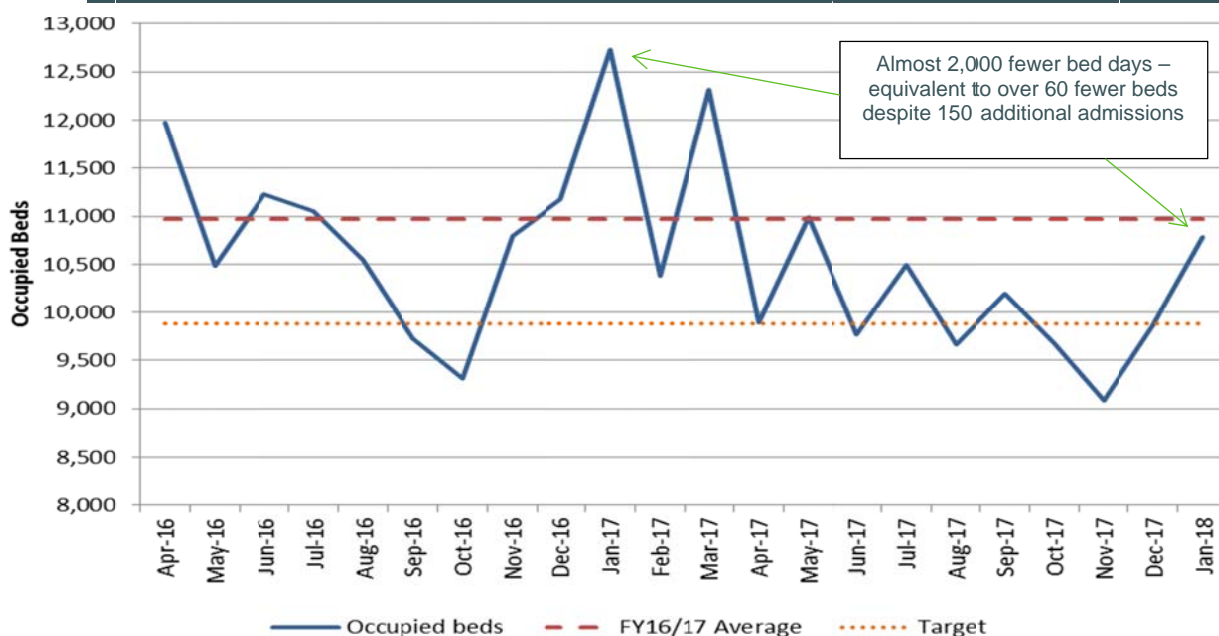
communication between teams. Future developments will include early intervention to support earlier discharge planning and a new electronic referral system.

As referenced above, in December 2016 we re-provided the 22 beds at Archways through an expansion of the York Community Response Team. This has resulted in a 14% increase in the number of people being able to access intermediate care services (either to support earlier discharge or to prevent an admission to hospital) and improvement from 33% of these being delivered at home to 50%. To support the **optimisation of community beds** we have undertaken a comprehensive audit of the needs of patients in our community units and commenced a clinical review of our model of community inpatient care. Given the finding that culture is one of the key factors resulting in people having prolonged stays in hospital beds, we have also started a conversation with local people about Home First and what we would need to do differently to deliver this approach.

Since the publication of the strategy we have seen an increased national and local focus on reducing delayed transfers of care (DToc). We have worked closely with local authority colleagues and the CCGs who have increased capacity within the community to support people to leave hospital. We have also run a number of 'stranded patient reviews' to understand what people are waiting in hospital for. The CQC review has resulted in an action plan being developed for the local system to accelerate integration of health and social care.

The following chart shows the impact of all these developments on the amount of time older people are spending in hospital. It is possible to see that every month of the current financial year has seen fewer occupied bed days than the average from 2016-17, despite higher admission levels (particularly in December and January).

Occupied Bed Days for Patients Aged Over 65 years (Non-elective admissions, York Hospital)



2.3 Moving services from acute to community settings

The directorate strategy planning process in 2016 included all directorates being introduced to the Out of Hospital Care Strategy and challenged to **review care pathways to identify community alternatives**. It is possible to see a number of areas where this has been implemented including the urology one-stop diagnostic centre in Malton, ophthalmology developing electronic links with community optometrists to provide specialist advice, the development of advice and guidance as an alternative to outpatient appointments and paediatrics working with primary care to develop e-learning to support GPs in managing urgent presentations from children.

Musculo-skeletal services (MSK) implemented a new service model in April 2017. This saw an increased focus on self-care, improved links with primary care and redesigned pathways. It also saw the launch of www.yourphysio.org.uk a web based resource offering self-care advice and the ability to self-refer into the service. The Trust has also partnered with City HealthCare Partnerships (the community services provider in East Riding) to provide MSK services in the East Riding.

The Trust has developed **ambulatory care services** on both the York and Scarborough Hospital sites. Both sites have dedicated space and agreed pathways to ensure that patients with acute needs who do not require overnight care can receive their treatment without an inpatient stay.

The Trust continues to work with partners to deliver **planned care in the community**. Oncology have worked with York Against Cancer to develop a mobile chemotherapy service to prevent patients needing to travel into the acute hospital sites for their treatment. The Friends of Malton Hospital have supported the cardio-respiratory service to develop a local 24 hour ECG monitoring service (preventing patients in Ryedale needing to travel to Scarborough by 10am to return equipment).

3. Proposed Next Steps

We have identified that refreshing the Out of Hospital Care Strategy is a priority for the Trust. Given the rapidly changing environment in which we are operating it is timely, two years after publication, to review if the aims of the strategy remain valid and identify the work we will undertake in order to deliver these. It will also allow us to ensure that the strategy is in line with the intentions of our commissioners, national best practice and emergent Sustainability and Transformation Partnership place-based plans. The refreshed strategy will sit as part of the overall Trust Clinical Strategy.

In order to inform the refresh of the strategy the following engagement timetable is proposed.

1. Review the progress against the strategy aims and present a summary report to Board of Directors (this document);
2. A desktop review against commissioning intentions, STP place-based plans and national documents (for example NHS operating framework, Kings Fund reports) (Apr 18);

3. Launch review with Out of Hospital Care directorate staff – starting with Operational Managers at directorate Time Out and then using them to cascade through their teams together with Heads of Service induction meetings (Apr-Jun 18);
4. Engage with directorate managers/directorates on how they have delivered against the strategy and their future plans (May-Jun 18, as part of the clinical strategy development sessions);
5. Identify external stakeholders to engage with – including CCG, local authority, primary care, mental health, voluntary sector (May-Jun 18).

For each of the groups the questions would broadly be:

- Are the three theme areas still the priorities for us through to 2021?
- What are the key pieces of work we need to do in each priority area over the next 1-2 years?
- What do we need to start planning for in the period 2021-26?


4. Recommendation

The Board of Directors is asked to note the contents of this report and the proposed refresh of the strategy (including the stronger link with the STP place-based plans).



5. Appendices

Appendix 1: Out of Hospital Care Strategy Plan on a Page

York Teaching Hospital 
 NHS Foundation Trust

Out of Hospital Care Strategy - Community First

We will work within the local system to adopt a 'Community First' culture which focuses on prevention and self care; delivers care closer to home and allows the system to manage growing demand by increasing efficiency through integration.

DRIVERS:			
<ul style="list-style-type: none"> Harm caused by bed based de-conditioning; Predicted rise in demand from an ageing population; Need for new models of care to meet £22bn efficiency challenge; Need to deliver seamless, co-ordinated care; Implement best practice in delivering place-based population health; Close the gap in health inequalities across our communities. 			
DEVELOPMENTS:			
<p style="color: #0056b3; margin: 0;">Developing integrated community services for localities</p>	<ul style="list-style-type: none"> New integrated care models Programme of self-management and peer support Care co-ordinators Supporting care homes 		
<p style="color: #0056b3; margin: 0;">Developing the interface between acute and community services</p>	<ul style="list-style-type: none"> Discharge to Assess / Early Supported Discharge Integrated intermediate care and reablement services Community Geriatrician / Advanced Clinical Practitioner roles Integrated discharge liaison services Optimise use of community beds 		
<p style="color: #0056b3; margin: 0;">Moving services from acute to community settings</p>	<ul style="list-style-type: none"> Review care pathways to identify community based alternatives Musculoskeletal services Ambulatory care pathways A wider range of planned care services in community settings 		
PRIORITIES:			
<ul style="list-style-type: none"> Promote independence through prevention and self care Person-centred, co-produced support involving families and carers Co-produced new models of care (services) with home as first choice (delivered over seven days) Co-ordinated, integrated and joined up care that people can easily navigate Timely and rapid response to prevent admission to hospital or a care home A seamless interface to facilitate safe and timely discharge from hospital Remove duplication, ensuring cost-effectiveness and value for money 			
ENABLERS: Workforce; Information Technology; Estates; Knowing how we are doing			
Caring about what we do	Respecting and valuing each other	Listening in order to improve	Always doing what we can to help



To be a valued and trusted partner within our care system delivering safe effective care to the population we serve.

Board of Directors – 28 March 2018 Finance & Performance Committee Minutes – 20 March 2018

Attendance: Mike Keaney Chairman, Mike Sweet, Wendy Scott, Steve Kitching, Lynette Smith, Lynda Provins, Graham Lamb, Sarah Barrow, John Lester NHSI, Sue Symington, Joanne Best

Apologies for Absence

Andrew Bertram

MK welcomed John Lester from NHSI to the Committee meeting and noted apologies for Andrew Bertram.

Minutes of the meeting held on the 20 February 2018.

The Committee confirmed that the minutes were an accurate record of the meeting, there were no amendments.

Matters Arising

Winter Funding - MS asked the Committee if the Trust had received the £1.2m winter funding which had been withheld. GL confirmed that it had now been received.

York ED (Ernst & Young Work) - MS asked for an update on the work being done by Ernst & Young - WS stated that they were in week three of a six week diagnostic initiative and that they had met with Patrick Crowley and given him an initial working hypothesis. A report will be taken to the Acute Board on 4 April 18.

SS enquired if they had offered any positive feedback. WS stated that they were focusing on the non-admitted breaches and that she had asked them to look at the return to operating standards. She noted that E&Y had picked up on the fact that although the initiatives were all good, there was too many of them and that it was their intention to identify three or four areas to focus on.

MS asked for an update on the ambulance handovers – LS stated that contact with YAS is ongoing.

MS enquired if there an update with regards to the cancer targets, LS stated that this would be covered later in the meeting.

MS noted that the Trust is constantly struggling to meet demand and enquired how demand could be reduced. WS stated that work was ongoing through the A&E Delivery Board on how to manage demand differently.

MS stated that he had discussed risk registers with AB, as EEC saw the whole risk register once a quarter. AB will consider this.

Emergency Care Standards (ECS) – LS gave an update of the key headlines in relation to the ECS. February's performance was 81.8% which has marginally improved on January 2018 (81.5%) and February 2017 (81.4%). LS stated that last week was an extremely challenging week but the Trust still achieved 81.9% and this placed the Trust 75th of reported nationally for that week. The planned trajectory for February was 92% it was noted that delivery was 10% less.

LS explained that one of the reasons February was so challenging was because of extremely high bed occupancy levels with Scarborough showing 99% occupancy at midnight for most of the month. She stated that whilst the overall ECS for the Trust had been maintained patients waiting for longer times in ED departments had increased.

MS asked if the Trust had enough beds. He stated that as the Trusts occupancy plan states 92%, the current position is high risk. He noted that bed occupancy is high after the weekend, reduces through the week then increases again and wondered if any further could be done. LS stated that staffing challenges had prevented the opening of further escalation areas.

LS explained that the winter plans had been implemented, with some impact on acute DToCs, but that community delays have increased. WS gave an update in relation to some of the discharge challenges stating that the Trust is working with City of York on access to services over seven days, she also stated that an additional doctor had been used to concentrate on discharges and that they were looking to extend the process surgical consultants in Scarborough have implemented to identify patients that that can be discharged over the weekend to other specialities. WS told the Committee that they had met with consultants to discuss their suggestions to support patient flow, one of which was to offer financial incentives to staff to fill shifts.

MK stated that moving forward the Trust needs to find a different solution but noted the workforce difficulties.

WS discussed the potential of moving some electives from Scarborough to Bridlington Hospital site as a way of creating capacity.

MK told the Committee that there is a need to work towards one plan with a reduction in the number of initiatives, this was agreed and WS stated that E&Y had not yet visited the Scarborough site but that they had agreed that the Trust is doing a lot of the right things but that there is a need for one clear pathway. It has been suggested that there may be some value in pooling budgets/workforces.

WS stated that the previous day (Monday 19 March) had been very difficult and that she had escalated to OPEL 4 which meant that a member of the CCG had been present on site and this had led to 6 patients being discharged yesterday and 4 today.

MK enquired when the Committee will receive the report from E&Y. WS stated that E&Y would be delivering their diagnostic report to the York Hospital Acute Board on 4 April, it will be available for the F&P Committee at the April meeting.

SS stated that there should be joint working with the STP to find solutions, especially around the workforce pressures.

LS stated that the increase in bed occupancy has affected the flow across the sites noting that waiting times in ED has increased, and this was on the agenda for Executive Board to assess any potential clinical risk and consider any further mitigations is required.

MS highlighted that re-admission numbers were lower as noted on page 16, however, it was noted that they were up overall.

WS stated that the Scarborough Acute Medical Model would be reliant on capital investment and this was needed to be supported by the STP as a priority and NHSI would be lobbied to access the required funding.

LS stated that there had been 14 12 hour trolley breaches in February at Scarborough Hospital and WS had agreed with NHSI to provide separate reports for York and Scarborough sites which would highlight the challenges on the Scarborough site.

Cancer – LS stated that the Trust achieved all but one of the cancer waiting time targets in January, narrowly missing the 31 days subsequent surgery by 0.1%, which equates to 3 breaches. Noting that one of the breaches was due to an administrative error.

It was noted that nationally the Trust is above the national average for January and placed the Trust 3rd of 14 with peer comparator Trusts. (based on CHKS comparators groups). This performance placed the Trust ahead of Hull and NLAG in relation to the 62 wait for 1st Treatment from GP referral.

The Trust continues to show a significant improvement in relation to its two week wait fast track performance with skin at around 80% this has improved from a low of 37%. LS stated that a new Consultant has started in dermatology.

LS noted that the 62 day performance remains fragile with current performance projections showing that this will not be achieved for February. This is due to treating patients who have had long waits for treatment Urology, Head and Neck and Lung. The NHSI Elective Intensive Support Team are currently providing support to implement improvement that will improve 62 day performance, this will particularly focus on improved 1st outpatient appointment times and suspected long wait cancer patients.

One of the biggest challenges in the Humber Coast and Vale STP is cancer targets. The Cancer Alliance has a funding allocation to support transformation in local cancer services. This money has now been aligned to the overall STP 62 day performance with the proportion of the allocation received depending on the level of performance in December. Across the STP area the 85% target was not met which has led to a 25% reduction of funding.

WS told the committee that a delegation of staff had recently visited NHS North West London looking at joint working radiology reporting and that James Haselden from this Trust is a key driving force for this and was involved in the visit.

Planned Care – LS stated that the validated position for RTT in February is 84.8%. Based on the January performance the Trust is tracking below the national position and is 9th of 14th of peer comparator Trusts.

It was noted that the RTT position has been affected by winter pressures and that although the total waiting list has remained comparatively stable the number of backlog patients has increased over the last year with 4051 patients waiting more than 18 weeks.

MK enquired if this was a patient safety issue. LS stated that Executive would be asked to consider any clinical concerns and mitigation actions as this would require a clinical opinion and may differ from speciality to speciality. WS stated that the Trust had known the position would deteriorate due to the cancellation of electives which many Trusts had been doing over winter.

WS stated that she was keen to demonstrate some progress despite the national request just to hold the position. LS stated that there was a spike towards the end of 52 week waits. LS told the committee that the planning model is being overseen by the Planned Care Board and the Trust was focused on theatre productivity and Out-patient transformation aligned with the NHSI productivity team support. She stated that the Trust is being asked to consider seasonal planning in the national planning guidance

A discussion continued in relation to the overdue follow up partial bookings and the capacity required to improve the position.

Diagnostic – LS stated that the Diagnostic performance target had not been met with an unvalidated performance of 97.9%. Primary causes for this are MRI General Anaesthetic delays (primarily children), sleep study delays, ECHO's and colonoscopy. The Commissioners are considering a proposed business case for sleep studies to improve performance.

LS noted that the ECS trajectory for 2018-19 is ambitious and as the Trust would need to achieve 95% in March 2019 to align with national planning requirements the Trust would need to achieve this to gain access to STP funding. SS stated that the funding is worth £17m for 2018-19 and the Trust needed to gear itself up so as not to lose it.

Finance – GL stated that there had been an expected deterioration in the Trusts' income and expenditure position at the end of February of £2.4m resulting in a deficit of £25.9m. A deterioration of £3.1m had been expected. It was noted that expenditure has remained under control with income levels dropping due to less days in the month of February.

It was noted that to date the financial position is £10.8m better than the original 'do nothing' trajectory originally predicted. The profile of the Trust's NHSI control total assumed a year to date deficit of £8.9m (before STF), leaving the Trust £17m away from meeting its control total and as a result the Trust has not been able to access any of the available sustainability funding.

GL referred to the long-term income vs operational expenditure chart, which illustrated the drop in income during February, but also a continued low rate of spend. GL stated that the CIP position for month 11 shows £19.8m removed from budgets in the full year term against a £22.8m target.

He noted that income was £9.8m behind plan at the end of February and that this correlates mainly with the loss of £10.5m sustainability funding.

GL stated that operational expenditure in February totaled £39.6m (January £40.6m) noting that this continues at the lower average level established in September and considerably lower than peak levels reported in June and August of £42.4m and £42.1m respectively.

Pay continues to cause significant spend pressures on the Trust. The Trust has an agency cap of £17.2m, with a proportionate part for the period of February of £15.8m compared to spend to the end of February of £16.6m. This equated to a 5% overspend compared to a peak levels of overspend of 23% reported last the previous August.

MS enquired if the Trust was able to remain within the pay rate cap for agency staff and GL stated that the Trust has had to exceeded the caps on a couple of occasions due to patient safety.

It was noted that the drugs overspend was primarily linked to high cost drugs for which the Trust recharges the full additional cost direct to the commissioners, and therefore this pressure is directly compensated by an over recovery of income.

GL stated that there have been no changes to the Trust's forecast outturn this month. WS highlighted the impact on the ECS of the work around agency spend and that this should be discussed at Board. A discussion continued in relation to the risk and future plans. The Committee was told that the Trusts move to use bank staff rather than agency staff when possible was successful, but it was noted that 30% of shifts are not filled and this has an impact on patient flow.

MK noted that there was an £8.5m overspend on pay and suggested that this be discussed at Board to plan how this will be managed for the forthcoming year.

GL stated that a draft plan had gone to the Board in February with the final plans will be taken to the Board in April. MK asked if there had been any feedback from NHSI, and it was agreed that AB would discuss with at the Board.

The Trust has £11.5m cash in the bank, which is down from the predicted £30m due to the NHSE required change in the profile of contract payment from commissioners instigated earlier in the year. The Trust has currently received £20.6m from the distressed cash regime. MS enquired if there were any plans to apply for further cash. SK confirmed that a further £2.3m was drawn done in March, but noted that the Trust could only apply for loans up to the amount of its reported I&E deficit otherwise it was liable to pay back the money.

Efficiency – SK stated that the CIP delivery for February was at £19.8m which is 87% of the total £22.8m. SK noted that it is expected that the Trust will achieve the remaining required £3m CIP during March although he noted it will be very challenging.

NHS productivity work continues with Directorate plans, the first plans will be submitted to Corporate Directors in March for support and approval.

It was noted that the three key risks are delivery of the Efficiency Programmes (£3m) the proportion of non-recurrent to recurrent (£11.4m non-recurrent and £8.4m recurrent) and planning.

WS stated that three new radiologists had been appointed with a fourth position under offer.

SK stated that CIP plan for 2018-19 is £21.7m which will be very challenging.

A discussion continued in relation to aligning plans to support productivity over the next year. SK noted that the Directorate Managers are key to increasing productivity.

GL stated that if there was a move to the aligned incentive contract a contract variation would need to be submitted by the end of this week. The Committee discussed how soon the Trust could move to an aligned incentive contract and whether this could be done early in the new financial year.

WS stated that if the Trust moved to an aligned incentive contract it would mean that more transformational work could be adopted working in partnership with the CCGs as the Trust would still get paid regardless of the level of activity.

SS asked if this could be communicated to the Board of Directors

Financial recovery plan – SK stated that the Trusts financial recovery plan delivered £10.7m against the planned £10.8, it was noted that some of the savings achieved were not sustainable into next year, and that something different would be required. WS stated that this would be discussed at the Executive Board.

CQUIN – LS stated that there had been no significant changes from the previous report. The Trust achieved the uptake of Flu Vaccination CQUIN achieving 74.5% and LS noted that next year's target will be 75%.

It was noted that the national planning guidance had stepped down 8a and that the money would be reallocated across the existing community indicators

GL noted that end of year contracts have been agreed so this will minimise risk.

Tender Register – SB noted that there had been some print omitted from P48 and asked for the following to be noted: -

Musculo Skeletal Service – VOYC unsuccessful – {**service regained**}

TEND2016-17-03 Cervical Screening services – {Contract awarded to Newcastle Upon Tyne NHS Foundation Trust, YHFT lead on quality for bid, Newcastle presented a significantly cheaper model. {The services were mobilized on 1st April 2017}}

TEND2016.17-05 Early finance appraisal suggested this isn't a viable option for the Trust, we therefore did not proceed. Incumbent HDFT awarded

SB gave the Committee a brief overview of the situation in relation to current and future tenders. Stating that after investigation it was deemed that the Darlington Sexual Health Service tender was not financially viable therefore the decision was taken not to proceed with the bidding for this service.

Scarborough community service contract has been awarded to Humber. WS noted that objections have been raised with the CCG as there are issues over the 28 beds at Malton Hospital. YTHFT consider that the Malton Hospital ward was included as part of the specification. Humber have proposed a 20 bedded unit. The Committee continued to discuss this situation now that the contract has been awarded to Humber.

MK stated that there is some concern over losing the 8 beds at Malton hospital and the implications for the Trust of losing these beds. WS discussed with the Committee the risk involved when these beds are lost.

SS noted that she had met with the Chair of Humber and that they are very excited at being awarded this contract.

SB told the Committee that there are two future tenders, the first is the HPV Primary Screening. SB stated that NHSE intend to centralise the number of laboratories across England to between 10 and 15 by the end of 2019. The current cytology service provided by the Trust has been extended to December 2019, it is anticipated that the tender will be issued within the next 12 months.

The second tender relates to the Integrated Sexual Health Service which the Trust is contracted to provide until the end of June 2018, whilst the option within the procurement was an extension of 2 years, the City of York council have extended the contract for one year to the end of June 2019. It is expected that procurement for this service will be published during the next 12 months. The Sexual Health Directorate intends to place a bid with a view to retaining the service.

SB noted that although the Trust is not currently engaged in any other procurement exercises opportunities continue to be evaluated as they arise.

Terms of Reference – the Committee approved the terms of reference subject to the following additional amendments:

- Remove 'includes' following each TAP reference
- 8.2 remove 2 days from the last line

Risk – LS noted that the Operational risk on 62 day waits should read a current score of 16 and a previous score of 15

It was noted that there is an increased risk to diagnostics.

Items for Board

- Trajectories for sign off
- Operational Performance including ECS
- Ernst & Young Work
- Concerns around RTT
- Aligned incentive contract

Any Other Business

SS stated that a paper regarding the Strategic Time Out outcomes would be taken to the Board next week and suggestions regarding the BAF would be included.

Blank page

Board of Directors – 28 March 2018

Finance Report

Recommendation

- | | |
|--------------------------|-------------------------------------|
| For information | <input checked="" type="checkbox"/> |
| For discussion | <input checked="" type="checkbox"/> |
| For assurance | <input checked="" type="checkbox"/> |
| For approval | <input type="checkbox"/> |
| A regulatory requirement | <input type="checkbox"/> |

Current approval route of report

Overview report prepared for the Finance & Performance Committee and Board of Directors meeting.

Purpose of report

To report on the financial position of the Trust.

Key points for discussion

This report details the financial position for York Teaching Hospital NHS Foundation Trust for the period ended 28 February 2018 (month 11).

At the end of February the Trust is reporting an Income and Expenditure (I&E) deficit of £25.9m. The Income & Expenditure position places the Trust behind its Operational plan.

Trust Ambitions and Board Assurance Framework

(https://www.yorkhospitals.nhs.uk/about_us/our_values/)

The Board Assurance Framework is structured around the four ambitions of the Trust. How does the report relate to the following ambitions:

- Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.
- Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.
- People and Capability** - The quality of our services is wholly dependent on our teams of staff.
- Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

Reference to CQC Regulations

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

Version number: Version 1

Author: Andrew Bertram, Finance Director

Executive sponsor: Andrew Bertram, Finance Director

Date: March 2018



Briefing note from Andrew Bertram for the Finance & Performance Committee & Board of Directors Meeting - March 2018

1. Summary Reported Position for February 2018 (month 11)

February has seen an expected deterioration in our income and expenditure position with the deficit increasing by £2.4m from £23.5m to £25.9m.

Expenditure has remained under control in month but, as expected, income levels have dropped due to the number of days in the month of February.

This position is broadly in line with that predicted in the Trust's revised forecast outturn.

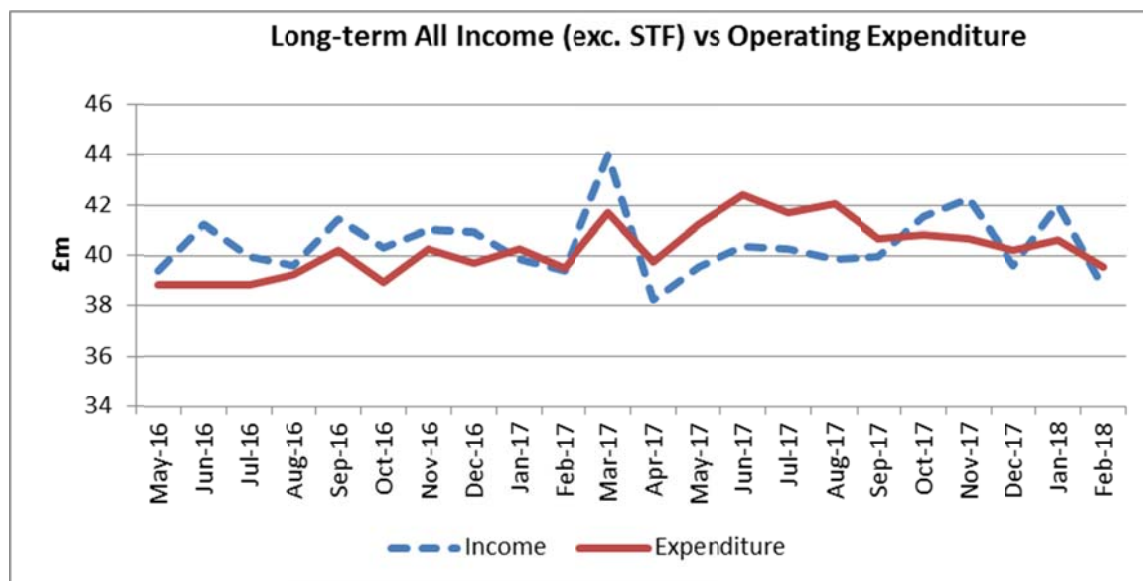
Of note is that the position fully reflects the agreed year-end trading deals for VOY CCG, ER CCG, NHSE and relevant other minor commissioners. The position also incorporates the agreed value of technical contract disputes with S&R CCG, although the position on underlying activity with S&R CCG is as per the Trust's current forecast. This is higher than that assessed by the CCG but, of note, is that the value for January was in fact higher than both the Trust and CCG's assessments.

To date the financial position is £10.8m better than the original deficit trajectory predicted at August with the prevailing adverse run rate at that time.

The profile of our NHSI control total plan assumed a year-to-date deficit of £8.9m (before STF) and, with our actual deficit at £25.9m, we are currently reporting an adverse variance to plan of £17.0m. As a result we continue to lose out on our available sustainability funding and our reported position continues to exclude this.

The chart below looks at our long term income and operational expenditure (above the EBITDA line) trend. During the first 5 months of 2017/18 operational expenditure is shown as routinely exceeding income. This was expected in the Trust's deficit plan but the early year indications were that the trend lines were diverging at an unplanned rate.

Notably, operational expenditure in September was reduced and the gap between income and expenditure reduced. This reduced spend level continued into October and we have seen an increase in reported income levels. In October, for the first time this financial year, in-month income exceeded operational expenditure (above EBITDA). This trend continued into November with further operational expenditure reductions and income gains. Notably in December the Trust extended even further its grip and control around expenditure with the lowest level of in-month expenditure reported this financial year. However, income was low in December, largely as expected, due to reductions in elective activity over the planned holiday break. January saw a full return to the targeted FRP position of income exceeding operational expenditure. Spend rates remained low in January and income has recovered from the expected December blip. February spend was particularly low but income levels predictably fell.



The month 11 CIP position shows £19.8m removed from budget in full year terms against the £22.8m target (87%). Whilst there still exists a £1.5m planning gap for the final month of the year work is underway with all Directorates to identify any and all saving possibilities for the final month of the year.

Every effort is being made to step up programme activity in the remaining period, including continuing to work directly alongside NHSI’s Operational Productivity Team.

2. Income Analysis

Overall, income is showing as £9.8m behind plan in February. Of this year-to-date shortfall £10.5m relates to lost sustainability funding. Excluding STF the report shows overall income levels are ahead of plan by £0.7m.

Excluded from tariff drug income is running ahead of plan and is compensating for most of the drug expenditure pressure of £3.8m. This income is reported under other clinical income and at this significant value continues to mask shortfalls in other income areas.

3. Expenditure Analysis

Operational expenditure in February totalled £39.6m (£40.6m in January). This continues at the lower average level established in September. The position is considerably lower than peak levels reported in June and August of £42.4m and £42.1m respectively.

Pay costs continue to cause a significant spend pressure on the Trust’s financial position. At the end of month 11 the reported adverse variance stands at £8.5m.

The Trust has an agency cap of £17.2m. For the period to February this gives a proportionate cap of £15.8m. Spend to the end of February has been £16.6m. Over the

last 6 months the cumulative expenditure variance has steadily been coming down in percentage terms and now stands at 5% (peak variance was 23% in August).

The Board Report charts show a slight increase in February spend on that reported for January, but the overall spend was still below the monthly capped figure. Cumulative nursing agency expenditure is £4.8m against a trajectory of £5.6m. Consultant spend is £5.7m against a cap of £3.8m. Junior medical spend is now slightly under plan at £5.4m against a plan of £5.6m.

Drug spend has been broadly in line with plan this month but remains higher than plan overall; this pressure relates almost exclusively to pass through high costs drugs outside of normal tariff arrangements. In this instance the Trust recharges the full additional cost direct to commissioners and therefore this pressure is directly compensated by an over recovery of income.

4. I&E Forecasting

There have been no changes to the Trust's forecast outturn this month.

5. Cash Forecasting

Our applications for distressed cash continue to be supported by NHSI and approved by the Secretary of State. These have been drawn down as planned.

6. Commissioner Contracts

The Trust has now agreed outturn positions, including all elements of the acute contracts, for VOY CCG, NHSE, ER CCG and some of the minor commissioner contracts. The Trust has agreed a settlement for all contract disputes with S&R CCG although the final activity trading forecast figure is currently different between the Trust and the CCG; with the CCG expecting the outturn to be significantly lower than the Trust is expecting. Discussions continue with the CCG in an attempt to provide income certainty at the year-end but should these fail then the Trust will clearly document its position with our External Auditors and the final assessment will fall due later in the year under the normal national reconciliation timetable.



Finance Performance Report

March 2018

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



Finance Report Chapter Index

Chapter	Sub-Section
Finance	Finance Chapter Index
	Summary Income and Expenditure Position
	Forecast
	Contract Performance
	Agency
	Expenditure Analysis
	Cash Flow Management
	Debtor Analysis
	Capital Programme
	Efficiency Programme
	Carter
	SLR

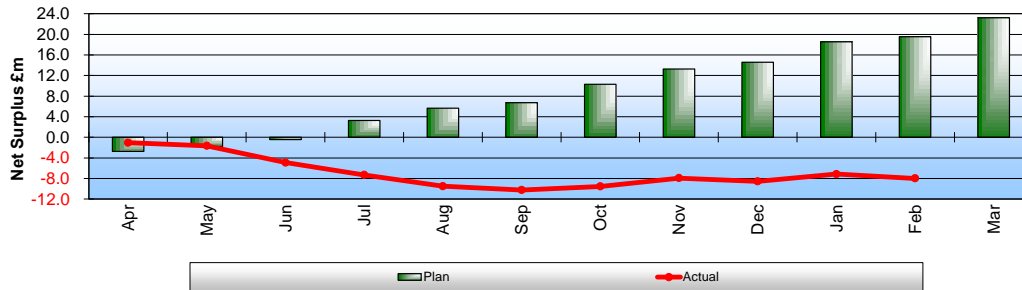
Summary Income and Expenditure Position

Month 11 - The Period 1st April 2017 to 28th February 2018

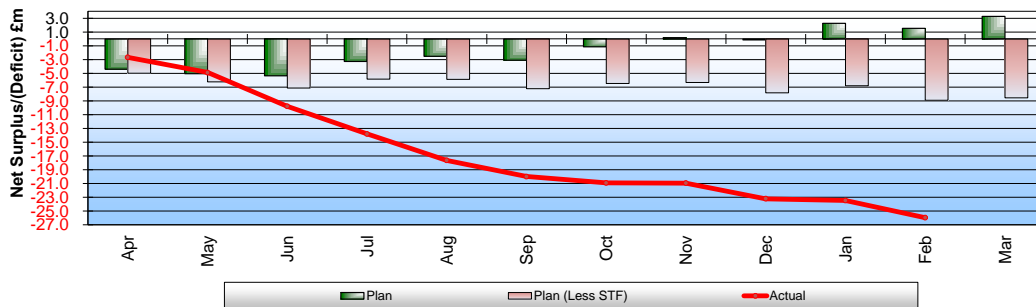
Summary Position:

- * The Trust is reporting an I&E deficit of £26m, placing it £27.5m behind the operational plan.
- * Income is £9.8m behind plan, with clinical income being £1.4m behind plan and non-clinical income being £8.4m behind plan.
- * Operational expenditure is ahead of plan by £17.6m, with further explanation given on the 'Expenditure' sheet.
- * The Trust's 'Earnings before Interest, Depreciation and Amortisation' (EBITDA) is -£8m (-1.81%) compared to plan of £19.4m (4.35%), and is reflective of the reported net I&E performance.

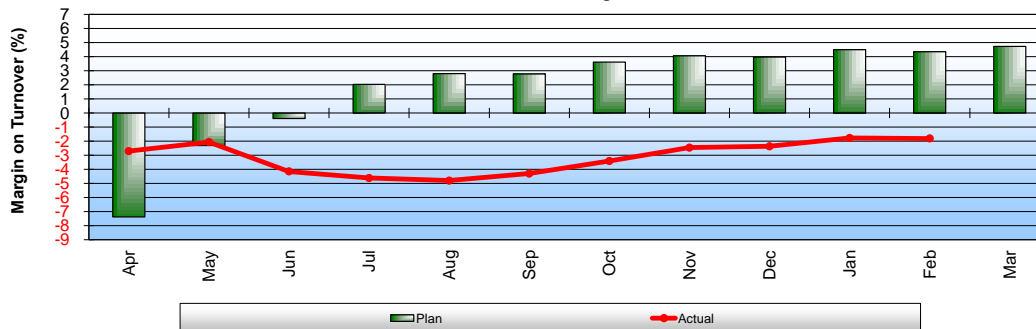
Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA)



Income and Expenditure



EBITDA Margin



NHS Clinical Income

Elective Income	23,353	21,435	22,290	855	25,244	1,891
Planned same day (Day cases)	37,810	34,661	36,695	2,034	40,147	2,337
Non-Elective Income	111,619	102,113	104,003	1,890	113,506	1,887
Outpatients	59,333	54,362	52,519	-1,843	57,627	-1,706
A&E	15,699	14,348	14,915	567	16,588	889
Community	29,976	27,479	28,006	527	30,688	712
Other	157,534	143,757	137,738	-6,019	152,679	-4,855
Total	435,324	398,155	396,166	-1,989	436,479	1,155

Non-NHS Clinical Income

Private Patient Income	956	876	903	27	1,029	73
Other Non-protected Clinical Income	1,510	1,384	1,909	525	1,902	392
Total	2,466	2,260	2,812	552	2,931	465

Other Income

Education & Training	13,939	12,860	13,262	401	13,928	-11
Research & Development	3,296	3,021	2,972	-49	3,216	-80
Donations & Grants received (Assets)	0	0	0	0	0	0
Donations & Grants received (cash to buy Assets)	623	571	891	320	850	227
Other Income	23,615	21,919	23,353	1,434	29,923	6,308
Sparsity Funding	2,600	2,383	2,383	0	2,600	0
STF	11,832	10,452	0	-10,452	0	-11,832
Total	55,905	51,207	42,862	-8,345	50,517	-5,388

Total Income

Total Income	493,695	451,622	441,840	-9,782	489,927	-3,768
---------------------	----------------	----------------	----------------	---------------	----------------	---------------

Expenditure

Pay costs	-326,794	-298,040	-306,502	-8,462	-332,086	-5,292
Drug costs	-52,414	-48,111	-51,940	-3,829	-55,846	-3,432
Clinical Supplies & Services	-46,322	-42,453	-42,985	-532	-46,205	117
Other costs (excluding Depreciation)	-48,099	-45,135	-48,004	-2,869	-55,364	-7,265
Restructuring Costs	0	0	-387	-387	-387	-387
CIP	3,022	1,545	0	-1,545	0	-3,022
Total Expenditure	-470,606	-432,194	-449,817	-17,624	-489,888	-19,282

Total Expenditure

Total Expenditure	-470,606	-432,194	-449,817	-17,624	-489,888	-19,282
--------------------------	-----------------	-----------------	-----------------	----------------	-----------------	----------------

Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA)

EBITDA	23,089	19,429	-7,977	-27,406	39	-23,050
---------------	---------------	---------------	---------------	----------------	-----------	----------------

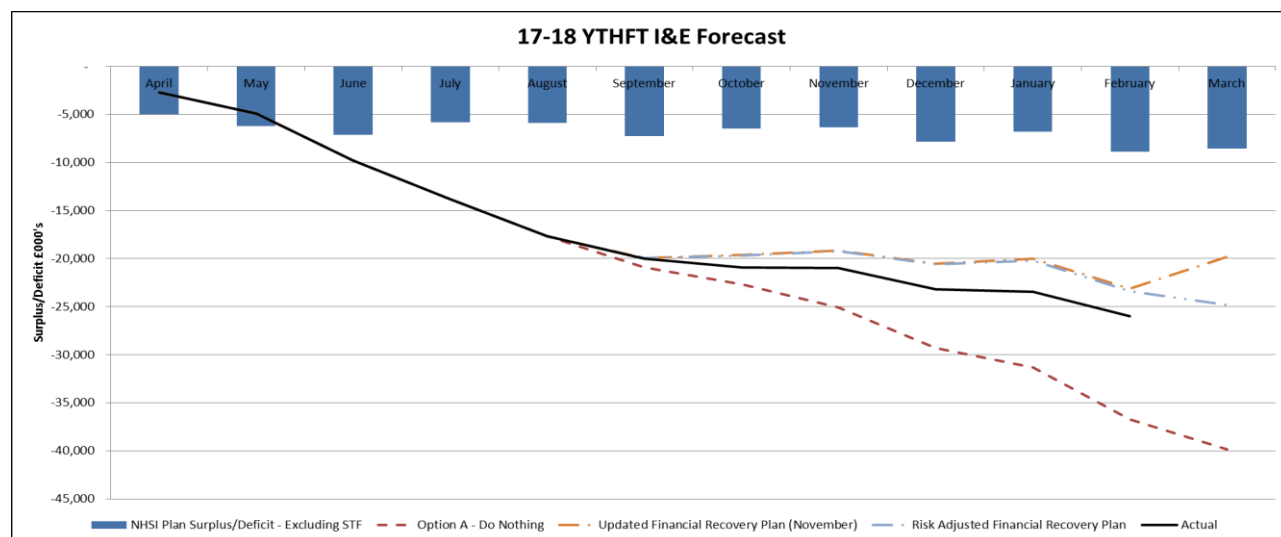
Profit/ Loss on Asset Disposals	0	0	1	1	0	0
Fixed Asset Impairments	-300	0	0	0	-300	0
Depreciation - purchased/constructed assets	-11,604	-10,637	-10,637	0	-11,604	0
Depreciation - donated/granted assets	-396	-363	-363	0	-396	0
Interest Receivable/ Payable	130	119	80	-39	103	-27
Interest Expense on Overdrafts 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	-420	-385	-453	-68	-417	3
Interest Expense on Finance leases (non-PFI)	0	0	0	0	0	0
Other Finance costs	0	0	0	0	0	0
PDC Dividend	-7,216	-6,615	-6,615	0	-7,216	0
Taxation Payable	0	0	0	0	0	0

NET SURPLUS/ DEFICIT

NET SURPLUS/ DEFICIT	3,283	1,548	-25,964	-27,512	-19,791	-23,074
-----------------------------	--------------	--------------	----------------	----------------	----------------	----------------

Summary Trust Forecast Month 11 - The Period 1st April 2017 to 28th February 2018

Option A: Assumes no change to current trends and therefore assumes current rate of CIP delivery is maintained. Adjustments have been made to reflect the impact of non-recurrent expenditure already incurred.
Financial Recover Plan: Assumes delivery of the full financial recovery plan and full achievement of the CIP target.
Risk Adjusted Plan: Each element of the Financial Recovery plan is given a weighted adjustment based on its Risk Score.



Year End Position (£000's)

	Option A	Financial Recovery Plan	Risk Adjusted Plan
Clinical Income	432,139	436,479	436,479
Other Income	46,553	53,448	48,748
Total Income	478,692	489,927	485,227
Pay Expenditure	-338,988	-332,473	-332,573
Drug Expenditure	-59,456	-56,350	-56,350
CSS Expenditure	-47,538	-45,055	-45,055
Other Expenditure	-52,713	-56,010	-56,255
Total Operating Expenditure	-498,695	-489,888	-490,233
Other Expenditure	-19,831	-19,831	-19,831
Surplus/Deficit	-39,834	-19,792	-24,837

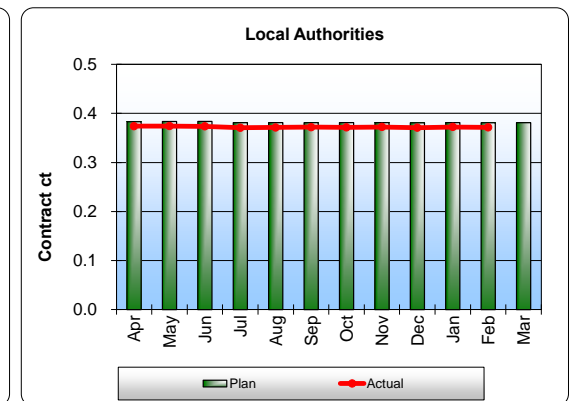
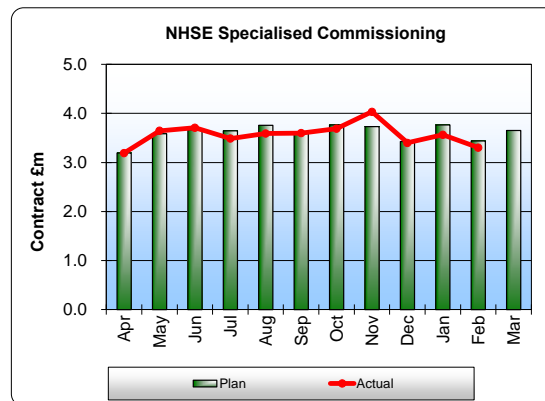
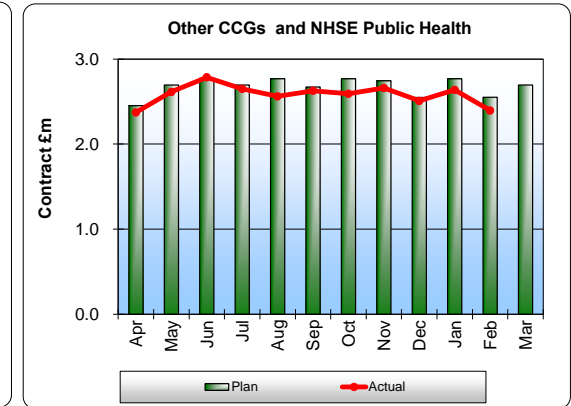
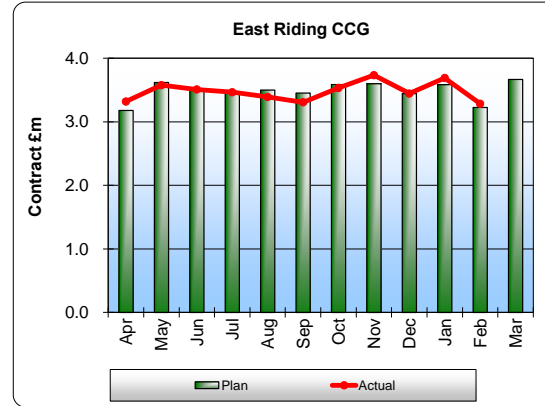
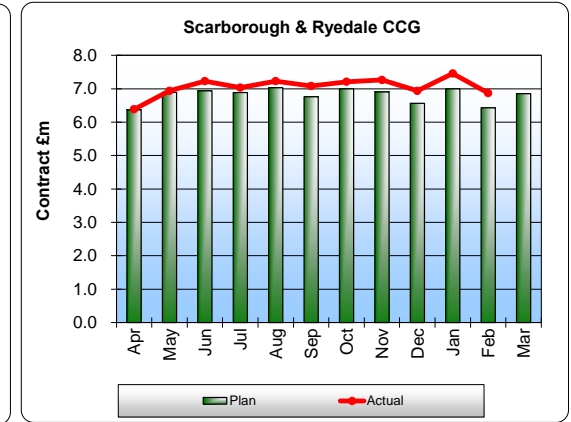
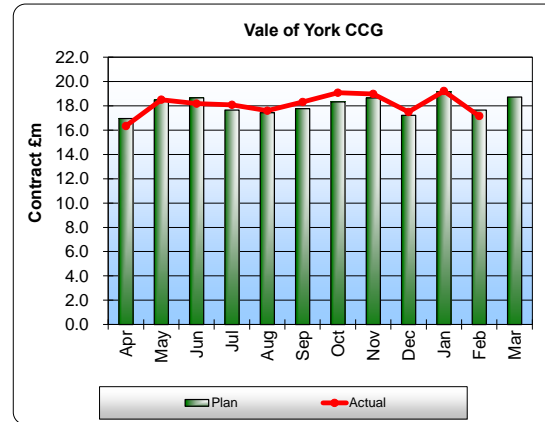
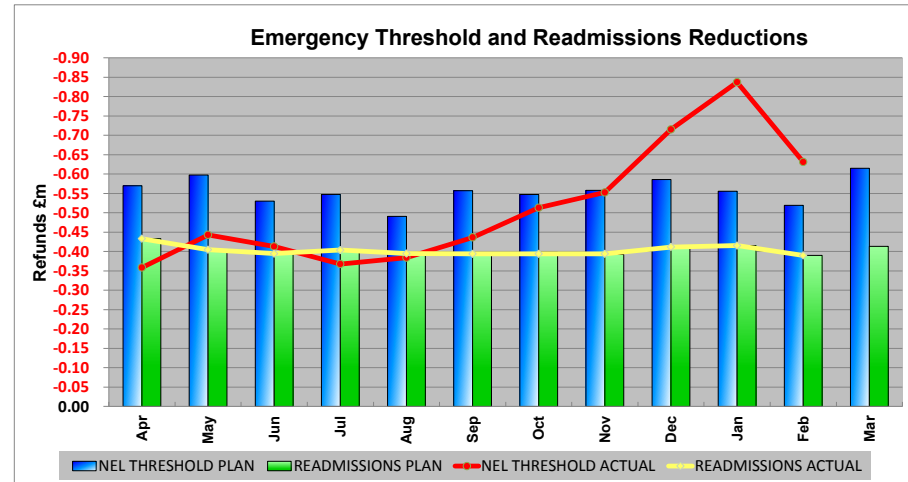
Contract Performance

Month 11 - The Period 1st April 2017 to 28th February 2018

Contract	Annual Contract Value	Contract Year to Date	Actual Year to Date	Variance
	£000	£000	£000	£000
Vale of York CCG	216,623	197,902	198,586	684
Scarborough & Ryedale CCG	81,615	74,763	77,433	2,670
East Riding CCG	41,841	38,175	38,223	48
Other Contracted CCGs	16,822	15,405	15,775	370
NHSE - Specialised Commissioning	43,255	39,602	39,210	-392
NHSE - Public Health	15,319	14,040	12,620	-1,420
Local Authorities	4,581	4,200	4,091	-109
Total NHS Contract Clinical Income	420,056	384,087	385,938	1,851

Plan	Annual Plan	Plan Year to Date	Actual Year to Date	Variance Year to Date
	£000	£000	£000	£000
Non-Contract Activity	15,072	13,888	12,611	-1,277
Risk Income	196	180	0	-180
Total Other NHS Clinical Income	15,268	14,068	12,611	-1,457
Sparsity funding income moved to other income non clinical			-2383	
Winter resilience monies in addition to contract			0	
Total NHS Clinical Income	435,324	398,155	396,166	-1,989

Activity data for February is partially coded (74%) and January data is 97% coded. There is therefore some element of income estimate involved for the uncoded portion of activity.



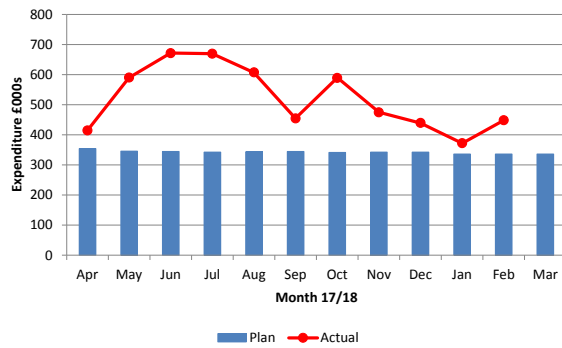
Agency Expenditure Analysis

Month 11 - The Period 1st April 2017 to 28th February 2018

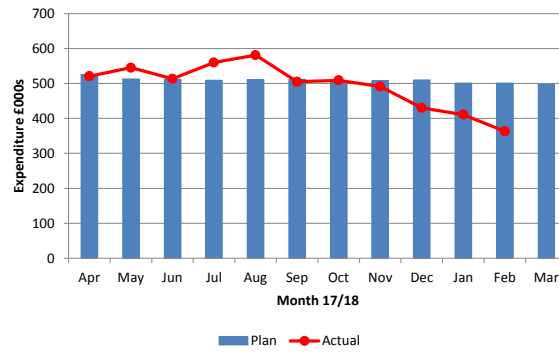
Key Messages:

- * Total agency spend year to date of £16.6m, compared to the NHSI agency ceiling of £15.8m.
- * Consultant Agency spend is ahead of plan by £2m.
- * Nursing Agency is behind plan by £0.8m.
- * The Trust is ahead of the Medical Locum Reduction target by £1m.

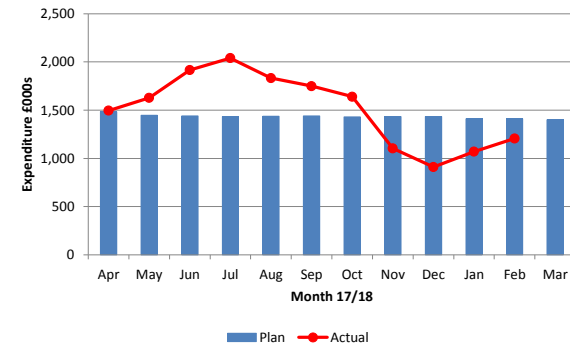
Consultant Agency Expenditure 17/18



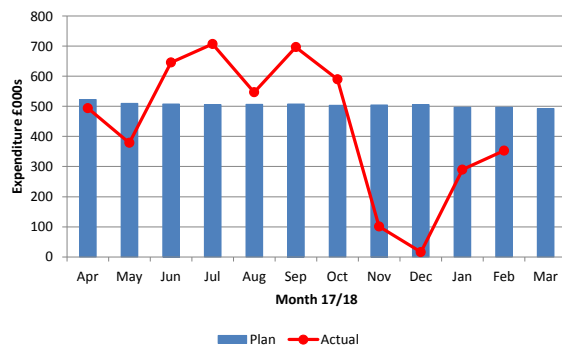
Other Medical Agency Expenditure 17/18



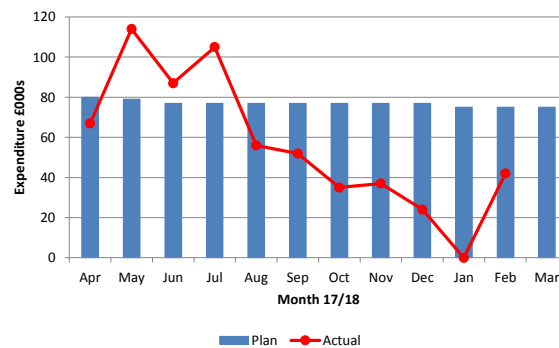
Total Agency Expenditure 17/18



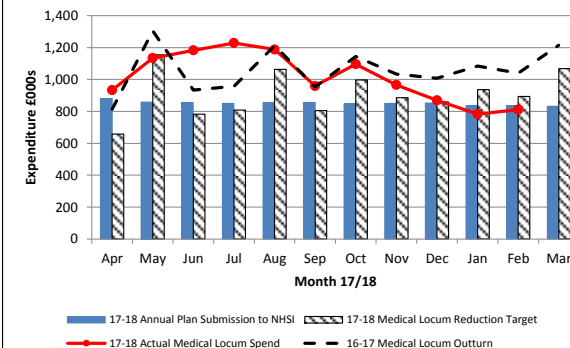
Nursing Agency Expenditure 17/18



Other Agency Expenditure 17/18



17/18 Medical Locum Reduction Target

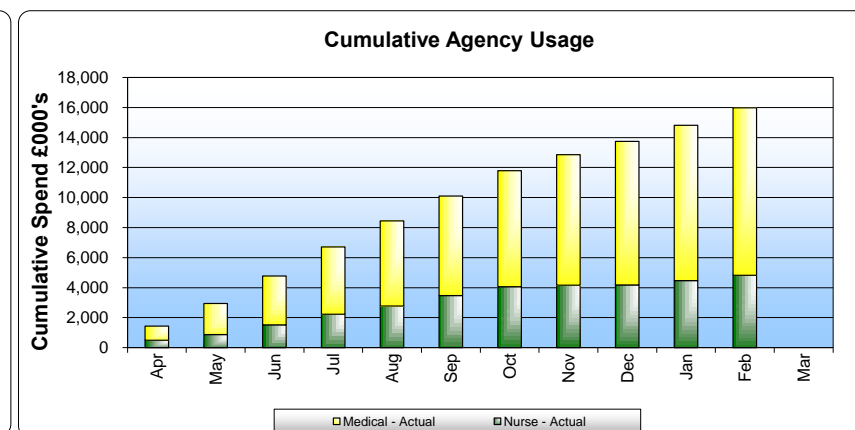
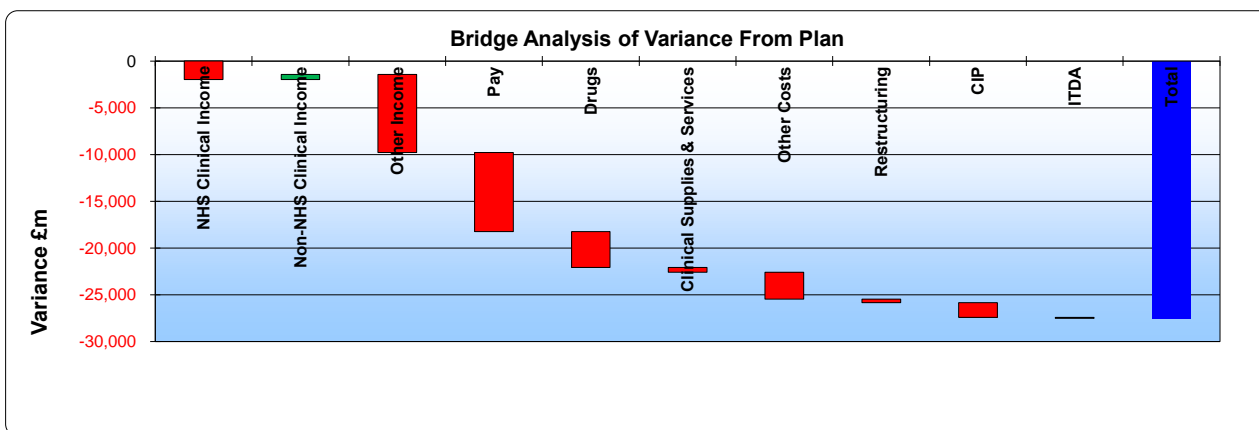


Key Messages:

There is an adverse expenditure variance of £17.6m at the end of February 2018. This comprises:

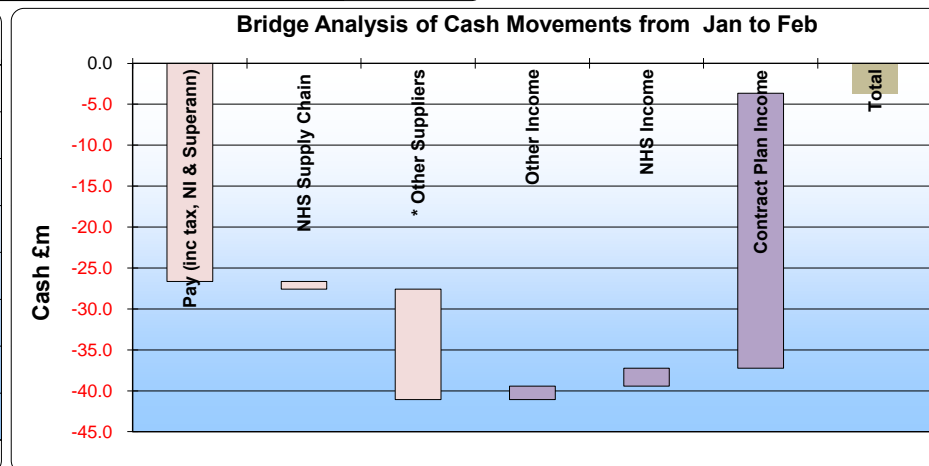
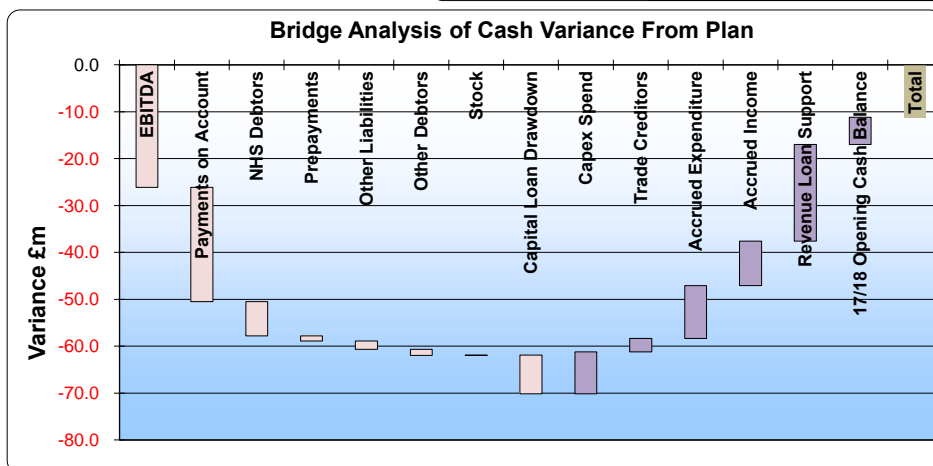
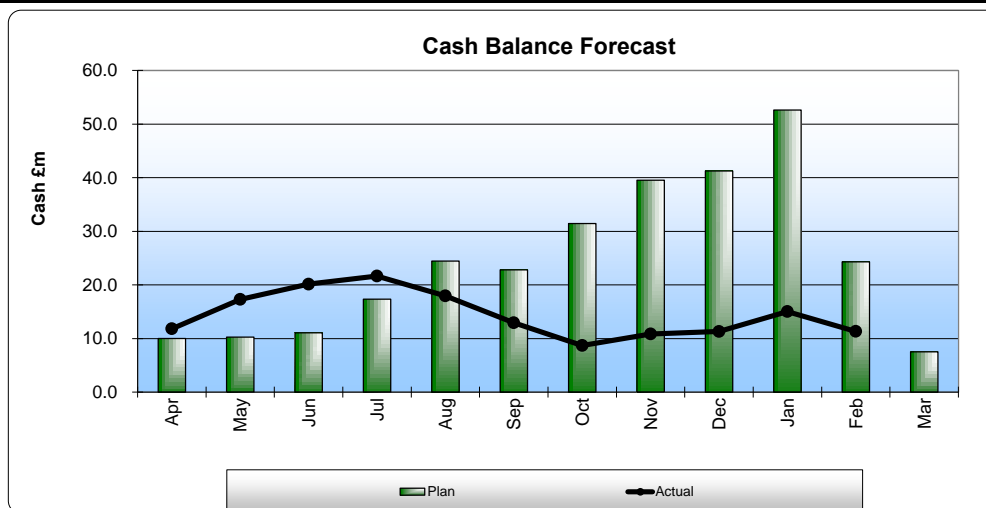
- * Pay budgets are £8.5m ahead of plan.
- * Drugs budgets are £3.8m ahead of plan, mainly due to pass through costs for drugs excluded from tariff.
- * CIP achievement is £1.5m behind plan.
- * Other budgets are £3.8m ahead of plan.

Staff Group	Annual	Year to Date								Previous	Comments
	Plan	Plan	Contract	Overtime	WLI	Bank	Agency	Total	Variance	Variance	
Consultants	59,630	54,456	47,866	0	1,082	0	5,726	54,674	-218	334	
Medical and Dental	29,423	26,852	27,364	0	278	0	5,429	33,070	-6,218	-5,520	
Nursing	95,271	87,027	73,438	413	330	8,018	4,820	87,020	8	426	
Healthcare Scientists	11,190	9,749	9,152	203	116	40	131	9,642	107	104	
Scientific, Therapeutic and technical	16,148	14,722	13,331	106	1	37	128	13,603	1,119	1,239	
Allied Health Professionals	25,886	23,595	22,205	54	239	29	77	22,604	991	1,032	
HCA's and Support Staff	45,326	41,400	37,826	617	111	71	175	38,800	2,600	2,569	
Chairman and Non Executives	186	170	159	0	0	0	0	159	11	10	
Exec Board and Senior managers	14,009	12,803	12,816	9	0	0	0	12,825	-22	-56	
Admin & Clerical	37,083	33,830	32,421	219	87	110	106	32,944	886	937	
Agency Premium Provision	5,064	4,634	0	0	0	0	0	0	4,634	4,203	
Vacancy Factor	-13,614	-12,291	0	0	0	0	0	0	-12,290	-11,306	
Apprenticeship Levy	1,192	1,093	1,163	0	0	0	0	1,163	-70	-70	
TOTAL	326,794	298,040	277,740	1,620	2,243	8,306	16,592	306,502	-8,462	-6,098	



Key Messages:

- * The cash position at the end of February was £11.3m, which is £13m behind plan.
- * The 17/18 opening cash balance was £5.8m favourable to the planned forecast outturn balance.
- * The key factors influencing cash are:
 - Negative impact due to the I&E position.
 - Negative impact due to changes in payment profiles with our main commissioners.
 - Positive impact from accessing revenue loan support.
 - Positive impact from management of creditor payments.



* Categorisation of expenditure was not available at the time of reporting

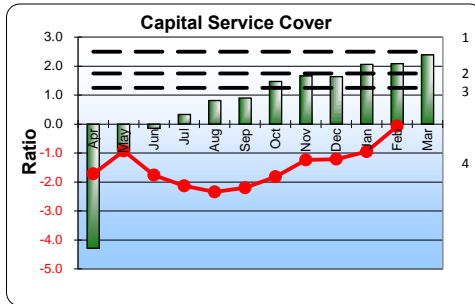
Key Messages:

- * The receivables balance at the end of February was £14m, which is slightly below plan.
- * The payables balance at the end of February was £10m, which is below plan. This is in the main attributable to the implementation of the new financial ledger system.
- * The Use of Resources Rating is assessed as a score of 3 in February, and is reflective of the I&E position.

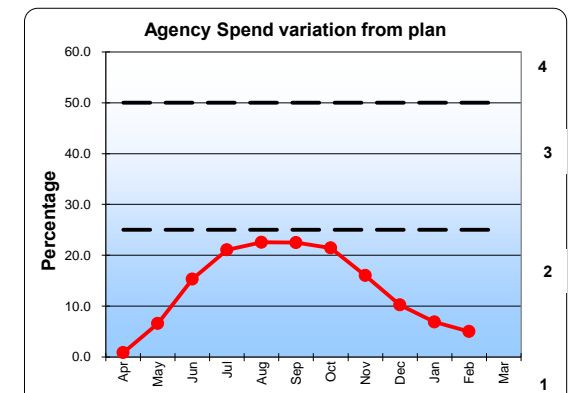
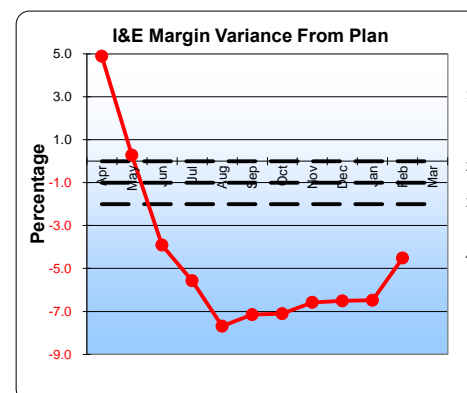
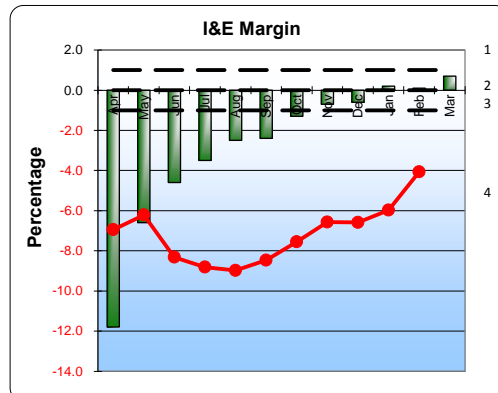
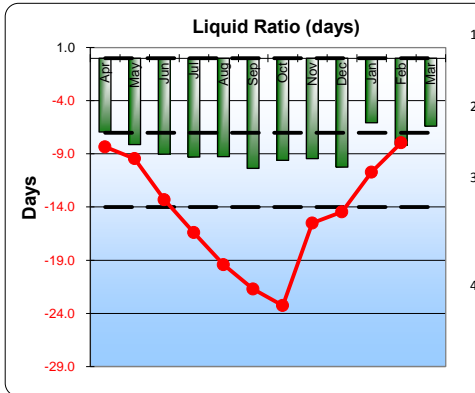
Significant Aged Debtors (+6mths)

NHS Property Services	£228K
Hull & East Yorkshire NHS Trust	£155K
Depuy Ireland	£142K

	Current £m	1-30 days £m	31-60 days £m	Over 60 days £m	Total £m
Payables	2.50	1.66	2.47	3.58	10.22
Receivables	8.73	2.10	0.64	2.64	14.11

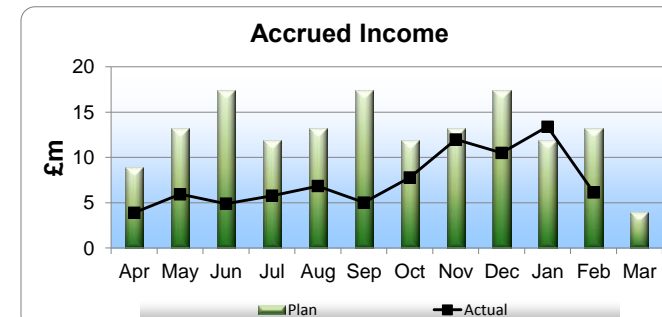
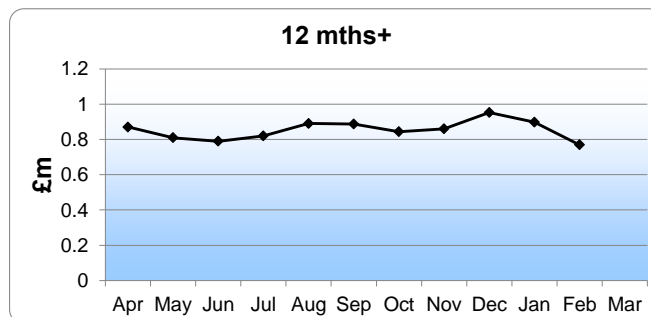
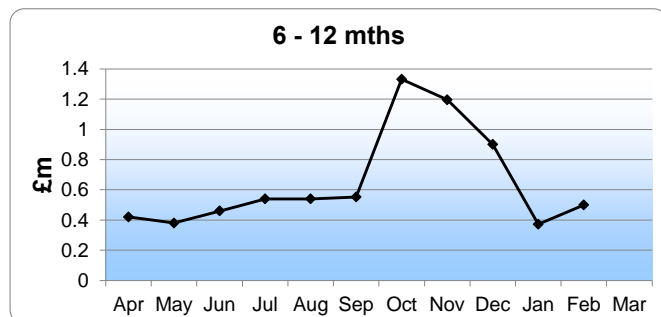
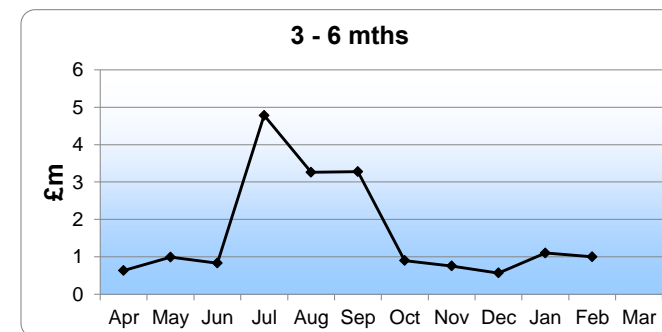
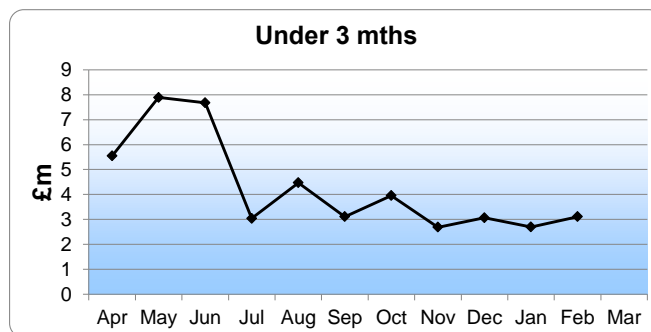
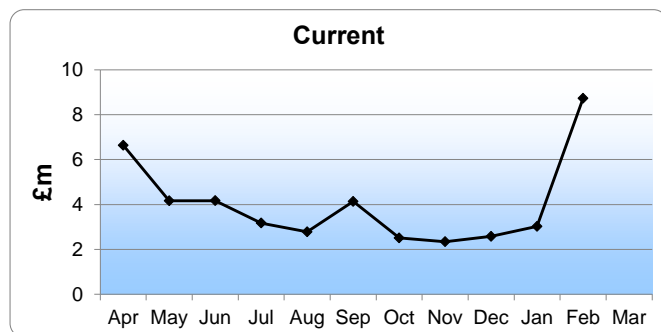
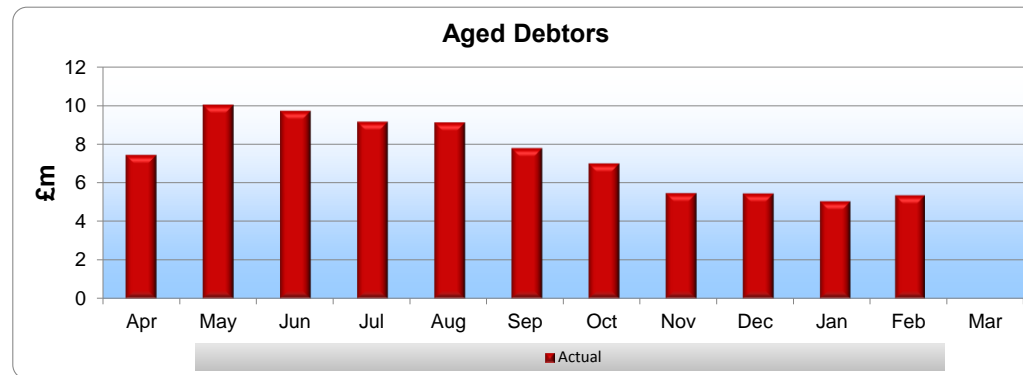
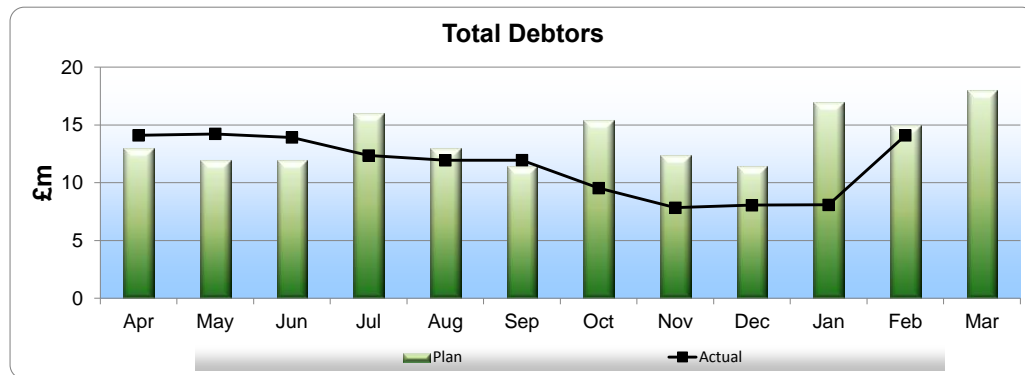


	Plan for Year	Plan for Year-to-date	Actual Year-to-date	Forecast for Year
Liquidity (20%)	2	3	3	3
Capital Service Cover (20%)	2	2	4	4
I&E Margin (20%)	2	2	4	4
I&E Margin Variance From Plan (20%)	1	1	4	4
Agency variation from Plan (20%)	1	1	2	1
Overall Use of Resources Rating	2	2	3	3



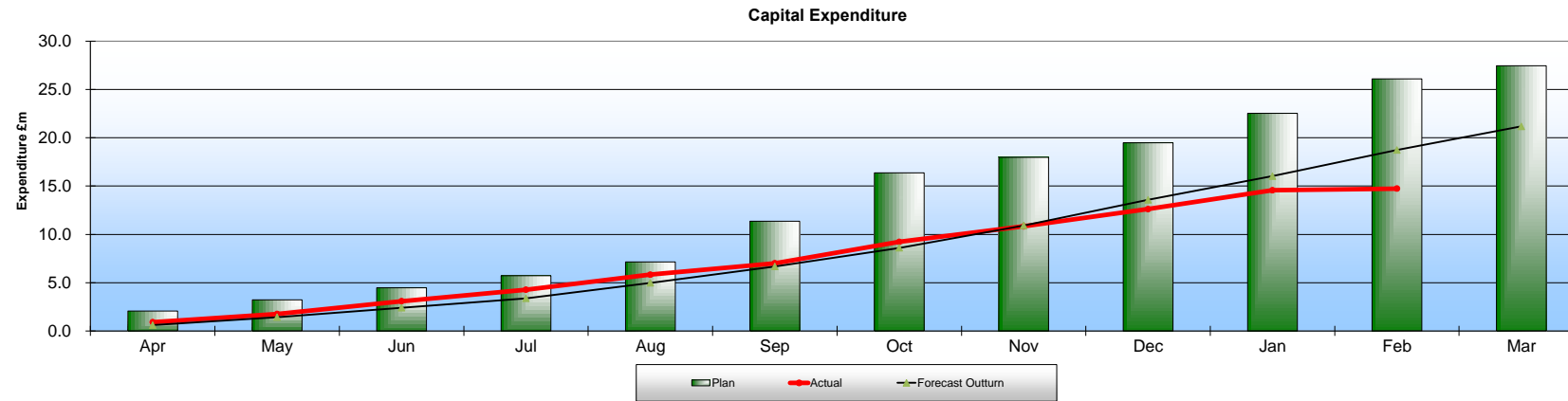
Key Messages:

- * At the end of February, the total debtor balance was £14m, with £8.7m relating to 'current' invoices not due.
- * Aged debt totalled £5.4m, which represents a reduction of £350k from the previous year February position.
- * For the fourth consecutive month, the aged debt figure remains below the previous years comparative figures.
- * Debt collection activity remains a focus for the Trust.



Key Messages:

- * The Capital plan for 2017-18 totals £27.5m, with a forecast outturn position of £21.2m
- * The reduction is partly due to slippage of the Endoscopy scheme due to the delay in funding approval
- * Depreciation funded schemes have also being slipped to preserve the cash position.
- * Work on the Endoscopy extension has commenced on site in November 2017 and detailed designs for the VIU/ Cardiac extension will be developed at an expected cost of approx £1m.
- * Included in the forecast outturn are two schemes at York & Scarborough to deliver primary care streaming and are to be funded from PDC awarded from the Department of Health



Scheme	Approved in-year Expenditure	Year-to-date Expenditure	Forecast Outturn Expenditure	Variance	Comments
	£000	£000	£000	£000	
York Micro/ Histology integration	2,411	71	71	2,340	
SGH Pathology /Blood Sciences	1,251	364	400	851	
Theatre 10 to cardiac/vascular	1,265	1,571	1,600	-335	
Radiology Replacement	5,526	855	4,450	1,076	
Radiology Lift Replacement SGH	799	359	625	174	
Fire Alarm System SGH	940	326	425	515	
Other Capital Schemes	985	3,267	3,386	-2,401	
SGH Estates Backlog Maintenance	1,300	806	1,072	228	
York Estates Backlog Maintenance - York	1,200	1,056	1,000	200	
Cardiac/VIU Extention	1,000	581	1,000	0	
Medical Equipment	500	309	410	90	
IT Capital Programme	1,500	1,064	1,703	-203	
Capital Programme Management	1,450	1,374	1,584	-134	
SGH replacement of estates portakabins	1,339	1,599	1,652	-313	
Endoscopy Development	5,500	560	1,800	3,700	
Contingency	500	0	0	500	
Estimated In year work in progress	0	904	0	0	
TOTAL CAPITAL PROGRAMME	27,466	14,740	21,178	6,288	

This Years Capital Programme Funding is made up of:-	Approved in-year Funding	Year-to-date Funding	Forecast Outturn	Variance	Comments
	£000	£000	£000	£000	
Depreciation	10,554	10,194	10,003	551	
Loan Funding b/fwd	4,450	1,700	1,700	2,750	
Loan Funding	6,500	401	4,450	2,050	
Charitable Funding	623	75	948	-325	
Strategic Capital Funding	5,339	2,300	3,247	2,092	
PDC Funded Schemes	0	70	830	-830	
TOTAL FUNDING	27,466	14,740	21,178	6,288	

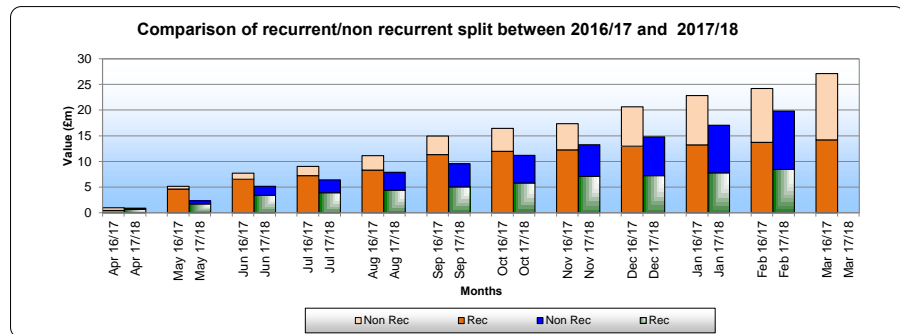
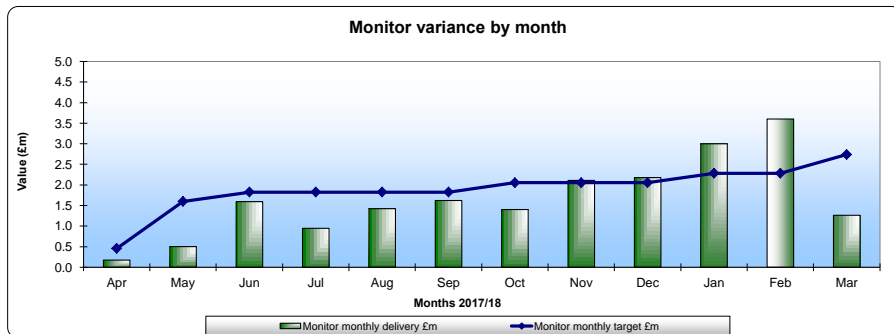
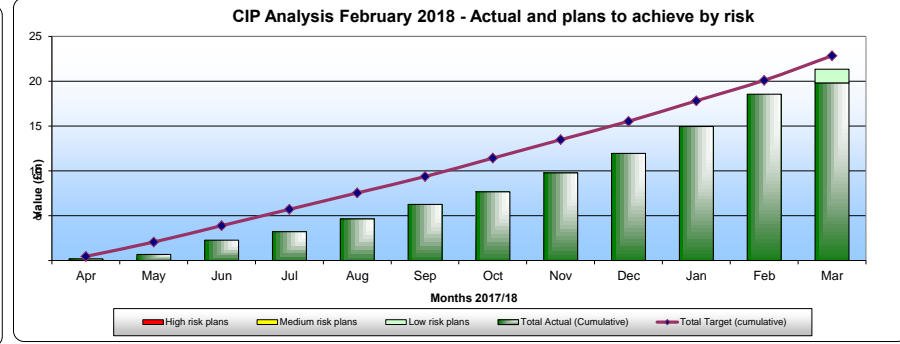
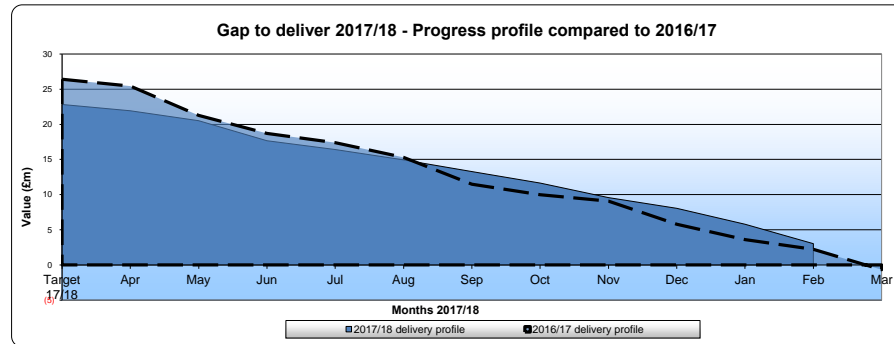
Key Messages:

- * Delivery - £19.8m has been delivered against the Trust annual target of £22.8m, giving a shortfall of (£3m).
- * Part year NHSI variance - The part year NHSI variance is (£1.5m).
- * In year planning - The 2017/18 planning gap is currently (£1.5m).
- * Four year planning - The four year planning gap is (£2.3m).
- * Recurrent delivery - Recurrent delivery is £8.44m in-year, which is 37% of the 2017/18 CIP target.

Executive Summary - February 2018	
	Total £m
TARGET	
In year target	22.8
DELIVERY	
In year delivery	19.8
In year delivery (shortfall)/Surplus	-3.0
Part year delivery (shortfall)/surplus - NHSI variance	-1.5
PLANNING	
In year planning surplus/(gap)	-1.5
FINANCIAL RISK SCORE	
Overall trust financial risk score	HIGH

4 Year Efficiency Plan - February 2018					
Year	2017/18	2018/19	2019/20	2020/21	Total
	£m	£m	£m	£m	£m
Base Target	22.8	12.7	12.7	12.7	61.0
Plans	21.3	20.2	13.2	8.6	63.3
Variance	-1.5	7.4	0.4	-4.1	2.3
%	93%	159%	103%	68%	104%

Risk Ratings			
Financial			
Risk	January	February	Trend
High	15	14	↓
Medium	5	5	↔
Low	7	8	↑
Governance			
Risk	January	February	Trend
High	0	0	↔
Medium	8	7	↓
Low	19	20	↑



Key Messages:

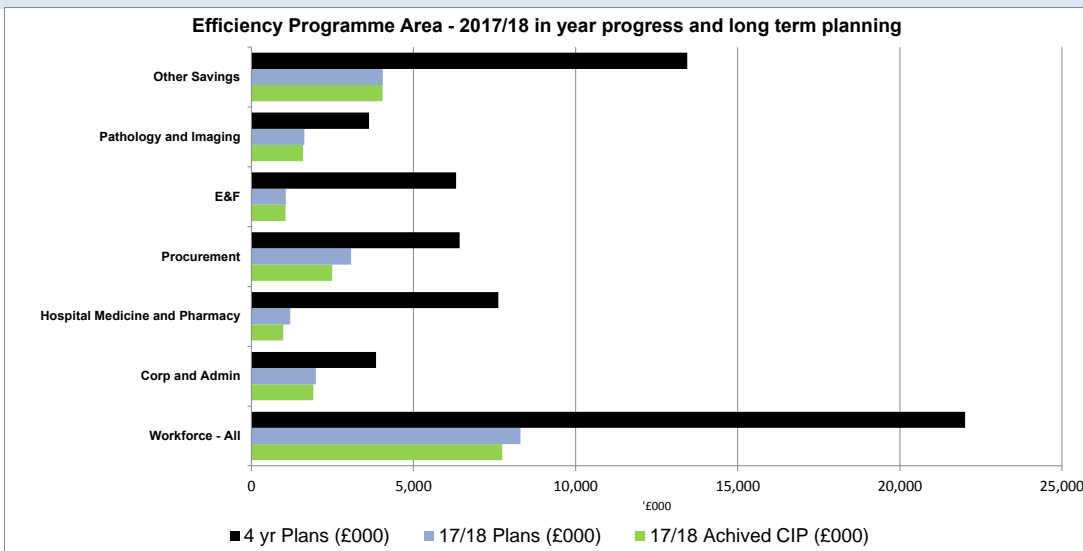
Model Hospital - Working through opportunities identified with Directorates.

Get It Right First Time (GIRFT) - Head and Neck, Max Fax, General Surgery visits held identifying a couple of areas to be reviewed around pathways and cost of procedures.

* NHSI Productivity Team, initial meetings held with first wave of programme (Radiology, Orthopaedics, Procurement, Estates and Facilities and Cardiology). Plans to be presented to Corporate Directors in March 2018 for support and sign-off.

EFFICIENCY PROGRAM - CARTER WORKSTREAM PERFORMANCE JANUARY 2018

Efficiency Programme Area	4 yr Plans (£000)	17/18 Plans (£000)	17/18 Achived CIP (£000)
Workforce - All	22,016	8,300	7,736
Corp and Admin	3,847	1,990	1,910
Hospital Medicine and Pharmacy	7,619	1,200	979
Procurement	6,422	3,079	2,492
E&F	6,310	1,061	1,051
Pathology and Imaging	3,626	1,637	1,590
Other Savings	13,446	4,050	4,045
TOTAL	63,287	21,318	19,803



WORKFORCE

- Successful recruitment to Trust Grade Doctors should realise savings of £386K between December 17 and August 18 through reduction in Agency spend.
- Expansion of eRostering to wider Trust is in the planning stages with forecast efficiencies of £1.4m over 5 year period after implementation.

HOSPITAL PHARMACY AND MEDICINE

- Electronic Prescribing is being rolled out across the Trust and upon full implementation an efficiency will be realised.
- The Pharmacy Department continue to work with the switch to Biosimilars with some efficiency being recognised by the Trust within the CIP Programme, however approximately £800K of savings is attached to CQUINs and does not contribute to the delivery of the Programme but it is recognised within the Model Hospital Pharmacy Dashboard.
- Warehousing project in planning stages.

PROCUREMENT

- NHSI Productivity Work - Procurement Plan identifies £0.58m opportunity.

ESTATES AND FACILITIES

- NHSI Productivity Work - E&F 4 Plans in development stage and being costed to identify efficiencies.

NHSI Productivity

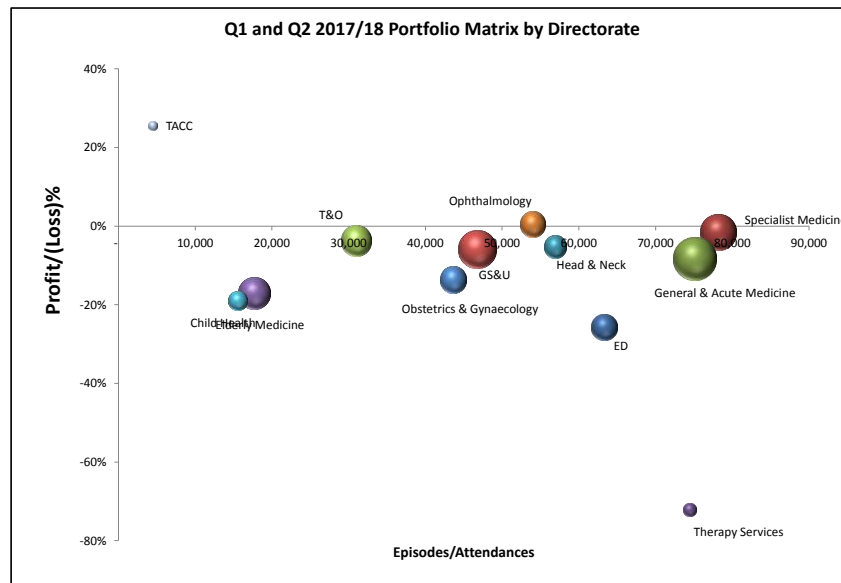
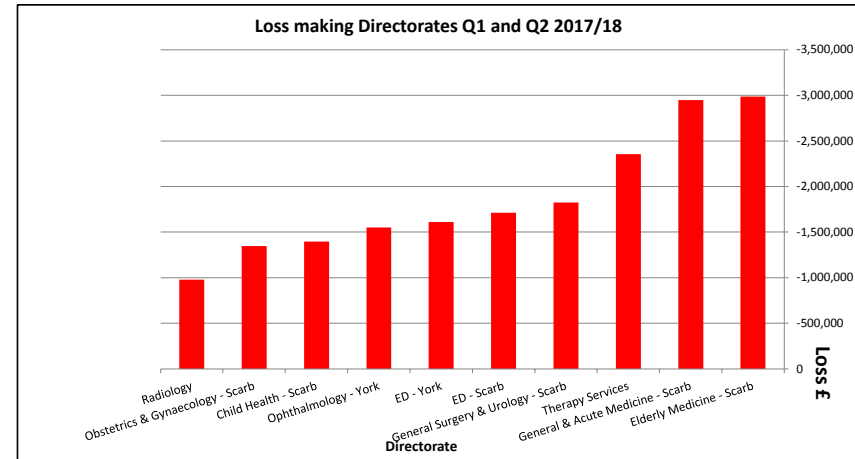
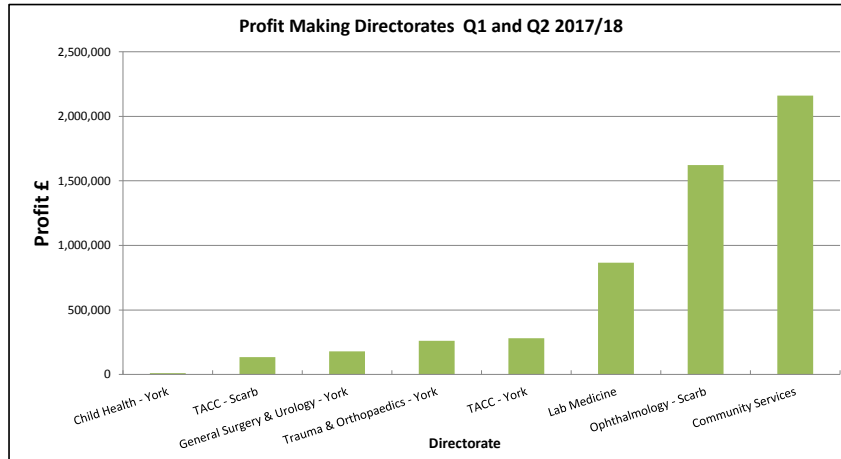
- Work has commenced with NHSI Productivity and initial meetings have been held with the 4 areas identified as the first wave (Radiology, Orthopaedics, Procurement, Estates and Facilities and Cardiology). NHSI are supporting the Trust in formulating cohesive plans for 3-4 schemes in each of the areas. Plans are to be presented to Corporate Directors in March 2018 for support and sign-off.

PATHOLOGY AND IMAGING

- Pathology data collection submitted and loaded on to Model Hospital. Directorate assessing and identifying areas of opportunity. The overall position is positive when compared to peers.
- Radiology data collection pro-formas for 2016/17 received by the Trust.

Key Messages:

- * Current data is based on Q1 and Q2 2017/18
- * It is expected that Q3 2017/18 data will be completed March 2018
- * The SLR Leadership Programme was launched on 25th September 2017



DATA PERIOD	Q1 and Q2 2017/18
CURRENT WORK	<ul style="list-style-type: none"> * Q3 2017/18 reports are now the key focus for the team * The SLR Leadership Programme was launched on 25th September 2017. The is a programme of work to enable the Finance Managers to become confident users of the SLR system and data, and also to provide a structured process for investigating loss making activity and areas for improvement * 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 released over the coming months
FUTURE WORK	<ul style="list-style-type: none"> * The SLR Leadership Programme will continue until May 2018 * Q4 2017/18 SLR reports will become the focus once the Q3 reports have been published * 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	£3.68m

Blank page

Board of Directors – 28 March 2018 Efficiency Programme Update

Recommendation

- | | |
|--------------------------|-------------------------------------|
| For information | <input checked="" type="checkbox"/> |
| For discussion | <input checked="" type="checkbox"/> |
| For assurance | <input type="checkbox"/> |
| For approval | <input type="checkbox"/> |
| A regulatory requirement | <input type="checkbox"/> |

Current approval route of report

This report is presented to the Board of Directors and Finance & Performance Committee.

Purpose of report

The Board is asked to note the February 2018 position.

Key points for discussion

This report provides a detailed overview of progress to date regarding delivery of the Trust's Efficiency Programme. The 2017/18 target is £22.8m and delivery, as at February 2018 is £19.8m.

Trust Ambitions and Board Assurance Framework

(https://www.yorkhospitals.nhs.uk/about_us/our_values/)

The Board Assurance Framework is structured around the four ambitions of the Trust. How does the report relate to the following ambitions:

- Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.
- Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.
- People and Capability** - The quality of our services is wholly dependent on our teams of staff.
- Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

Reference to CQC Regulations

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

Version number: 1

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

Executive sponsor: Andrew Bertram, Finance Director

Date: March 2018



Briefing note for the Finance & Performance Committee meeting 20 March 2018 and Board of Directors meeting 28 March 2018

1. Summary reported position for February 2018

1.1 Current position – highlights

Delivery - Delivery is £19.8m in February 2018 which is (87%) of the £22.8m annual target. This position compares to a delivery position of £24.2m in February 2017.

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

The relative Directorate positions are shown in **Appendix 1** attached.

In year planning – At February 2018 CIP planning is £21.3m (93%) with a gap of (£1.5m), the comparative position in February 2017 was 100% planned.

Four year planning – The four year planning gap is (£2.3m). The position in February 2017 was a gap of (£11.2m).

Recurrent vs. Non recurrent – Of the £19.8m delivery, £8.4m (42%) in-year has been delivered recurrently. Recurrent delivery is £5.3m behind the same position in February 2017.

Quality Impact Assessments (QIA) –

Directorates are currently assessing their CIP schemes. A review by the Clinical Lead for Efficiency is underway and schemes assessed to date are categorised as Low risk.

1.2 Overview

February delivery showed an improvement on previous months with £2.8m delivery.

The Corporate Efficiency Team has worked closely with Finance Managers reviewing non-activity related underspends and converting this to CIP. This amounted to £235K, the residual balance on delivery being Directorate plans.

Every effort is being focused on Procurement savings and work is continuing with the review of converting non-activity related underspends to CIP.

March remains a significant challenge to deliver the final £3m to meet the £22.8m target.

The NHSI Productivity work continues with Directorate Plans from the first wave to be submitted to Corporate Directors in March for support and approval. Work is ongoing to identify the second wave of Directorates and this will need to be aligned with the work we are engaged with our Commissioners.



RISK SCORES - FEBRUARY 2018 - APPENDIX 1

DIRECTORATE	Yr1 Target	4Yr Target	Yr 1 Plan v Target		Yr 1 Delivery v Target		Yr 1 Recurrent Delivery		4 Yr Plan v Target		Overall Financial Risk	Governance Risk
	£0	£0	%	Risk	%	Risk	%	Risk	%	Risk		
WOMENS HEALTH	2	3	38%	HIGH	34%	HIGH	30%	HIGH	53%	HIGH	12	LOW
RADIOLOGY	2	3	53%	HIGH	50%	HIGH	33%	HIGH	59%	HIGH	12	MEDIUM
CHILD HEALTH	1	2	63%	HIGH	56%	HIGH	39%	HIGH	50%	HIGH	12	LOW
SPECIALIST MEDICINE	3	7	59%	HIGH	56%	HIGH	32%	HIGH	59%	HIGH	12	MEDIUM
EMERGENCY MEDICINE	1	4	62%	HIGH	62%	HIGH	30%	HIGH	40%	HIGH	12	LOW
GS&U	2	5	76%	HIGH	65%	HIGH	40%	HIGH	100%	HIGH	12	LOW
AHP & PSYCHOLOGICAL MEDICINE	1	3	72%	HIGH	71%	HIGH	37%	HIGH	58%	HIGH	12	LOW
TACC	3	7	78%	HIGH	77%	HIGH	53%	HIGH	75%	HIGH	12	MEDIUM
GEN MED SCARBOROUGH	1	2	76%	HIGH	58%	HIGH	34%	HIGH	118%	LOW	10	LOW
MEDICINE FOR THE ELDERLY	1	3	106%	MEDIUM	97%	MEDIUM	12%	HIGH	61%	HIGH	10	LOW
HEAD AND NECK	1	2	103%	MEDIUM	99%	MEDIUM	49%	HIGH	96%	HIGH	10	LOW
COMMUNITY	0	1	96%	HIGH	74%	HIGH	67%	MEDIUM	150%	LOW	9	LOW
SEXUAL HEALTH	1	1	100%	MEDIUM	99%	MEDIUM	43%	HIGH	101%	MEDIUM	9	LOW
OPHTHALMOLOGY	1	3	104%	MEDIUM	102%	MEDIUM	41%	HIGH	109%	MEDIUM	9	MEDIUM
GEN MED YORK	1	4	105%	MEDIUM	98%	MEDIUM	50%	HIGH	155%	LOW	8	LOW
LAB MED	1	3	151%	LOW	148%	LOW	113%	LOW	80%	HIGH	6	MEDIUM
PHARMACY	0	1	191%	LOW	182%	LOW	50%	HIGH	130%	LOW	6	LOW
ORTHOAEDICS	1	3	195%	LOW	192%	LOW	107%	LOW	129%	LOW	4	MEDIUM
CORPORATE												
ESTATES AND FACILITIES	2	6	51%	HIGH	50%	HIGH	26%	HIGH	85%	HIGH	12	LOW
OPS MANAGEMENT YORK	0	1	50%	HIGH	50%	HIGH	35%	HIGH	23%	HIGH	12	LOW
CHIEF NURSE TEAM DIRECTORATE	0	1	82%	HIGH	72%	HIGH	5%	HIGH	72%	HIGH	12	LOW
CHAIRMAN & CHIEF EXECUTIVES OFFICE	0	0	179%	LOW	179%	LOW	43%	HIGH	73%	HIGH	8	LOW
MEDICAL GOVERNANCE	0	0	118%	LOW	118%	LOW	79%	LOW	65%	HIGH	6	LOW
HR	0	1	174%	LOW	158%	LOW	53%	HIGH	127%	LOW	6	LOW
SNS	0	1	123%	LOW	110%	LOW	68%	MEDIUM	105%	MEDIUM	4	LOW
LOD&R	0	1	262%	LOW	262%	LOW	85%	LOW	146%	LOW	4	MEDIUM
FINANCE	0	1	306%	LOW	306%	LOW	103%	LOW	112%	LOW	4	LOW
TRUST SCORE	23	61	93%	HIGH	87%	HIGH	37%	HIGH	104%	MEDIUM	11	LOW

YTD Directorate CIP Progress - February 2018

DIRECTORATE	Annual Target	YTD Budget	April Achieved	May Achieved	June Achieved	July Achieved	August Achieved	September Achieved	October Achieved	November Achieved	December Achieved	January Achieved	February Achieved	YTD Achieved	YTD Variance	% YTD Target Achieved
	(£000)	(£000)	(£000)	(£000)	(£000)	(£000)	(£000)	(£000)	(£000)	(£000)	(£000)	(£000)	(£000)	(£000)	(£000)	%
SPECIALIST MEDICINE	2,818	2,480	1	15	69	117	109	75	99	142	175	277	342	1,421	-1,059	57%
TACC	2,662	2,342	1	31	178	175	45	63	259	86	151	154	707	1,850	-492	79%
GS&U	1,952	1,718	33	19	51	103	83	77	83	181	134	178	197	1,138	-580	66%
RADIOLOGY	1,863	1,639	3	21	29	74	66	93	72	102	200	52	168	881	-758	54%
GEN MED YORK	1,801	1,548	1	11	48	84	245	47	133	39	81	380	182	1,251	-297	81%
WOMENS HEALTH	1,654	1,455	4	21	30	63	26	36	35	37	76	53	133	514	-941	35%
AHP & PSYCHOLOGICAL MEDICINE	1,257	1,106	1	25	28	77	39	209	34	110	104	137	89	852	-254	77%
MEDICINE FOR THE ELDERLY	1,225	1,078	11	30	30	33	49	28	83	249	142	256	164	1,076	-2	100%
EMERGENCY MEDICINE	865	798	0	6	36	44	44	28	27	280	65	65	77	671	-127	84%
CHILD HEALTH	849	747	4	0	49	61	103	23	20	59	64	22	50	455	-293	61%
OPHTHALMOLOGY	826	727	0	17	190	5	16	156	7	22	288	118	13	830	103	114%
HEAD AND NECK	717	631	0	55	108	1	10	69	3	142	69	149	65	670	39	106%
GEN MED SCARBOROUGH	696	613	2	5	25	60	34	23	37	37	37	71	38	368	-245	60%
ORTHOPAEDICS	682	601	21	37	308	155	68	41	184	42	98	104	215	1,272	672	212%
LAB MED	551	485	3	40	60	183	54	36	41	40	42	54	203	756	271	156%
SEXUAL HEALTH	540	476	9	19	84	87	45	46	41	38	36	79	28	513	38	108%
COMMUNITY	438	385	0	1	4	11	18	-3	30	128	23	43	44	299	-86	78%
PHARMACY	431	379	1	7	19	55	58	215	12	41	108	145	94	757	378	200%
CORPORATE																
ESTATES AND FACILITIES	2,101	1,849	18	28	28	100	53	109	37	35	40	54	489	992	-857	54%
FINANCE	465	409	0	28	52	93	162	80	81	133	90	98	503	1,320	911	323%
SNS	433	381	0	7	75	0	5	62	3	3	10	185	98	449	68	118%
CHIEF NURSE TEAM DIRECTORATE	351	309	0	10	21	0	14	91	0	0	104	4	5	249	-60	81%
HR	256	226	18	10	8	13	75	14	51	78	20	54	55	396	171	176%
CHAIRMAN & CHIEF EXECUTIVES OFF	192	169	0	0	42	34	14	36	48	40	36	42	29	319	150	189%
OPS MANAGEMENT YORK	171	151	0	0	8	3	1	1	1	1	8	2	56	79	-71	53%
LOD&R	169	148	19	14	33	27	59	25	39	50	81	55	27	429	280	289%
MEDICAL GOVERNANCE	117	103	0	22	-13	12	1	5	4	65	9	15	10	129	26	125%
TRUST SCORE	26,082	22,952	151	479	1,599	1,669	1,496	1,683	1,462	2,181	2,291	2,846	4,082	19,939	-3,013	87%

Blank page

Public Performance Report

March 2018

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



Performance Report Chapter Index

Chapter	Sub-Section
Performance	Trust Performance Index
	STF Trajectory
	Performance Benchmarking
	Trust Unplanned Care - Emergency Care Standard
	Trust Unplanned Care - Adult Admissions
	Trust Length of Stay & Delayed Transfers of Care
	Trust Paediatric Admissions
	Trust Planned Care Outpatients
	Trust Planned Care - Elective Activity & Theatre Utilisation
	Diagnostics & 18 Weeks RTT Incomplete
	Cancer

Activity Summary: Trust

Operational Performance: Unplanned Care	Monthly Target/ Threshold	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Emergency Care Attendances		15695	16099	16834	16330	17438	17134	15979	16570	15158	16236	14712	13719
Emergency Care Breaches		1680	1144	2018	1328	2268	2033	2697	2222	1263	2766	2728	2499
Emergency Care Standard Performance	95%	89.3%	92.9%	88.0%	91.9%	87.0%	88.1%	83.1%	86.6%	91.7%	83.0%	81.5%	81.8%
ED Conversion Rate: Proportion of ED attendances subsequently admitted		38.9%	37.9%	37.0%	36.8%	35.9%	36.5%	37.7%	37.7%	39.0%	40.8%	40.9%	40.0%
ED Total number of patients waiting over 8 hours in the departments		319	136	378	158	323	274	528	371	152	791	833	668
ED 12 hour trolley waits	0	9	0	3	0	2	1	1	2	0	5	14	15
ED: % of attendees assessed within 15 minutes of arrival		73.6%	79.7%	72.8%	72.9%	70.7%	68.8%	67.9%	66.7%	69.3%	57.1%	63.1%	61.2%
ED: % of attendees seen by doctor within 60 minutes of arrival		48.2%	51.8%	40.1%	43.3%	36.6%	43.6%	34.7%	35.5%	42.1%	40.5%	44.7%	42.7%
Ambulance Handovers waiting 15-29 minutes	0	430	211	272	335	360	446	469	745	649	823	702	679
Ambulance handovers waiting >30 minutes	0	183	68	164	150	215	258	331	368	172	537	424	360
Ambulance handovers waiting >60 minutes	0	67	35	92	75	96	106	207	257	55	548	390	367
Non Elective Admissions (excl Paediatrics & Maternity)		4574	4204	4378	4476	4421	4411	4251	4411	4304	4575	4514	4095
Non Elective Admissions - Paediatrics		791	675	664	607	616	495	673	790	800	934	736	655
Delayed Transfers of Care - Acute Hospitals		1089	875	908	902	806	1238	965	932	958	865	660	885
Delayed Transfers of Care - Community Hospitals		488	442	313	298	352	234	445	312	439	506	483	357
Patients with LoS >= 7 Midnights (Elective & Non-Elective)		1079	1047	1109	1013	1063	1014	1048	1057	1045	1130	1153	1033
Ward Transfers - Non clinical transfers after 10pm	100	111	79	90	60	110	70	84	67	57	113	99	106
Emergency readmissions within 30 days		798	707	800	815	772	744	712	739	795	868	2 months behind	months behind

Operational Performance: Planned Care	Monthly Target/ Threshold	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Outpatients: All Referral Types		18972	15688	17604	18568	17686	16977	16599	18088	17966	14977	17804	15711
Outpatients: GP Referrals		10707	8431	9208	10097	9386	9134	9044	9751	9758	7794	9672	8637
Outpatients: Consultant to Consultant Referrals		2302	1985	2209	2283	2286	2240	2007	2314	2215	1894	2143	1936
Outpatients: Other Referrals		5963	5272	6187	6188	6014	5603	5548	6023	5993	5289	5989	5138
Outpatients: 1st Attendances		13892	10352	12318	12517	11979	11741	11721	12797	12665	10091	12666	11171
Outpatients: Follow Up Attendances		29563	23150	27794	27820	26708	26558	26826	28311	29312	24019	29845	25553
Outpatients: 1st to FU Ratio		2.13	2.24	2.26	2.22	2.23	2.26	2.29	2.21	2.31	2.38	2.36	2.29
Outpatients: DNA rates		6.6%	6.8%	7.1%	7.2%	7.0%	6.7%	6.6%	6.1%	6.1%	6.1%	6.3%	6.2%
Outpatients: Cancelled Clinics with less than 14 days notice	180	222	151	163	147	147	140	203	197	190	133	224	150
Outpatients: Hospital Cancelled Outpatient Appointments for non-clinical reasons		912	906	891	942	834	823	817	862	780	702	949	757
Diagnostics: Patients waiting <6 weeks from referral to test	99%	99.0%	97.2%	98.1%	98.8%	98.9%	99.1%	98.9%	98.3%	98.5%	97.5%	98.1%	97.9%
Elective Admissions		787	610	749	758	715	720	683	790	790	597	568	601
Day Case Admissions		6800	5447	6216	6364	5896	6048	5846	6254	6151	5179	6069	5545
Cancelled Operations within 48 hours - Bed shortages		53	4	57	10	23	12	38	27	2	74	118	129
Cancelled Operations within 48 hours - Non clinical reasons		122	46	154	57	64	57	84	91	65	169	191	189
Theatres: Utilisation of planned sessions		90.4%	90.5%	86.9%	89.3%	88.4%	89.6%	89.2%	88.4%	92.5%	86.4%	82.7%	84.8%
Theatres: number of sessions held		706	531	621	633	629	590	619	704	718	542	599	543
Theatres: Lost sessions < 6 wks notice (list available but lost due to leave, staffing etc)		65	70	84	71	72	56	77	57	54	76	74	50



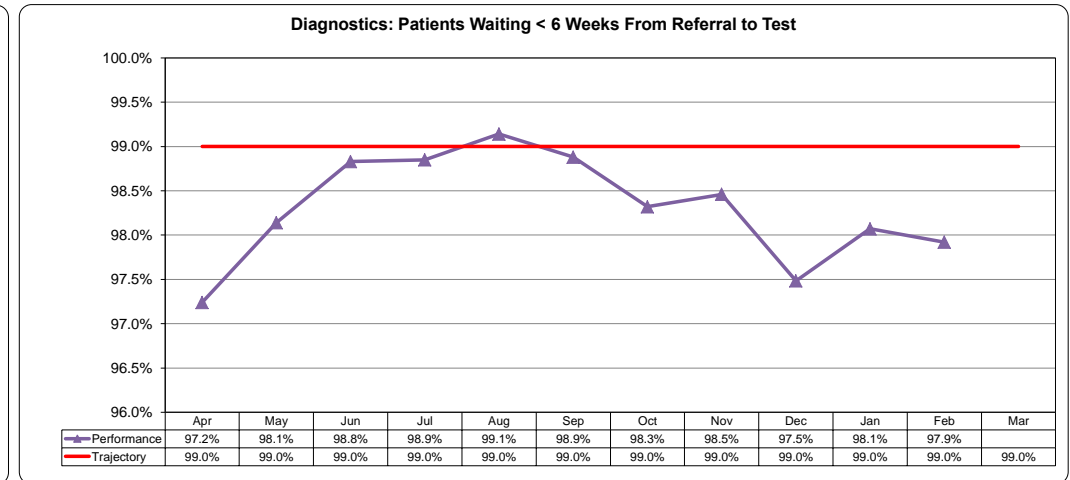
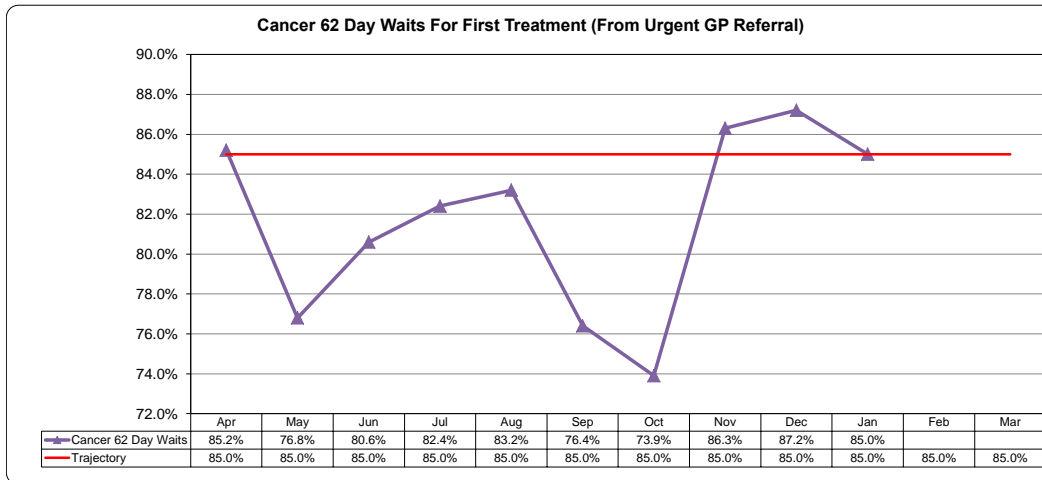
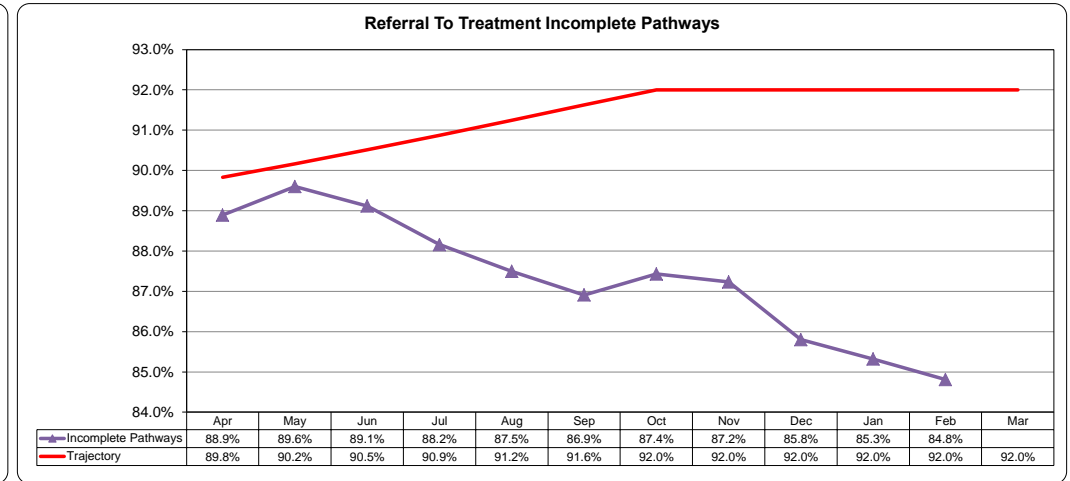
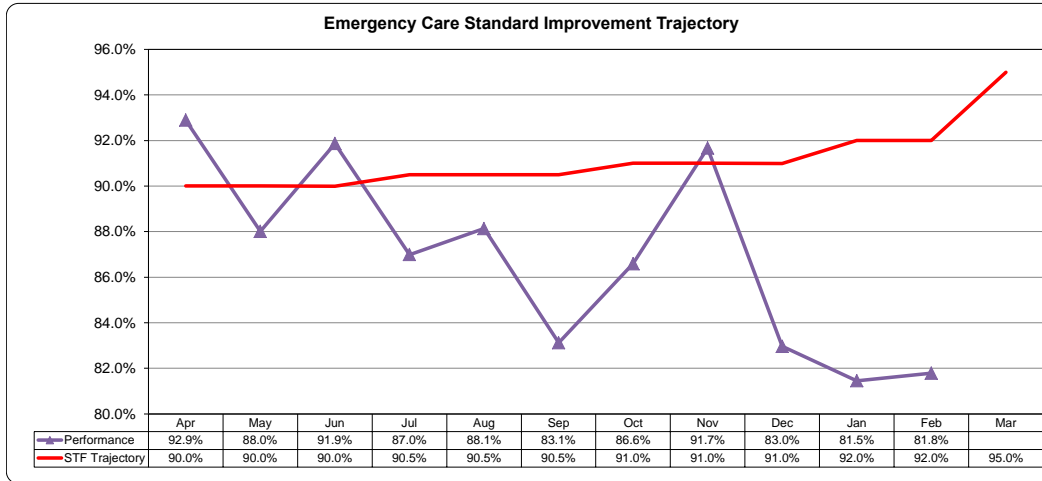
Activity Summary: Trust

18 Weeks Referral To Treatment		Monthly Target/ Threshold	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Incomplete Pathways	92%	89.5%	88.9%	89.6%	89.1%	88.2%	87.5%	86.9%	87.4%	87.2%	85.8%	85.3%	84.8%	
Waits over 52 weeks for incomplete pathways	0	1	0	1	0	1	1	0	1	0	0	0	1	
Waits over 36 weeks for incomplete pathways	0	168	159	165	156	152	197	197	199	202	238	260	297	
Number of patients on Admitted Backlog (18+ weeks)	-	1220	1426	1357	1331	1418	1353	1457	1465	1448	1623	1818	1928	
Number of patients on Non Admitted Backlog (18+ weeks)	-	1427	1380	1302	1520	1720	1976	1884	1699	1761	1816	1880	1921	

Cancer (one month behind due to national reporting timetable)		Quarterly target	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Cancer 2 week (all cancers)	93%	90.9%	86.4%	86.2%	87.0%	80.7%	83.4%	84.8%	86.8%	93.4%	92.5%	94.4%	1 month behind	
Cancer 2 week (breast symptoms)	93%	94.9%	88.0%	95.0%	95.1%	97.1%	98.2%	98.6%	97.0%	94.5%	94.0%	94.6%	1 month behind	
Cancer 31 day wait from diagnosis to first treatment	96%	96.1%	96.6%	96.6%	98.4%	98.3%	97.7%	97.9%	96.8%	98.7%	99.6%	99.2%	1 month behind	
Cancer 31 day wait for second or subsequent treatment - surgery	94%	97.5%	92.5%	94.1%	97.2%	95.2%	97.1%	95.7%	82.5%	97.4%	96.9%	93.9%	1 month behind	
Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	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	
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	82.5%	85.2%	76.8%	80.6%	82.4%	83.2%	76.4%	73.9%	86.3%	87.2%	85.0%	1 month behind	
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	86.0%	91.7%	93.5%	96.4%	86.8%	98.5%	93.1%	90.9%	90.6%	89.5%	95.5%	1 month behind	

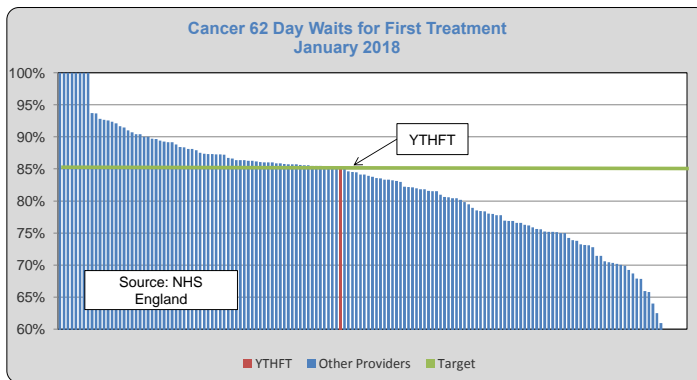
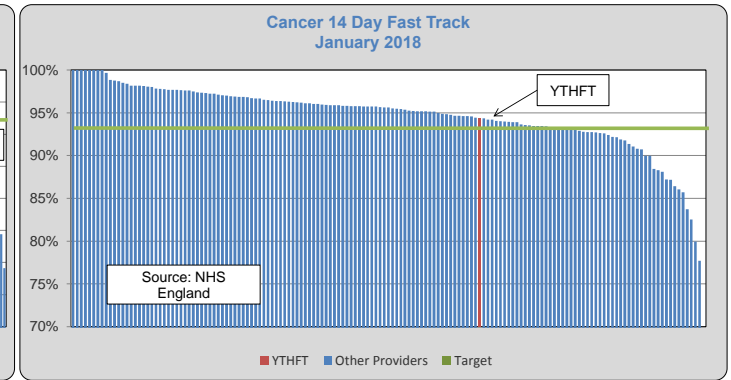
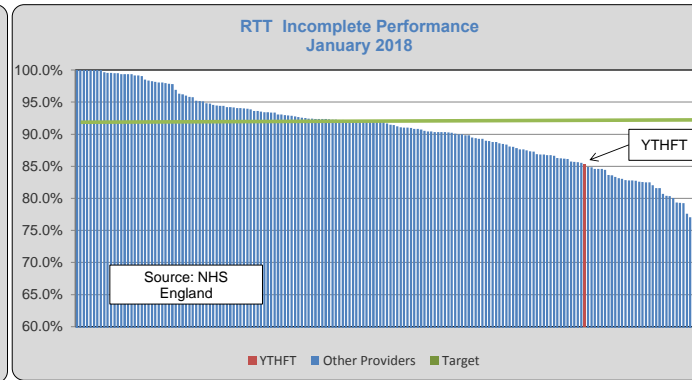
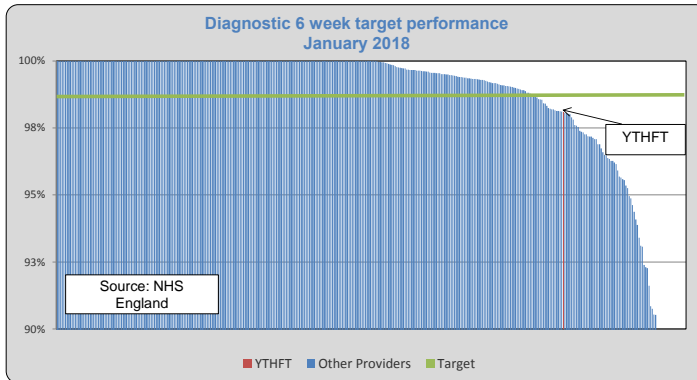
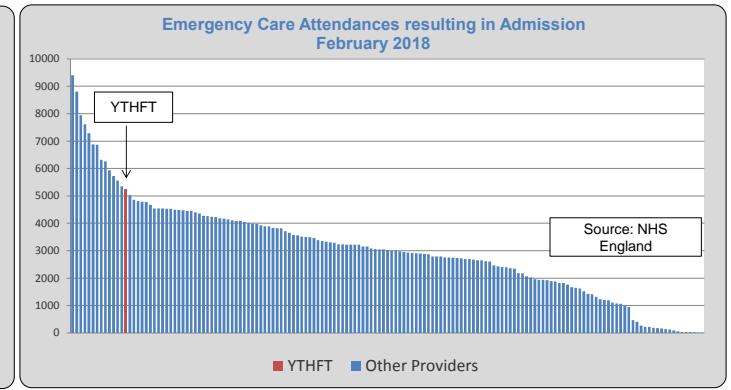
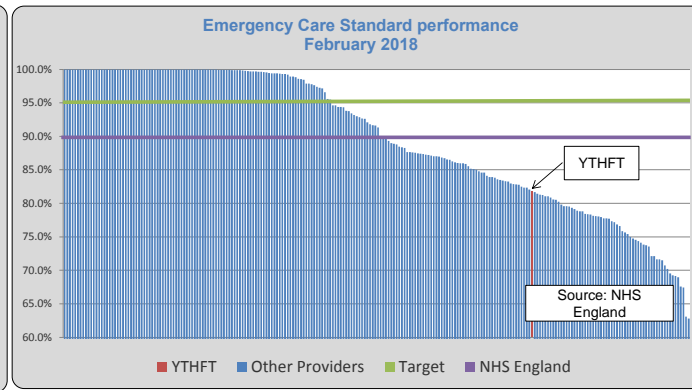
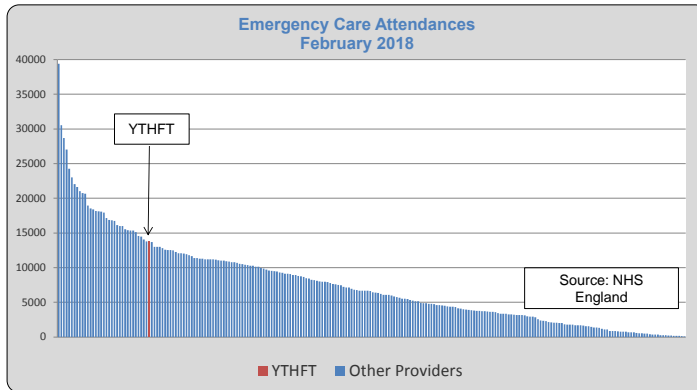
Sustainability and Transformation Fund Trajectory (STF) and Performance Recovery Trajectories

March 2018



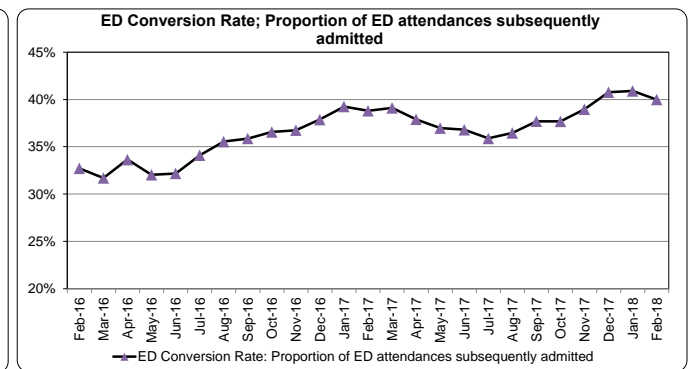
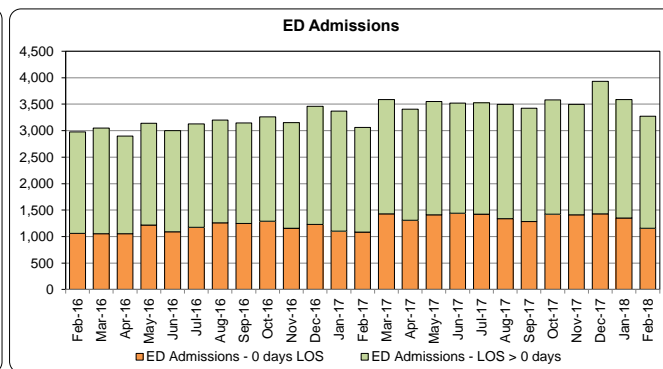
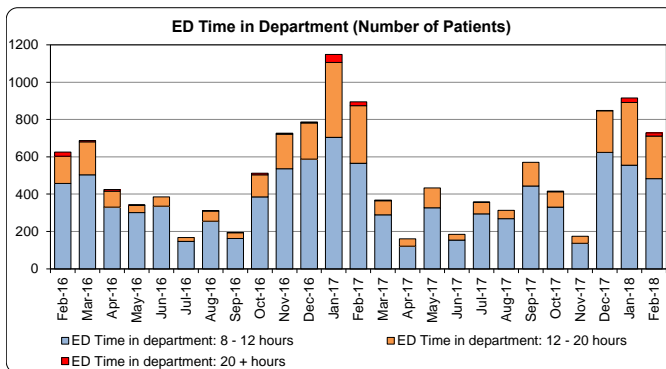
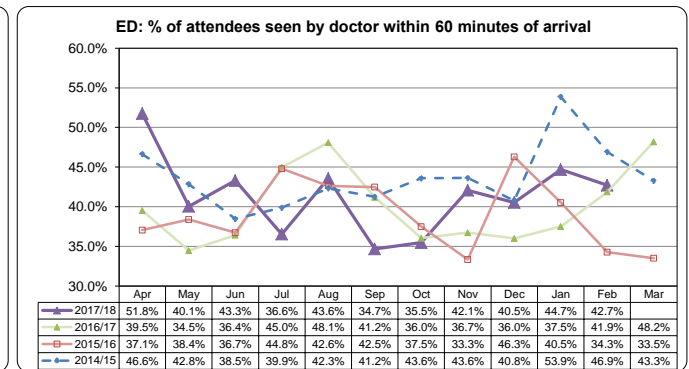
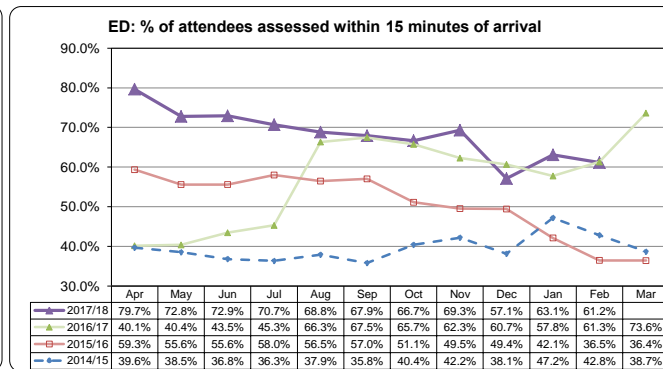
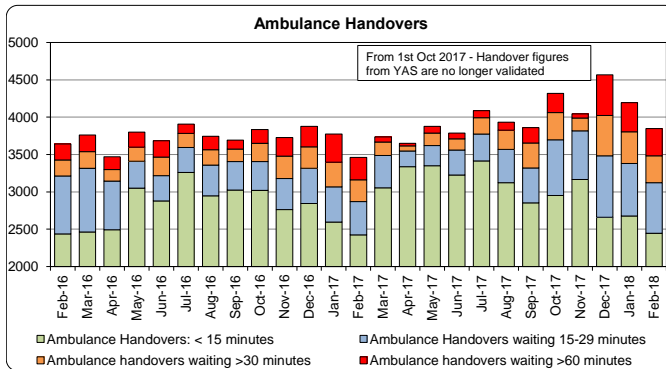
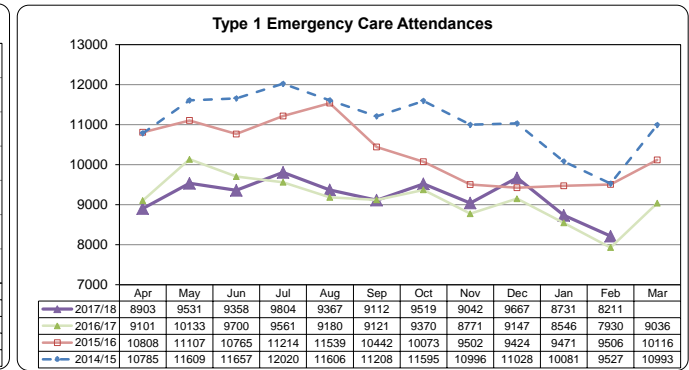
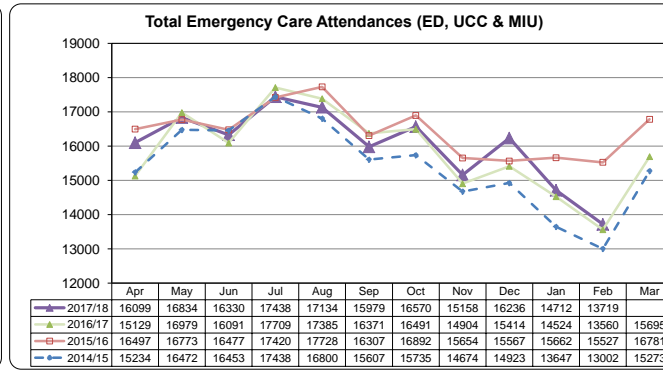
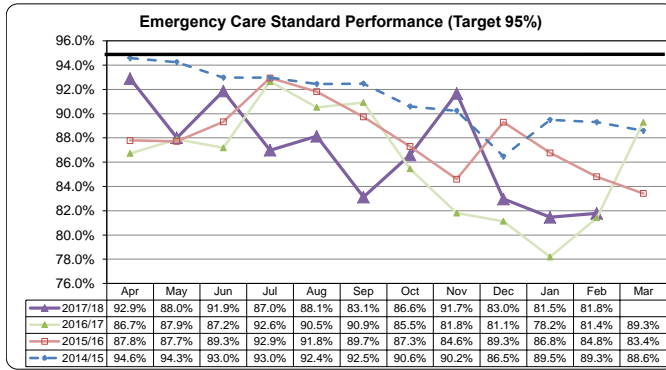
Performance Benchmarking

March 2018



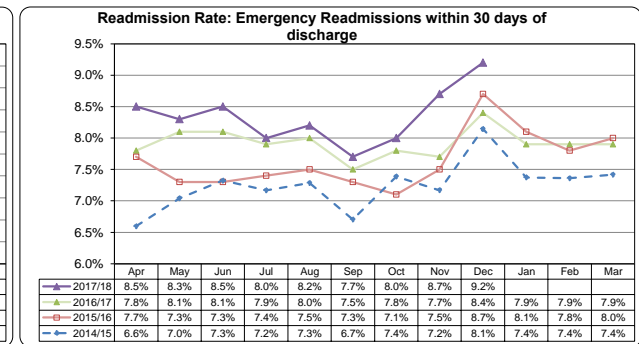
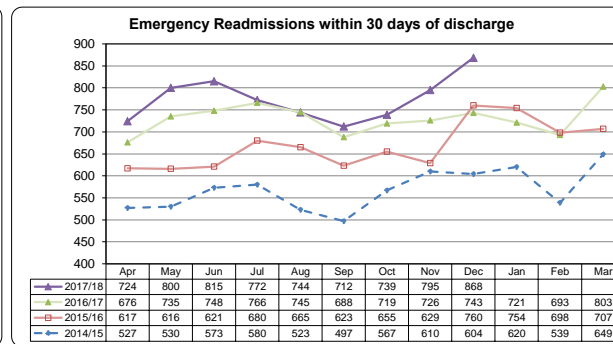
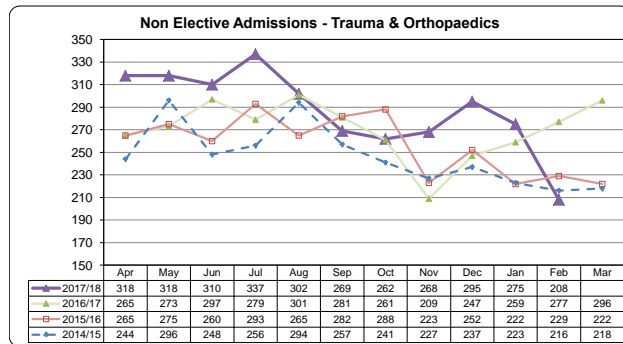
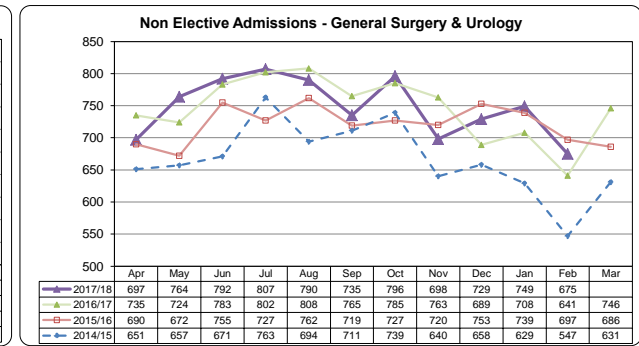
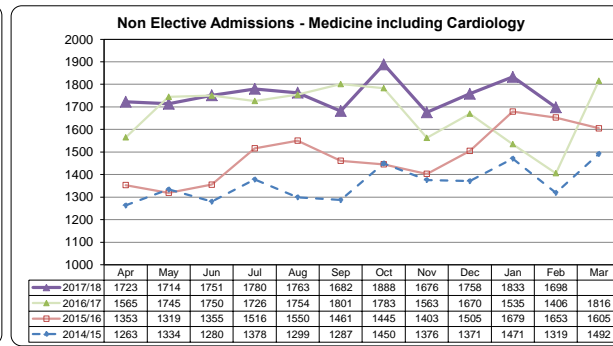
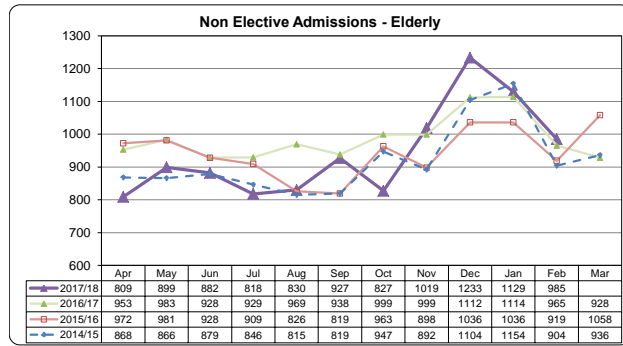
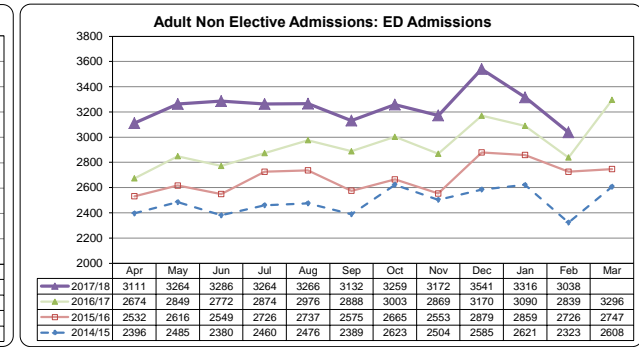
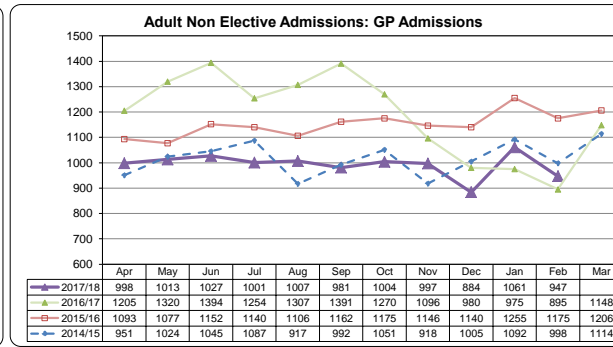
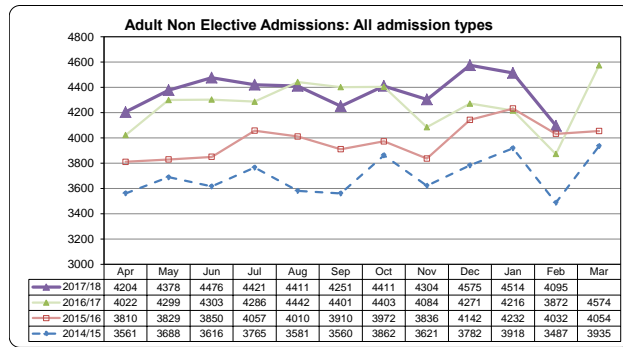
Trust Unplanned Care Emergency Care Standard

March 2018



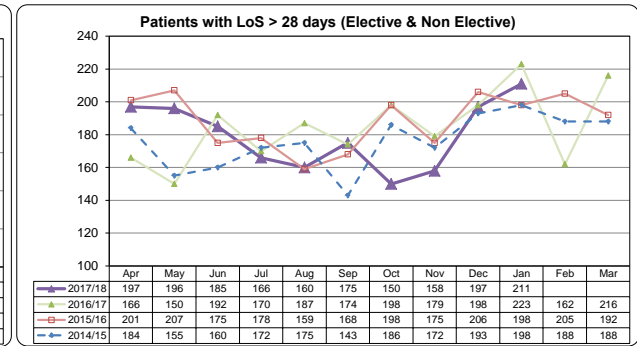
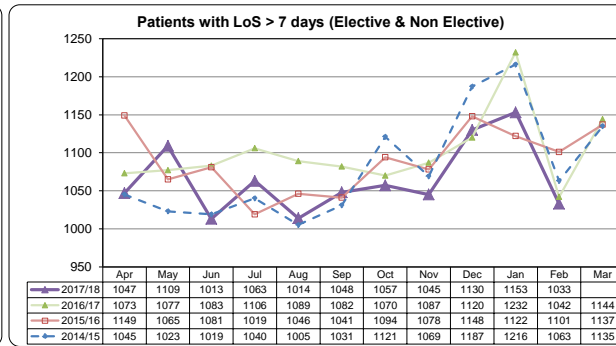
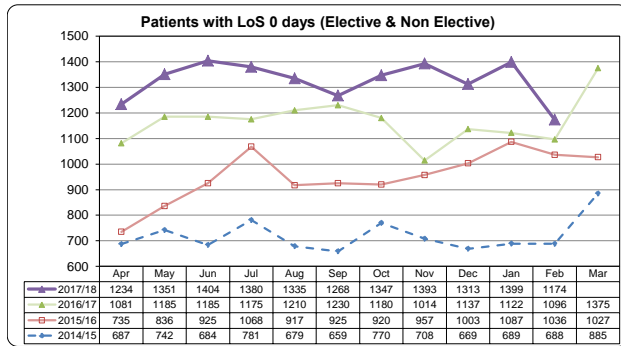
Trust Unplanned Care Adult Admissions

March 2018

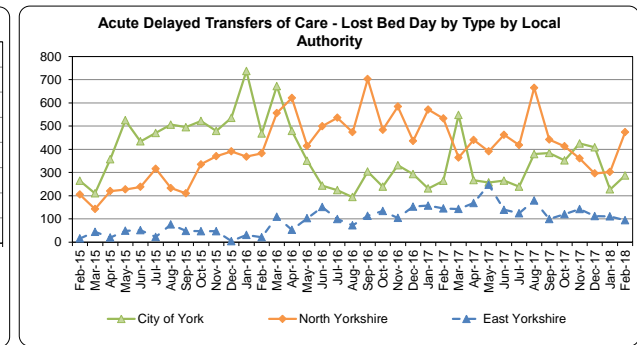
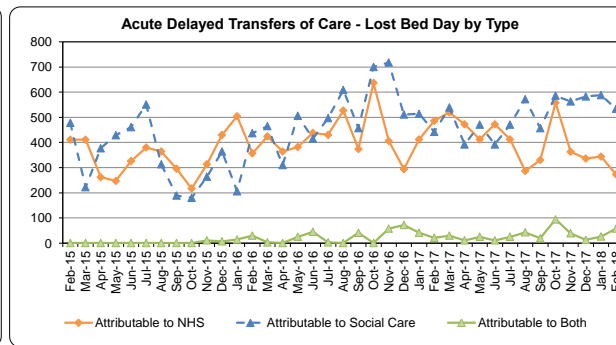
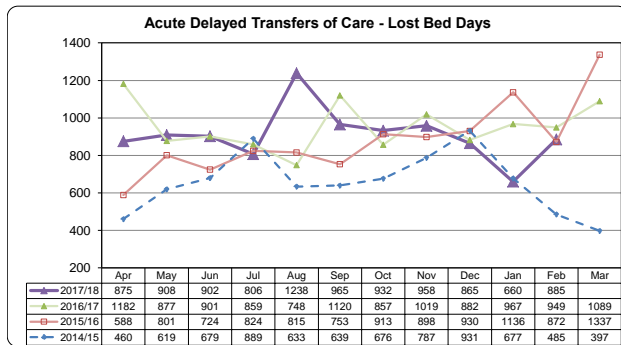
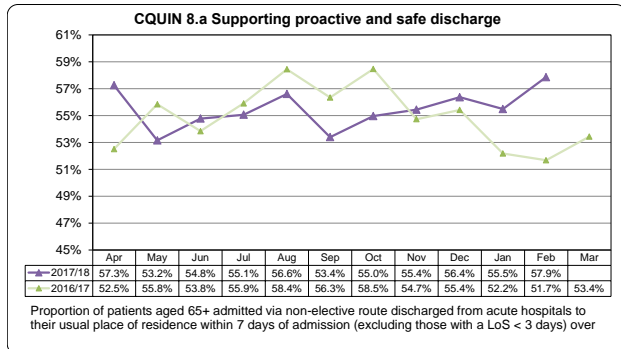


Trust Length of Stay & Delayed Transfers of Care (DTOC)

March 2018

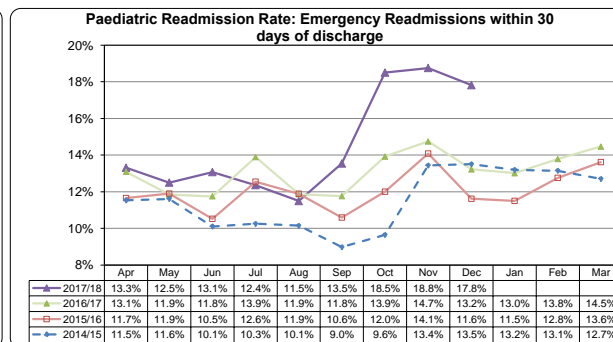
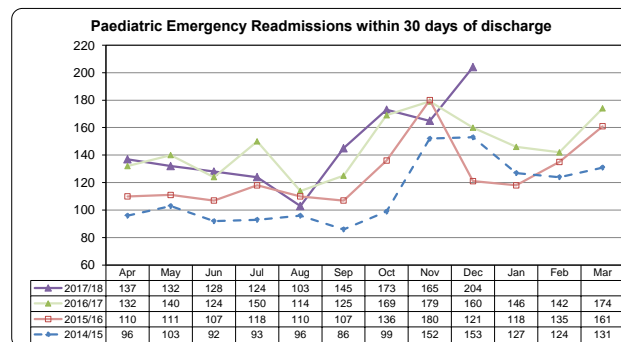
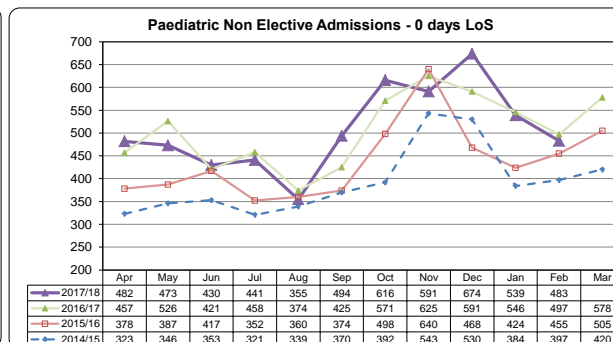
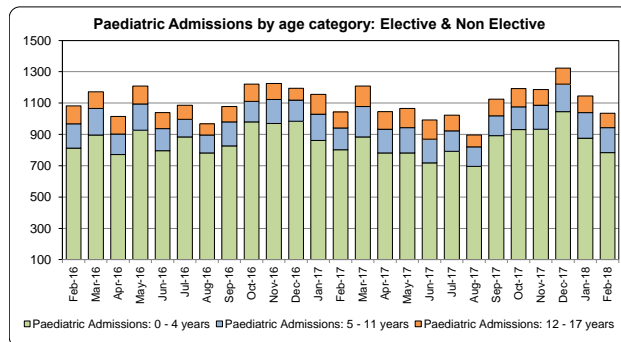
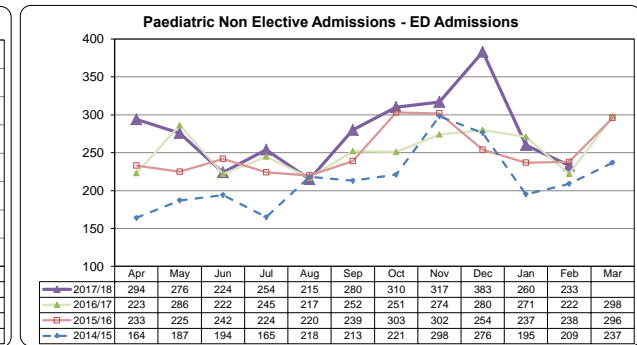
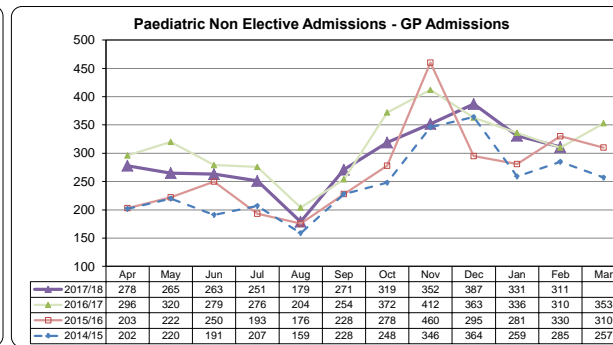
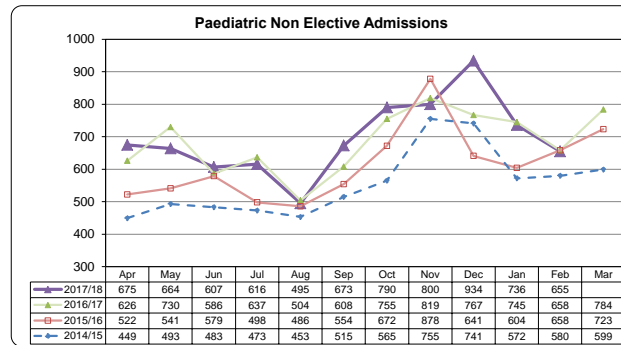


Updated one month in arrears



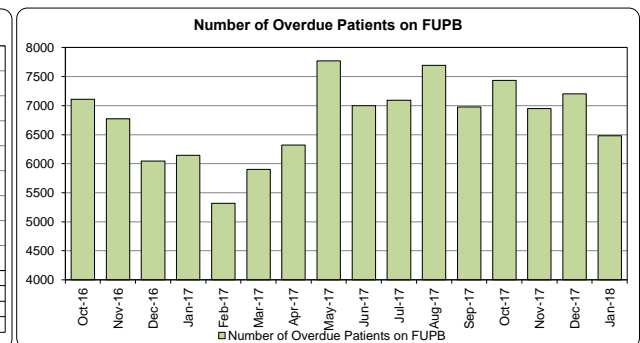
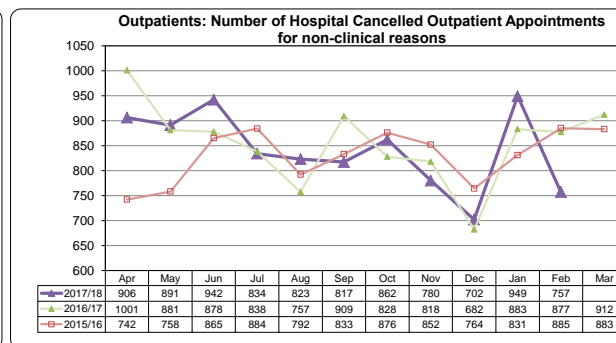
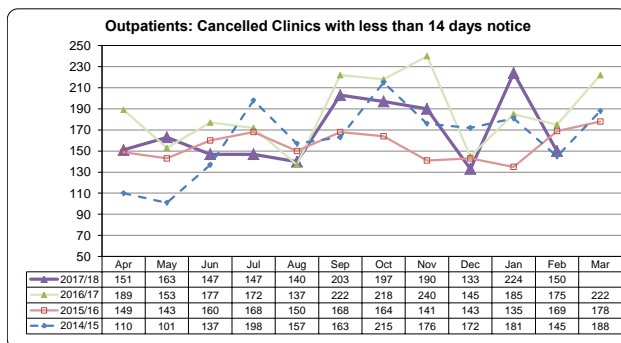
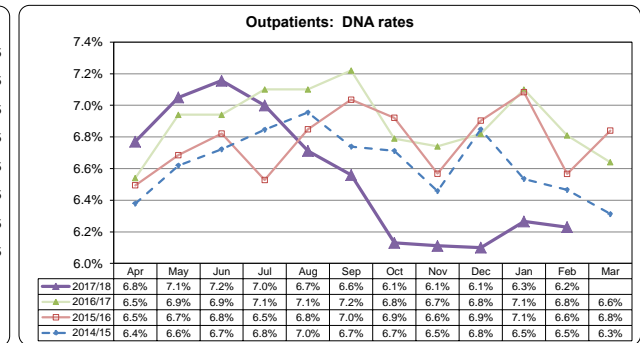
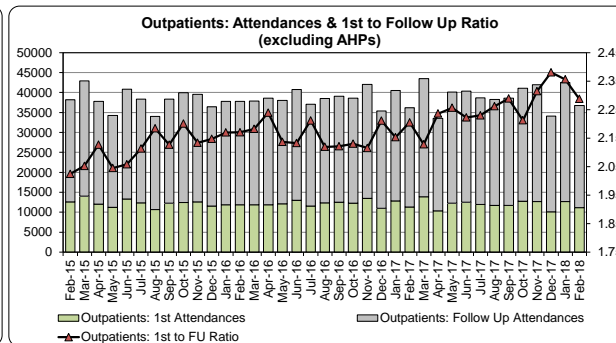
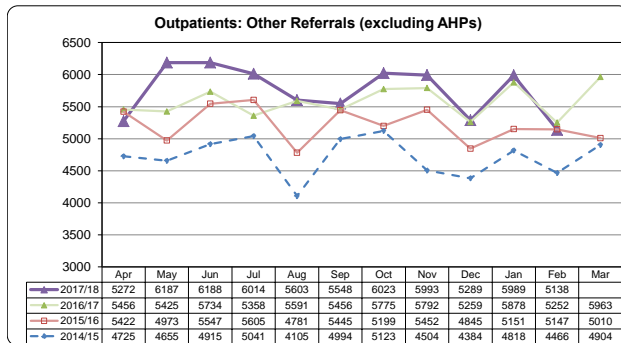
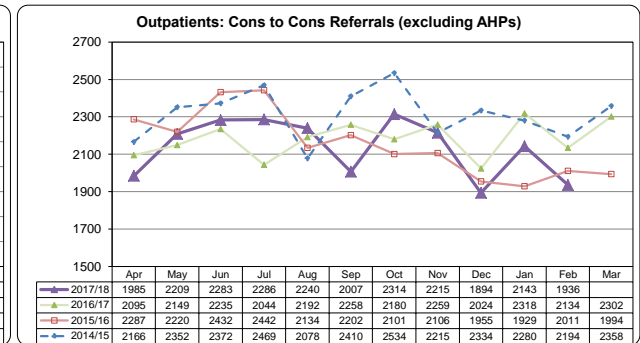
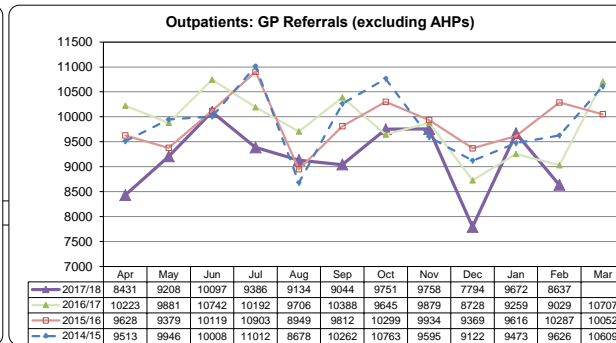
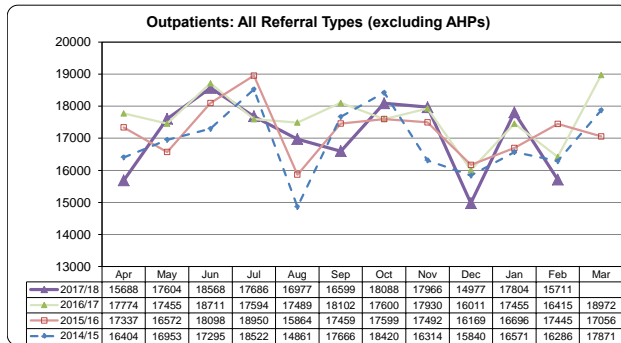
Paediatric Admissions

March 2018



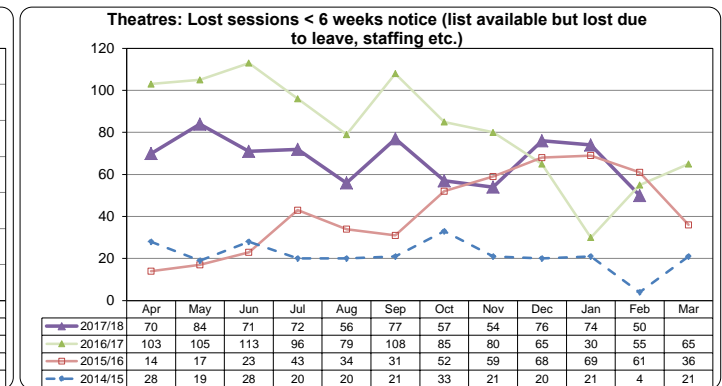
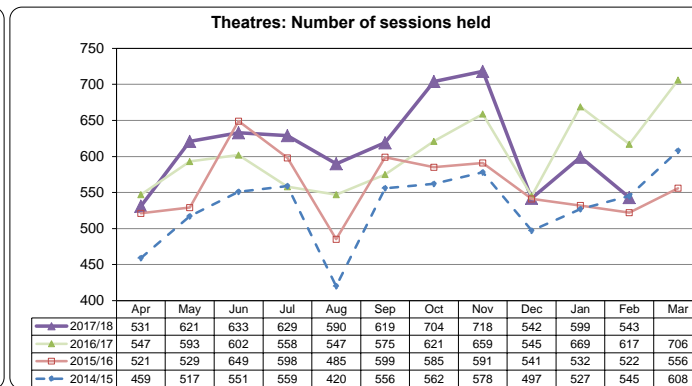
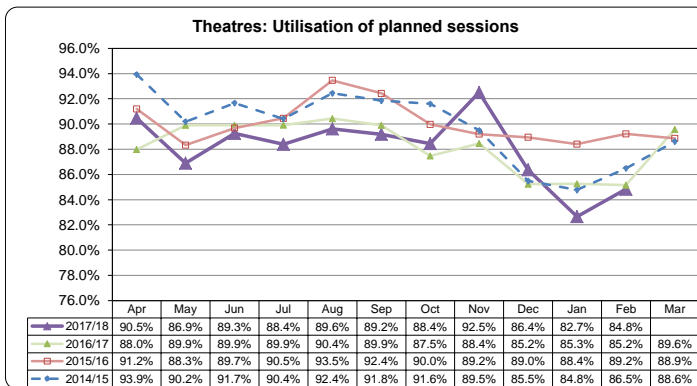
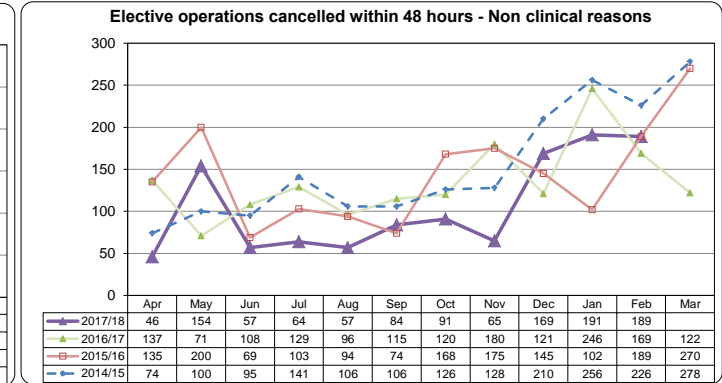
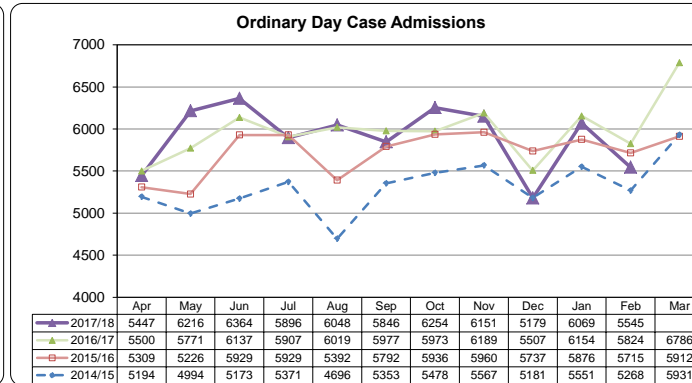
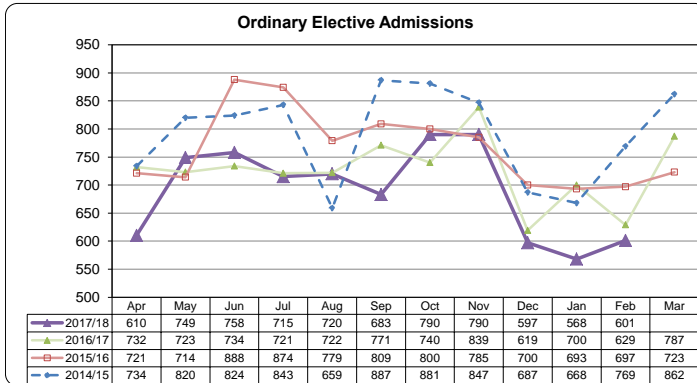
Trust Planned Care Outpatients

March 2018



Trust Planned Care Elective Activity & Theatre Utilisation

March 2018



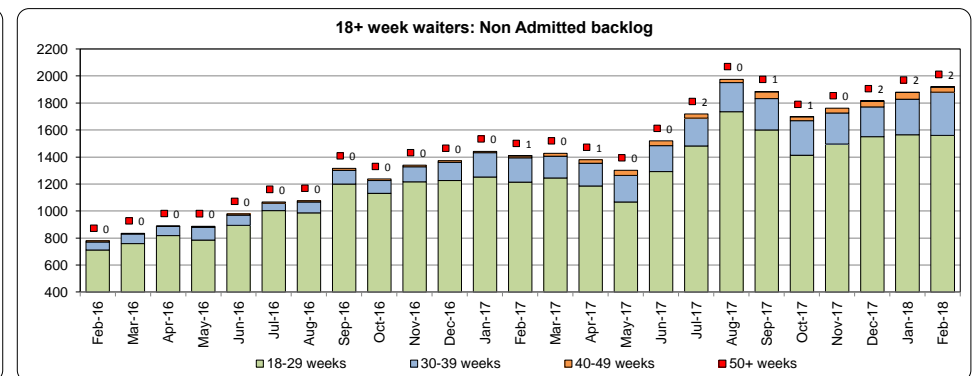
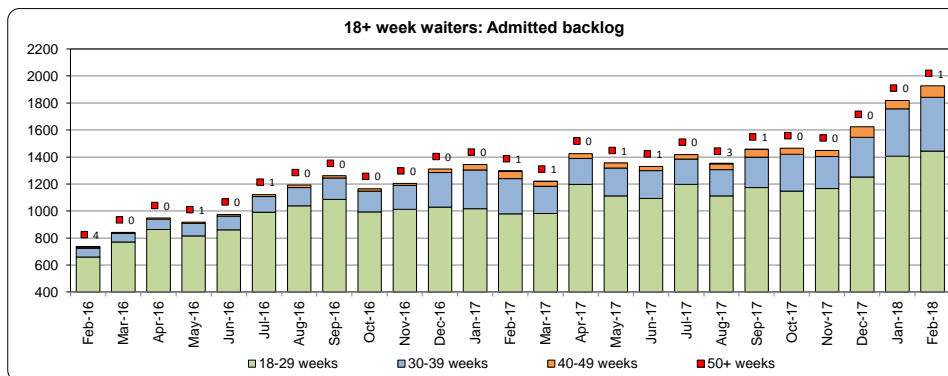
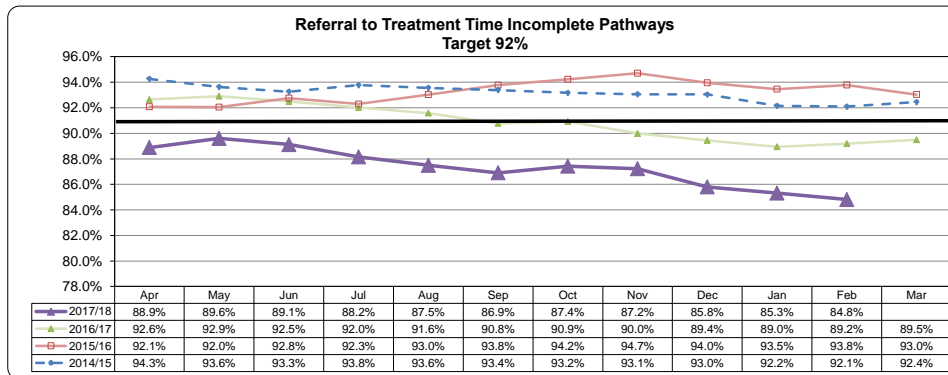
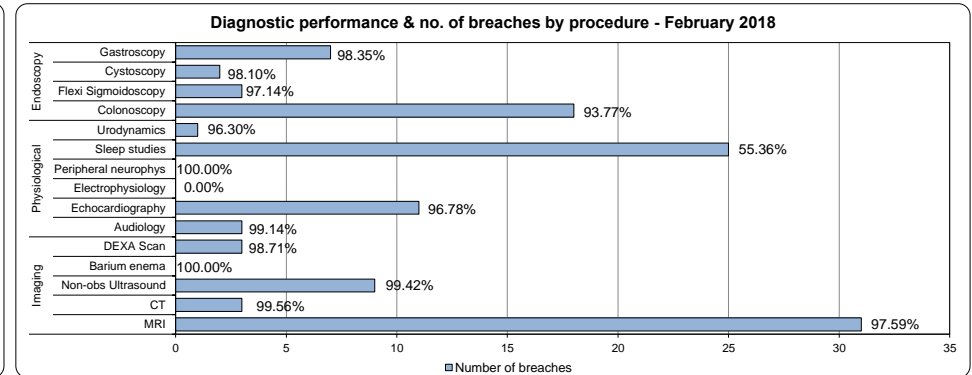
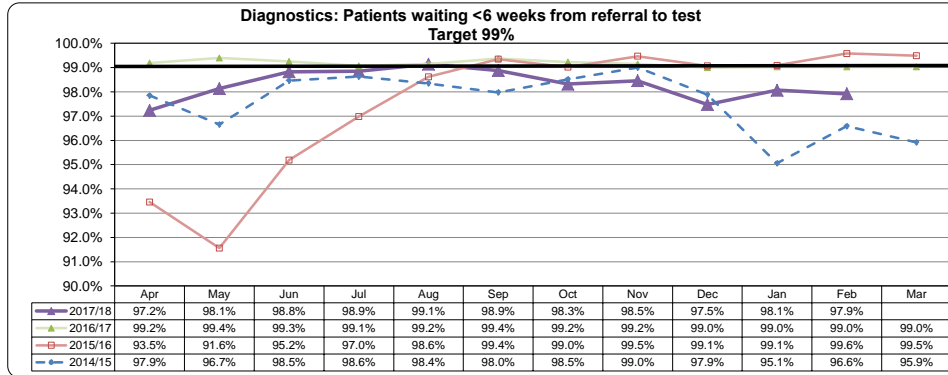
All cancellations are within 6 weeks of the planned procedure date. Cancellations exclude lists added in error and those that have been rescheduled.



Diagnostics & Referral To Treatment

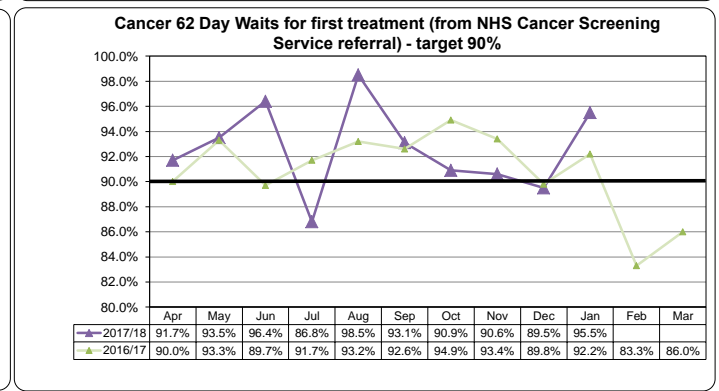
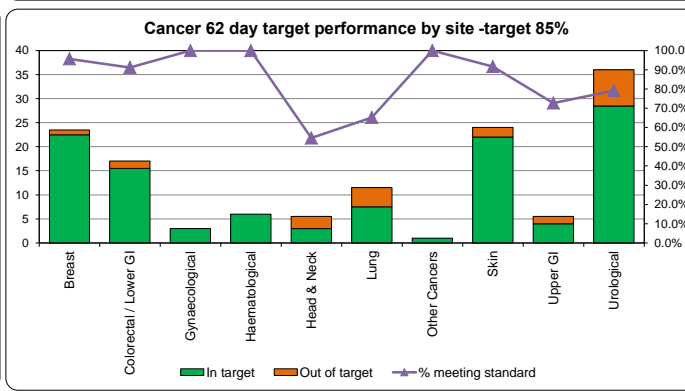
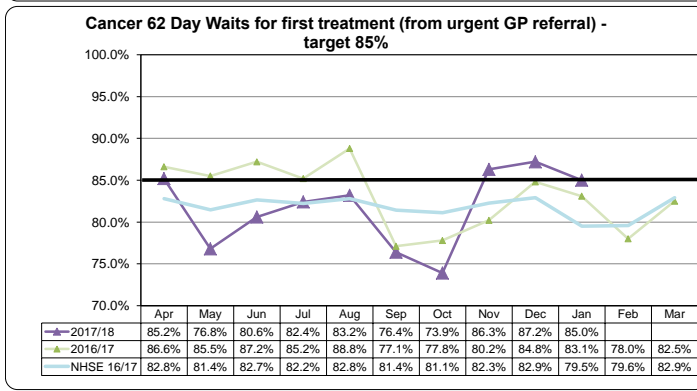
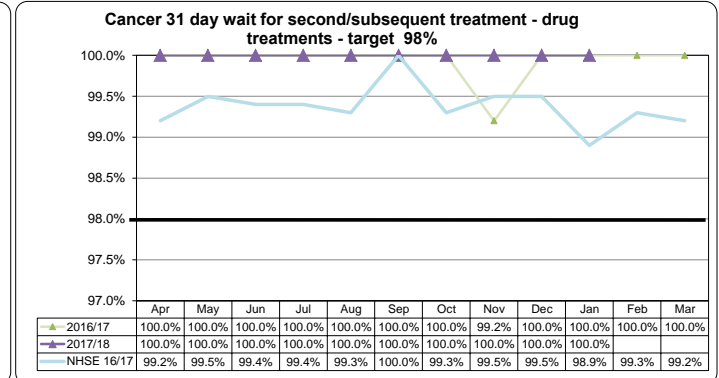
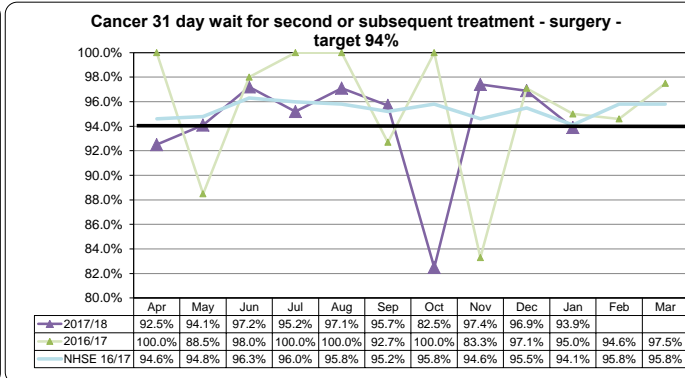
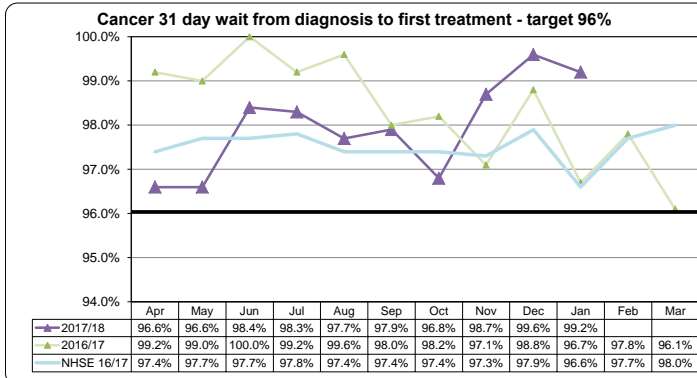
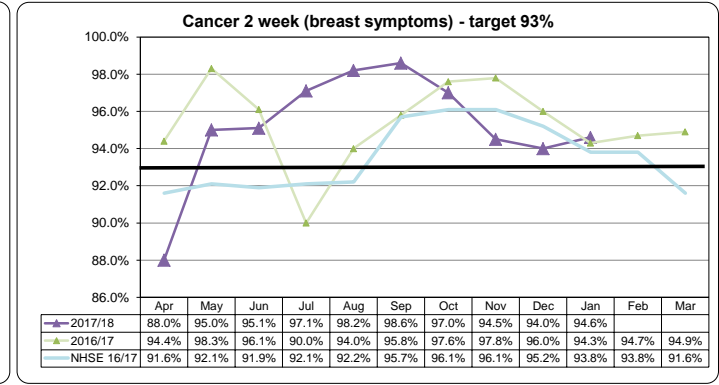
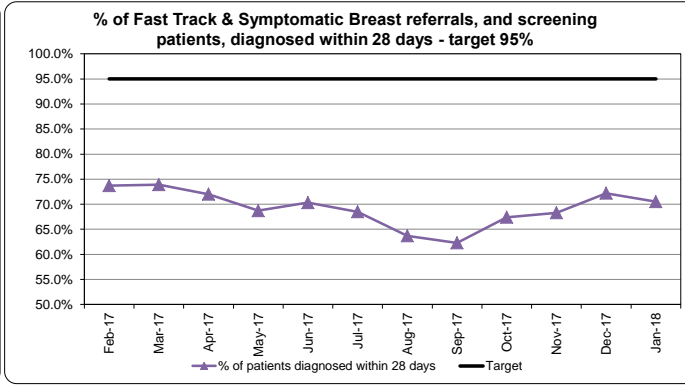
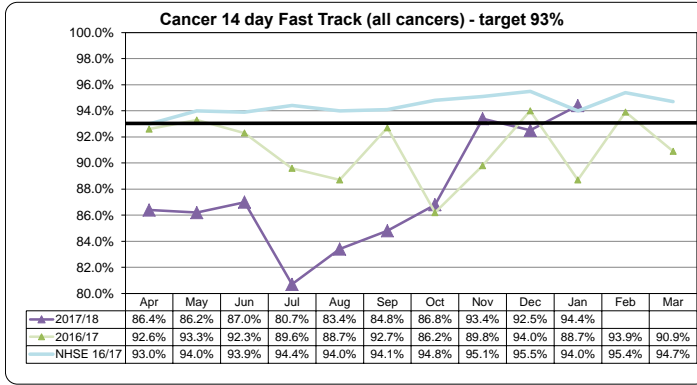
March 2018

The Trust is monitored at aggregate level against the Diagnostic & Referral to Treatment Incomplete Targets.



Trust Cancer

March 2018



Board of Directors – 28 March 2018 Environment & Estates Committee Minutes – 7 February 2018

Recommendation

- For information
- For discussion
- For assurance
- For approval
- A regulatory requirement

Current approval route of report

Board of Directors - 28 March 2018.

Purpose of report

The Board of Directors (BoD) is asked to receive the minutes of the Environment & Estates Committee meeting held on 7th February 2018 noting the assurance taken from these discussions and the key items discussed.

Key points for discussion / Decisions required

The BoD are specifically asked to note the work on the following items which are contained in the minutes:

Board Assurance Framework
Sustainable Development
Premises Assurance Model (PAM)
Risk Register
Capital

Trust Ambitions and Board Assurance Framework

(https://www.yorkhospitals.nhs.uk/about_us/our_values/)

The Board Assurance Framework is structured around the four ambitions of the Trust. How does the report relate to the following ambitions:

- Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.

- ☒ **Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.
- ☒ **People and Capability** - The quality of our services is wholly dependent on our teams of staff.
- ☒ **Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

Reference to CQC Regulations

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

Regulation 15: Premises and Equipment

Version number: 1

Author: Brian Golding, Director of Estates & Facilities

Executive sponsor: Michael Sweet, Non-Executive Director / Chair - EEC

Date: March 2018



Minutes - Environment & Estates Committee meeting – 7th February 2018

Attendance: Michael Sweet (MS) (Chair), Jennie Adams (JA), Brian Golding (BG), Andrew Bennett (AB), David Biggins (DB), Jane Money (JM), Colin Weatherill (CW), Lynda Provins (LP), Jacqueline Carter (JC) (Minutes)

In attendance: Sue Symington (Trust Chair), Margaret Jackson (Governor), Michael Reakes (Governor).

1. Apologies for absence

None.

2. Minutes of last meeting held on 6th December 2017

The minutes of the last meeting held on 6th December 2017 were agreed as a correct record subject to an alteration to the Board Assurance Framework minute:

Item 4.3 – it was noted that it would be helpful to have trend arrows on the BAF to identify improvement when interpreting the scoring.

Governance

3. EEC Protocol

The EEC received a paper which set out a process to follow for how the EEC will operate. Members were asked to note the contents.

4. Matters Arising and Action Log:

BAF documentation to be reviewed at the February BoD timeout - content will be refreshed following that session.

5. Policy & Procedure Schedule

The EEC reviewed the P&P schedule. There are currently 4 documents which are due for review; leads for those have been identified. BG assured the EEC the Trust was not at any time operating unsafely; this governance process was about having a standardised format in place across the Directorate.

6. Directorate Risk Register

The EEC received and reviewed the full Register. Highlights as follows:

1. "Review date" column to be updated. CW assured the EEC that whilst these dates required to be updated on the schedule, the RR continues to be subject to regular internal reviews.

2. EF01 - Red - Estates Capital - this item will continue to be a corporate risk. Following discussion the Trust chair asked that it be separated out into 2 risks to aid transparency, as the risk referred to is around 2 areas; essential maintenance and significant capital projects. This was agreed and would be raised with the Corporate Risk Committee. **Action: CW.**
3. EF02 - Red - Fire Alarm system upgrade - York and Scarborough sites - BG confirmed to the EEC it was essential that we have contracts let on both sites now to undertake the upgrade which was progressing on track. He anticipated as soon as this was operating he would be able to de-escalate this item on the RR.

7. E&F Management Structure

The Group received the latest Estates & Facilities Directorate management structure.

8. Internal Audit Reports

The following IA reports were noted as receiving high or significant assurance:

- Y1828 Lone Workers
- Y1811 Capital Planning
- Y1812 Capital Project appraisal & selection
- Y1838 Energy Management

9. Work Programme

The Group received the latest EEC Work Programme.

10. Board Assurance Framework (BAF)

In line with governance arrangements the EEC received the BAF schedule to assess the current RAG ratings applied. Following discussion at the last meeting all measures have been reviewed and scored. Highlights as follows:

1. Section 4.1 of the BAF - amber rating. MS queried the wording of 4.1. SR assured the EEC that this was quite deliberate to link the Trust to the wider community. The Trust can deliver health outcomes but cannot work in isolation.
2. Section 4.2 - amber rating. Although based on what evidence we have at present JA suggested this be subject to receiving the CQC report. It was agreed to include in the controls/assurance column a section on the CQC environment regulation in the future - to be considered at the next meeting. **Action: LP.**
3. Section 4.3 - green rating.
4. Section 4.4 - green rating. Concern was expressed that this rating might deteriorate as it has a link to our CRR score. It was noted the BAF document is being reviewed at the BoD Timeout when they will set their 5 year strategy and the purpose of this tool is to be able to highlight and provide assurance to the BoD.

For attention to the BoD.

Sustainability

11. Matters Arising and Action Log

Disposal of offensive waste

Last meeting action carried over to next meeting. **CW.**

12. SDMP update

JM provided an overview of current SD priorities as follows:

1. No formal SDG meetings have taken place recently however, JM has continued to work closely with the work stream leads to update their sections of the action plan and anticipated bringing a SDMP update report with updated scores to the next EEC meeting.
2. JM is continuing to work with WRM consultants on the 2nd phase of approved work on the sustainability engagement programme. A list of priorities to reduce carbon has been drawn up which has a cost benefit analysis linked to it; these are being put forward as part of the directorate CIP.
3. A question was raised regarding SD and its inclusion in the Trust staff induction and statutory and mandatory training programmes.
4. SR provided an update on the models of care section of the action plan. He felt the new SDAT was a better tool but felt he was starting the process again. He said there were a number of statements in that section that the Trust had to achieve compliance on, including new ones around nutrition/dietetics and food banks and because the scoring mechanism has changed we are expected to achieve a higher score than previously. A question for the Trust is how we define sustainability and the level of priority it is given in the organisation is something for this Committee to consider. In terms of the approved BoD SDMP and mission statement it is important that this picks up the link for the social and equality elements. BG thanked SR for this update and acknowledged the current statement/thinking on sustainability which clearly errs towards financial sustainability; also the Trust's current financial position would limit any SD plans we had. He suggested it was timely to refresh this documentation. SS suggested that this is brought to the BoD's attention at the Time Out.

13. NHS Sustainability Week 2018

The NHS sustainability week will be held 25th – 29th June and this will be used as platform to launch the WRM consultancy staff engagement work.

For attention to the BoD.

Capital and Property

14. Matters Arising and Action Log

Condition survey

The CPEG has agreed funding for the condition survey (plant and equipment) to take place. The Group recognised this work is important; and noted that it has been scaled back to a "condition b survey" only which will establish a baseline for a 25 year work plan.

At this point JA asked about the space assessment work being undertaken in the Trust. AB provided an update and confirmed that the Scarborough site has been completed.

15. Estates Strategy

AB is refreshing the Estates Strategy as the first version had been submitted to the BoD in 2016. The document should list any changes in general terms that have implications for developing the estate and includes properties that the Trust has sold or stopped leasing. The document needs to be linked to the Carter report information and more recently the DoH response to the Naylor report about managing disposals and that information needs to be reflected.

The current position is that we have looked at the condition of the estate; work is still on-going. The main body of the strategy refers to long term strategic themes including clinical strategies and those that link to funding from local authorities; decisions made about future of services will impact on this. A question was raised as to whether there would be anything site specific regarding the east coast surgical strategy. AB acknowledged the Trust needed to include this in its clinical strategy.

AB was intending to hold a time out in February to discuss future strategic plans. However, the Trust chair said the regulators will want to see a strategy feed into their STP process and the strategic direction will have to be set by April, and the broad direction of travel will have to be clear. This was noted.

16. Space Management Group - minutes of meeting held on 25/9/17

The EEC received the latest set of minutes for noting and comment. AB had provided a snapshot of highlights for the EEC at the beginning of the documentation.

JA had concerns around unmet accommodation needs/space requests where there was mention of older wards in Scarborough being used for non-clinical space as she felt this was at odds to the Carter recommendations and was conscious we needed to protect front line staff. This was noted.

Also, she suggested that for any change to a service area it was very important to have input from the affected service themselves and to consider frontline staff and patient involvement in any decision making. This was noted.

Health, Safety & Security

17. Matters Arising and Action Log

Datix

There had been a discrepancy in the reporting figures within the patient experience data in the Datix portal. It was agreed that JA would refer this to the Audit Committee. **Action: JA.**

HSE Sharps Surveillance Visit, 3/10/17

A meeting had been arranged for 6th March to progress this matter.

18. Fire Safety

CW provided a verbal update on current matters concerning fire safety in the Trust:

Fire alarms

See item 6. No significant concerns relating to fire safety.

The Trust reported 14 incidents of fire alarm activations / fire system management for this quarter reporting period.

Summary of the independent Review of Building Regulations and Fire Safety: Interim Report December 2017 (Grenfell Tower)

Impact on building regulations following Grenfell. The review to date has found that the current regulatory system for ensuring fire safety in high-rise and complex buildings is not fit for purpose. This applies throughout the life cycle of a building, both during construction and occupation, and is a problem connected both to the culture of the construction industry and the effectiveness of the regulators.

The report concludes that action for change is required relating to the fire safety industry and government oversight to ensure the necessary shift in culture. The report also states a summit will be called in early 2018 with key stakeholders to discuss taking this work forward. *(If required a copy of the report can be obtained from Colin Weatherill).*

19. Bi-monthly Report - Health, Safety & Security

The EEC received the latest report for health, safety and security performance in the Trust for comment. CW reported there were no significant concerns/trends to highlight to the EEC however, slips, trips and falls reporting figures had increased since the last quarter. He will monitor this closely but felt it linked to having better documentation and reporting processes in place in the Trust. Other highlights were provided in a snapshot at the beginning of the documentation.

The Trust chair noted there was little RIDDOR reporting in the document. CW explained there had been a legislation change in RIDDOR reportable requirements in recent years.

MS thanked CW for this update.

Finance and Efficiency

20. Matters Arising and Action Log

None.

21. Bio-monthly report - Carter Recommendations

The EEC received the latest update report. The Trust's current position against the Carter recommendations was set out at Appendix 1 of the documentation.

It was noted the Estates Strategy review and the condition survey work will provide the directorate with baseline assessment information from which to plan further estate optimisation including effective utilisation of space particularly in Bridlington.

It was confirmed that specific cost saving work streams have been developed and the Directorate will continue to identify and develop CIP plans and continue to work closely with NHSI.

22. Financial Recovery Plan

DB reiterated that cost saving work streams have been developed and he was due to meet with the Chief Executive where these would be interrogated further. The Trust Chair asked whether any of the plans had yielded benefit yet. DB confirmed that whilst some had there were still a number outstanding.

Operations

23. Matters Arising and Action Log

None.

24. Premises Assurance Group – minutes of meeting held on 17/11/17

The EEC received the latest set of minutes for noting and comment. Those items for escalation to the EEC were highlighted in the minutes.

JA queried the removal of water fountains in the Trust. It was agreed to report back on this at the next meeting. **Action: DB.**

25. Bi-monthly report – PAM

The EEC received the latest update report for noting and comment. DB confirmed this was the final report prior to submitting the required annual return to the DoH. He acknowledged that gaps associated with the PAM assessments still exist; the position against the model has slightly decreased in the last 8 weeks but our compliance position compared to 12 months ago is favourable.

He was currently focusing his work around the patient and public engagement agenda particularly on the Scarborough and Bridlington sites and he will also be urging those operational meeting groups that feed into PAM to ensure they review the Departmental RR at each of their meetings.

He provided a brief update on PLACE work and the pilot assessment undertaken at Bridlington using the TAPE documentation as an additional means to measure progress against PLACE. He confirmed he had also been undertaking some engagement work with assessors and governors to explain the rationale behind the latest results reported here last year in readiness for this year's PLACE programme.

MS thanked DB for these updates.

For attention of the BoD.

Out of Hospital Care

26. Matters Arising and Action Log

None.

27. Quarterly Report

The EEC considered the latest quarterly report which provided an overview of the activities within the Out of Hospital Care directorate. It was noted this report is sent to all BoD sub committees.

Mobile Working

A pilot is being undertaken in partnership with S&NS to pilot mobile working for community staff. The pilot aims to support teams to improve the efficiency of community based services and develop insight into the benefits of mobile working. SR explained that from an access and space point of view it links to sustainability and time. The next steps would be the development of a full Business Case to fully roll out the mobile working to community staff.

CW asked whether health & safety aspects had been considered in the pilot work. SR explained there had been some challenges around how users use the mobile technology. It was felt it was very much a personal judgement and JA was mindful of the staff culture change involved and staff having the confidence in using new devices. This was noted.

MS thanked SR for this update.

28. Any Other Business

MS asked for an update to be provided to the EEC on the directorate sickness absence rates to be provided for the next meeting.

29. Time and Date of Next Meeting

Wednesday 11th April 2018 @ 10.30am. Scarborough Hospital.

Blank page

Board of Directors – 28 March 2018 Workforce Report – March 2018

Recommendation

For information	<input checked="" type="checkbox"/>
For discussion	<input checked="" type="checkbox"/>
For assurance	<input type="checkbox"/>
For approval	<input type="checkbox"/>
A regulatory requirement	<input type="checkbox"/>

Current approval route of report

No approval route prior to Board; the report is shared with the Workforce and Organisational Development Committee for information.

Purpose of report

This report provides an overview of work being undertaken to address workforce challenges, and key workforce metrics (data up to February 2018).

Key points for discussion

- The monthly sickness absence rate in January was 5.61%, an increase from 5.12% from the previous month and significantly higher than in the same month of the previous year;
- The monthly absence rates have shown a sharp increase since September in line with seasonal sickness absence rates;
- A summary of the Trust's Gender Pay Gap Report for 2016/17 is provided and highlights the impact that the concentration of males in the medical and dental workforce has on the organisation's overall average pay gap.
- The results of the 2017 Staff Survey were released on 6 March 2018 and an overview of the initial analysis is provided.
- The Trust achieved a final flu vaccination uptake of 74.5% of frontline staff thus successfully achieving the final flu CQUIN target.

Trust Ambitions and Board Assurance Framework

(https://www.yorkhospitals.nhs.uk/about_us/our_values/)

The Board Assurance Framework is structured around the four ambitions of the Trust. How does the report relate to the following ambitions:

- Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.
- Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.
- People and Capability** - The quality of our services is wholly dependent on our teams of staff.
- Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

Reference to CQC Regulations

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

Version number: 1

Author: Polly McMeekin, Deputy Director of Workforce

Executive sponsor: Patrick Crowley, Chief Executive

Date: March 2018



1. Introduction and Background

March’s Workforce Report details a number of key workforce metrics, with commentary around: the Trust’s current sickness absence levels and the current levels of temporary medical and nurse staffing utilisation within the Trust. The report also provides an update on a number of campaigns including the flu vaccination, 2017 Staff Survey, Doctors in Training (DiT) Streamlining programme and the latest Nurse Recruitment Event. The report also provides an overview of the Trust’s Gender Pay Gap position for 2017.

2. Detail of Report and Assurance

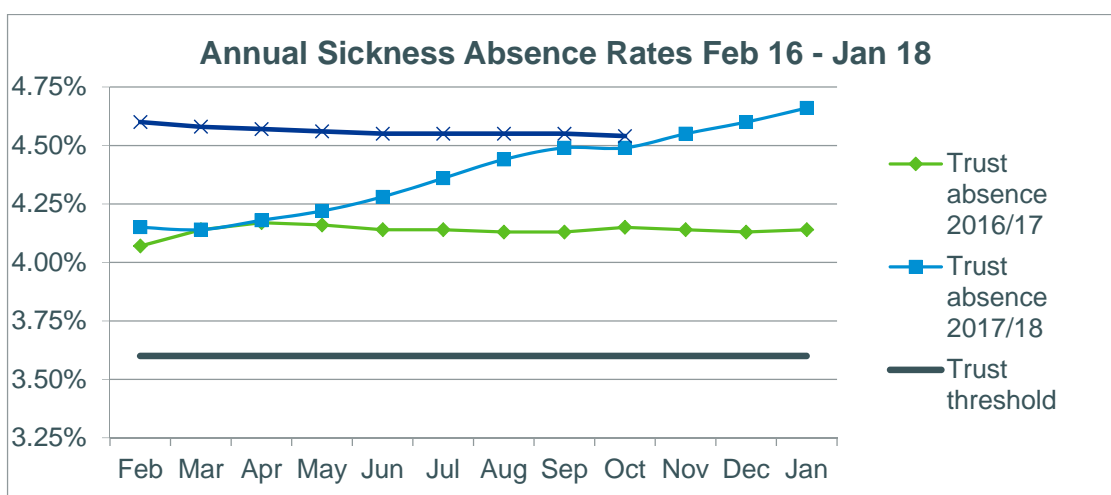
The work referred to in the report forms part of regular discussions around workforce, including at Staff Side and Workforce and Organisational Development Committees. It is informed by a number of key performance indicators which underpin directorate-level workforce plans, and link to the Trust’s overall Workforce Strategy.

2.1 Sickness Absence

Graph 1 compares the rolling 12 month absence rates to the Trust’s locally agreed threshold and to the regional (Yorkshire and Humber) sickness absence rates. In January 2018 the Trust’s cumulative annual absence rate was 4.66%. The Trust’s annual absence rate has increased month on month since March.

Based on data available up to October 2017, the gap between the Trust’s rate and the regional average has been narrowing since the start of the 2017/18 financial year. In the year to October 2017 the regional annual absence rate has showed a small level of reduction to 4.54%.

Graph 1 – Annual Sickness Absence Rates



Source: Electronic Staff Record and NHS Digital

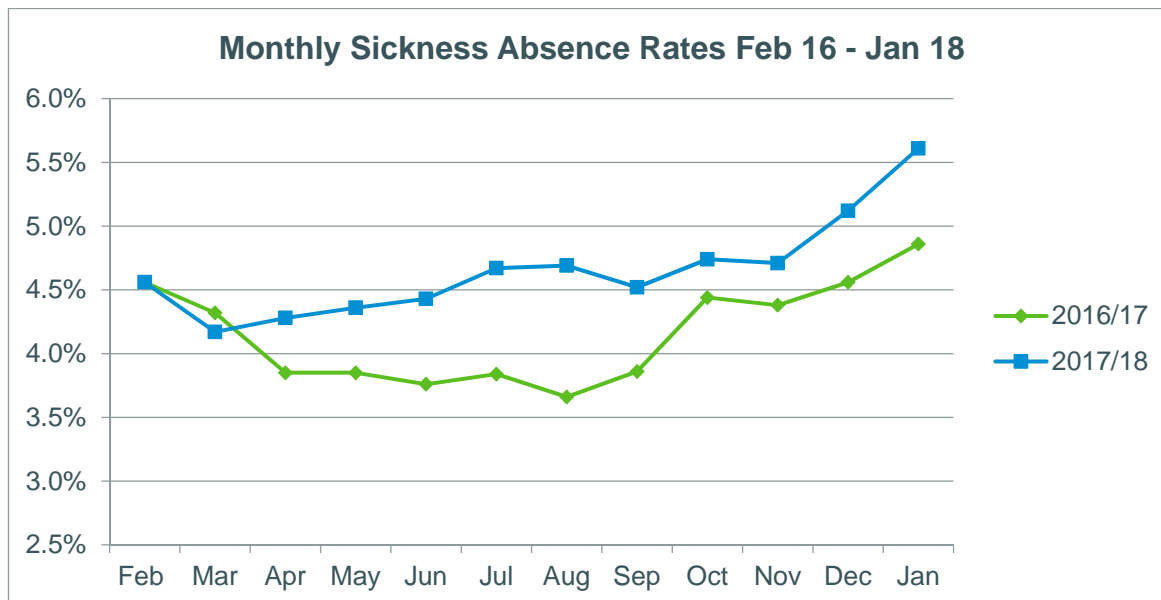
Graph 2 shows the monthly absence rates for the period from February 2016 to January 2018. The monthly absence rate of 5.61% in January 2018 was an increase from the previous month’s sickness absence rate of 5.12% and considerably higher than the sickness absence rate in the same month of the previous year (the absence rate in January 2017 was 4.86%). Sickness absence since April 2017 has been significantly

To be a valued and trusted partner within our care system delivering safe effective care to the population we serve.



higher than in the corresponding months in 2016/17 (which is also indicated in the increase in the cumulative annual absence figure over the same period).

Graph 2 – Monthly Sickness Absence Rates



Source: Electronic Staff Record

Sickness Absence Reasons

The top three reasons for sickness absence in the year ending January 2018 based on both days lost (as FTE) and numbers of episodes are shown in table 1 below:

Table 1 – Sickness Absence Reasons for January 2018

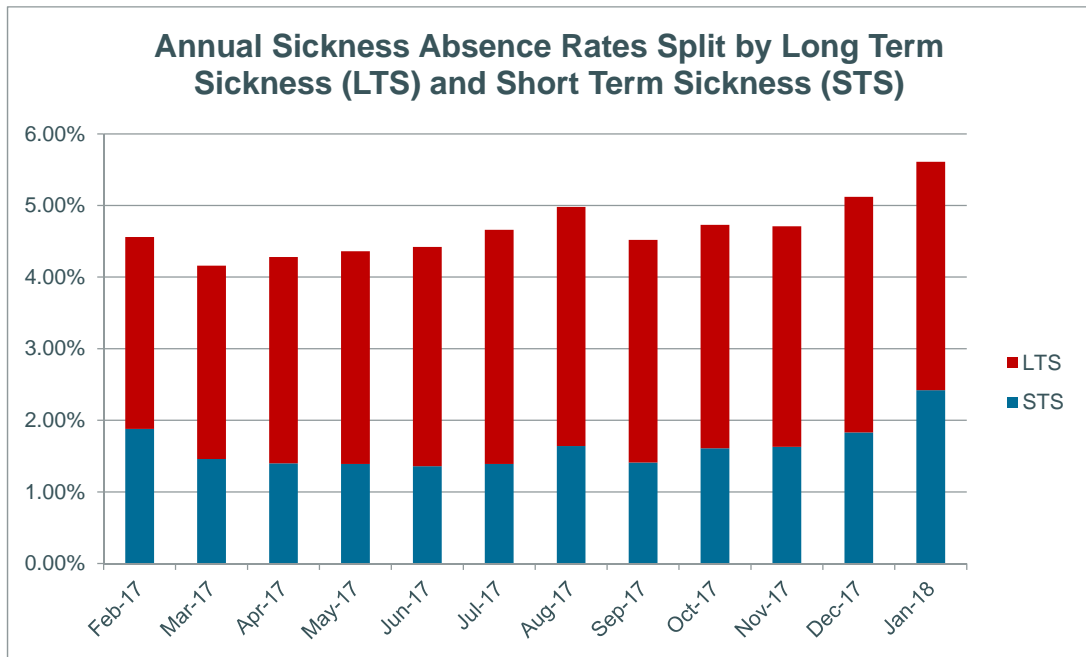
Top three reasons (days/FTE lost)	Top three reasons (episodes of absence)
Anxiety/stress/depression – 23.85% of all absence days lost	Gastrointestinal – 18.45% of all absence episodes
MSK problems, inc. Back problems – 16.79% of all absence days lost	Cold, cough, flu – 18.02% of all absence episodes
Gastrointestinal – 8.85% of all absence days lost	MSK problems, inc. back problems – 10.99% of all absence episodes

Whilst the sickness reason of Anxiety / Stress / Depression remains the top sickness reason based on FTE days lost followed by MSK problems, there was a significant increase in January in episodes due to seasonal sickness reasons. In particular sickness absence due to Cold, Coughs and Influenza has been increasing month on month since September 2017 (from 189 episodes in September 2017 to 759 episodes in January 2018). In terms of FTE Days lost, this has increased from 458.84 FTE Days lost in September 2017 to 2,779.04 FTE days in January – a near-fivefold increase.

The increase in seasonal sickness is consequently also reflected in an increase in short term sickness absence cases (as per Graph 3 below). Short term sickness absence cases increased from 1.83% in December to 2.42% in January 2018. There was no significant increase in long term sickness absence cases.



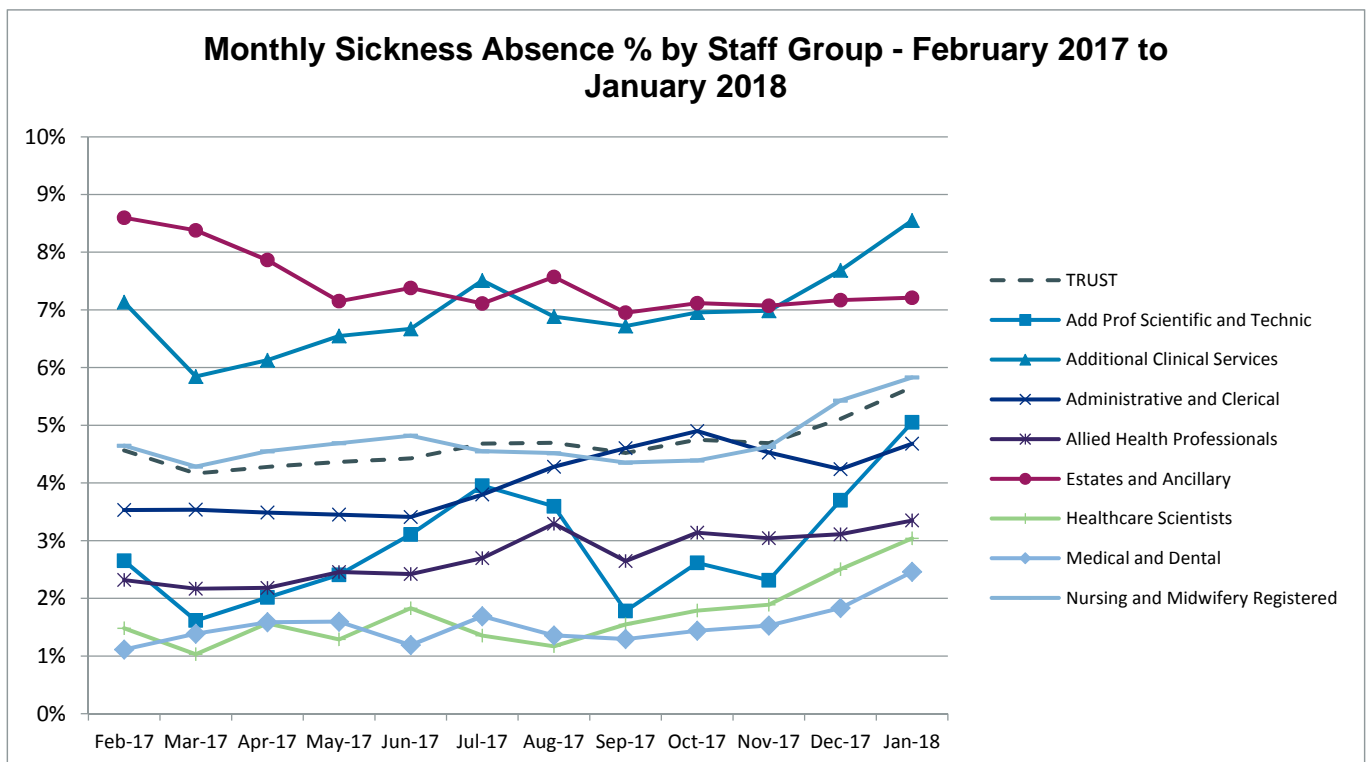
Graph 3 – Annual Sickness Absence by Long Term Sickness (LTS) and Short Term Sickness Cases (STS)



Source: Electronic Staff Record

By directorate, Estates & Facilities has the highest annual sickness absence rate in the year to January 2018 (Graph 5). By staff group, Additional Clinical Services and Estates and Ancillary, continue to have the highest sickness absence rates (as per Graph 4).

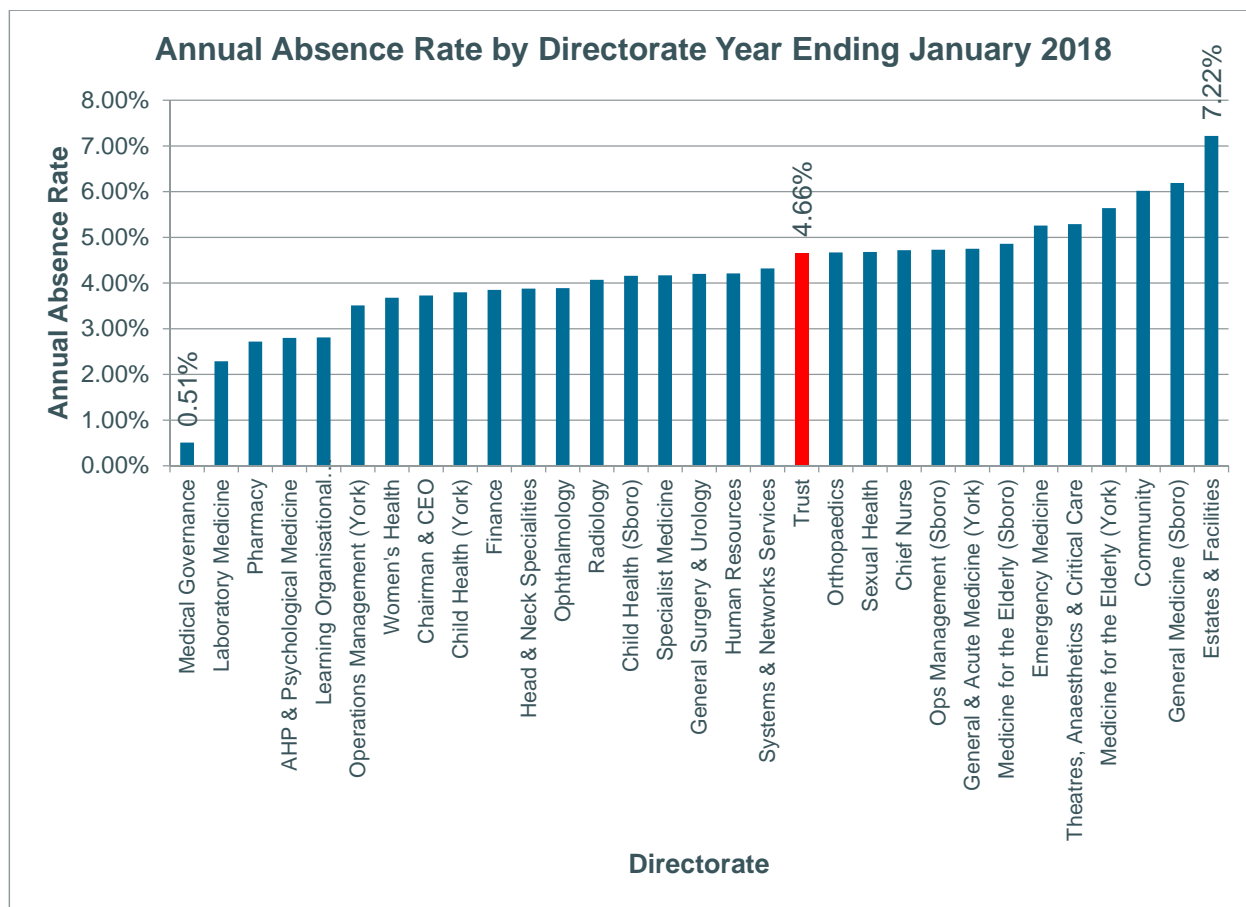
Graph 4 – Month Sickness Absence % by Staff Group



Source: Electronic Staff Record



Graph 5 – Annual Sickness Absence by Directorate



2.2 Flu CQUIN

Following an extensive campaign since the beginning of October 2017, the Trust reported on 28 February 2018 a final flu vaccination uptake of 74.5% of frontline staff. The Trust was therefore successful in maintaining the required 70% vaccination rate to achieve the full 'Flu CQUIN target.

2.3 Gender Pay Gap Reporting

Employers in Great Britain with more than 250 staff are required by law to publish information about their gender pay gap annually, covering the following:

- Gender pay gap (mean and median averages)
- Gender bonus gap (mean and median averages)
- Proportion of men and women receiving bonuses
- Proportion of men and women in each quartile of the organisation's pay structure

The gender pay gap deals with the difference between the average earnings of all women in an organisation compared to the average earnings of all the men; not issues of men and women being paid differently for the *same or comparable work* (this would be equal pay, not gender pay).



The Trust, like a number of other NHS organisations in the Yorkshire and Humber region, published its gender pay gap information on 8 March 2018 to coincide with International Women’s Day. The data provided a snapshot of pay within the organisation on 31 March 2017, when the Trust’s gender profile was 79% women and 21% men.

Within the Trust, the concentration of Medical and Dental staff in the upper pay quartile had a large impact on its gender pay gap. The gender profile for Medical and Dental Consultants was 29% women and 71% men. The average number of years’ service for male Consultants was higher than for women, impacting salary values. To demonstrate the effect on the Trust’s data, figures are also provided which exclude Medical and Dental staff from the calculations.

Table 2 - Proportion of men and women in each quartile of the organisation’s pay structure on 31 March 2017 (NB. Staff in the Upper Quartile were those with the highest hourly rates of ‘ordinary pay’, while the Lower Quartile was made up of staff with the lowest rates):

Quartile	All Trust Staff		Excluding Medical & Dental Staff	
	Male	Female	Male	Female
Upper	31.8%	68.2%	14.6%	85.4%
Upper Middle	14.2%	85.8%	14.3%	85.7%
Lower Middle	17.8%	82.2%	17.8%	82.2%
Lower	20.4%	79.6%	20.9%	79.1%

- The Trust’s mean gender pay gap was 28.7% weighted towards men. Taking the mean average, men in the organization earned £5.65 per hour more than women.
- The median gender pay gap was 9.51% weighted towards men. Taking the median average; men in the organization earned £1.32 per hour more than women.
- When Medical and Dental staff were removed from the analysis, there was a 0.02% mean gender pay weighting towards women, with women earning £0.24 per hour more than men.
- Similarly, taking the median data for non-medical staff, the weighting towards women was 0.10%, equating to women in the Trust earning £1.13 per hour more than men.

Bonus payments were made to 206 staff in the Medical and Dental group (for Clinical Excellence Awards). As a result:

- Proportionately, more men received bonuses than women (159 out of 1,977 male employees [8.04%], compared to 47 out of 7,418 female employees [0.63%]).
- The mean gender bonus pay gap was 39.59% weighted towards men. Taking the mean average, men in the organization received £4,214.61 more than women in bonuses.
- The median gender bonus pay gap was 33.33% weighted towards men. Taking the median average, men in the organization received £2,983.55 more than women in bonuses.

To be a valued and trusted partner within our care system delivering safe effective care to the population we serve.



- It is worth noting that the number of men as a proportion of the 206 Consultants who received a bonus was 77%. Comparing this figure with the gender profile of the Consultant workforce arguably provides a clearer indication of the level of 'bonus pay gap' than the overall workforce figure (which has to be reported).

The Trust has shared this information with Staff Side and is keen to create discussion around the figures. To an extent, there is a reliance on the wider system (e.g. for training doctors) to help reduce the gap; but reinforcing a culture which is positive about flexible and part-time working within the organization would also be an area which could support a long-term reduction.

2.4 Staff Survey 2017

The results of the 2017 Staff Survey were released on 6 March 2018, and are available to the public via the Survey Coordination Centre Web Site. As in the previous year's staff survey, the survey questions were used to calculate 32 Key Findings structured around nine themes including appraisal & support for development, equality & diversity, errors & incidents, health and wellbeing, working patterns, job satisfaction, managers, patient care & experience and violence, harassment & bullying. The Trust's scores have been benchmarked against 43 other Combined Acute and Community Trusts, and the Trust's scores from the last three surveys to provide a picture of staff engagement.

The Trust's scores in 2017 do appear to reflect some of the financial and operational challenges it has faced during the previous 12-months. 10 of the 32 scores from the Survey showed deterioration from 2016, while the overall staff engagement score (calculated from three findings related to job satisfaction) is also down from the previous year. At the same time, the Trust recorded more below average scores than in 2016. Overall, 14 of 32 findings were below average when compared with the benchmark group; 13 were average; and five were above average.

Initial analysis has shown:

- The proportion of respondents who experienced violence, bullying and harassment was similar to the number in 2016. The Trust has taken a number of actions over the previous 12-months aimed at reducing these occurrences, and 51% of respondents said that the role of the Freedom to Speak Up Guardian made them feel more confident about reporting any concerns;
- The relative rating for the fairness and effectiveness of the Trust's error and incident reporting procedures is one of its weakest findings for a second consecutive year. Moreover, the Trust approach to handling errors and incidents stands out as an area which requires further work, with three of the four key findings grouped around this theme scoring below the averages for Acute and Community Trusts. A response to a local question did however show that 26% of respondents believed that it was now easier to report an error, incident or near miss in the Trust compared with 12-months ago, indicating that some staff have witnessed an improvement in reporting procedures;



- Findings themed around patient care and experience are an area where the responses received by the Trust do not compare as favourably as in similar organisations. All three of the findings in this area were below average, with two of them (staff satisfaction with the quality of work and care they are able to deliver, and % of staff agreeing that their role makes a difference to patients and service users) showing deterioration from the Trust's scores in 2016;
- Two out of three findings themed around 'Managers' (% of staff reporting good communication between senior management and staff; and support from immediate managers) received scores which were below the average for Acute and Community Trusts;
- Despite a small deterioration from the 2016 results, fewer Trust staff indicated that they had suffered from work related stress in the previous 12-months than in comparable Trusts. For the second year running, this was one of the Trust's strongest findings. This is despite absences caused by stress, anxiety and depression remaining a significant challenge;
- There are positive health and wellbeing indicators amongst the Trust's results, with above average ratings compared with the benchmark group for the comparatively small number of staff working additional hours; and feeling pressure to attend work when unwell in the 3-months period prior to completion of the survey. It should be noted, however, that a likely consequence of the reduction in presenteeism is the increase to the Trust's sickness absence rate during the previous 12-months;
- The Trust continues to compare positively with other Acute and Community Trusts for the proportion of staff believing the organisation provides equal opportunities for career progression or promotion.

Further detailed Directorate level reports will be made available to the Trust which will provide question-level data and a comparison with responses from 2016.

2.5 Temporary Staffing

Temporary Medical Staffing

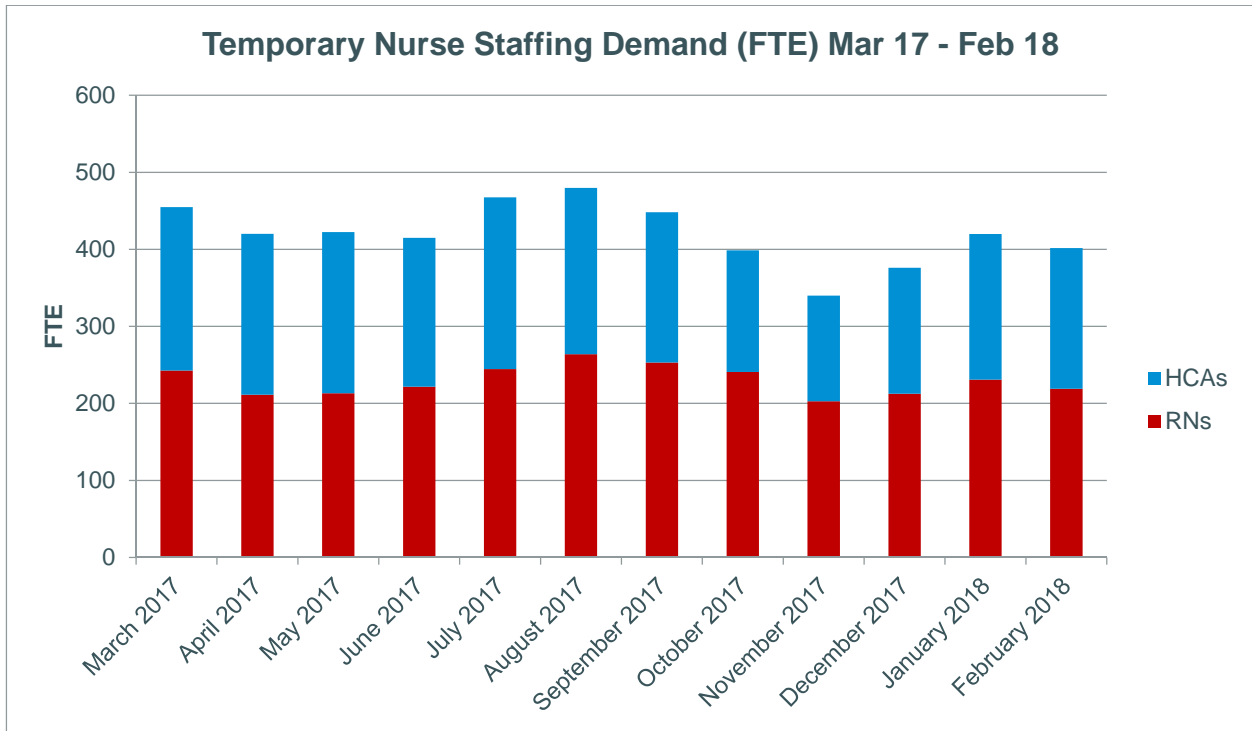
In February, 76.88 Full Time Equivalent (FTE) medical locums were requested at the Trust across both York and Scarborough Hospital. In total, 96% of the shifts were filled (73.79 FTE). 41% (35.49 FTE) were filled via Bank. This is the second consecutive month where Bank fill-rates have exceeded 40%. As a point of comparison, at the beginning of 2017, Bank fill-rates for Medical Staff were below 25%.

Temporary Nurse Staffing

Demand for temporary nurse staffing (RNs and HCAs) in the last year has equated to an average of 420 FTE staff per month. Demand in February 2018 equated to 401.69 FTE which was lower than demand in the same month of the previous year (demand in February 2017 was 411.70 FTE).

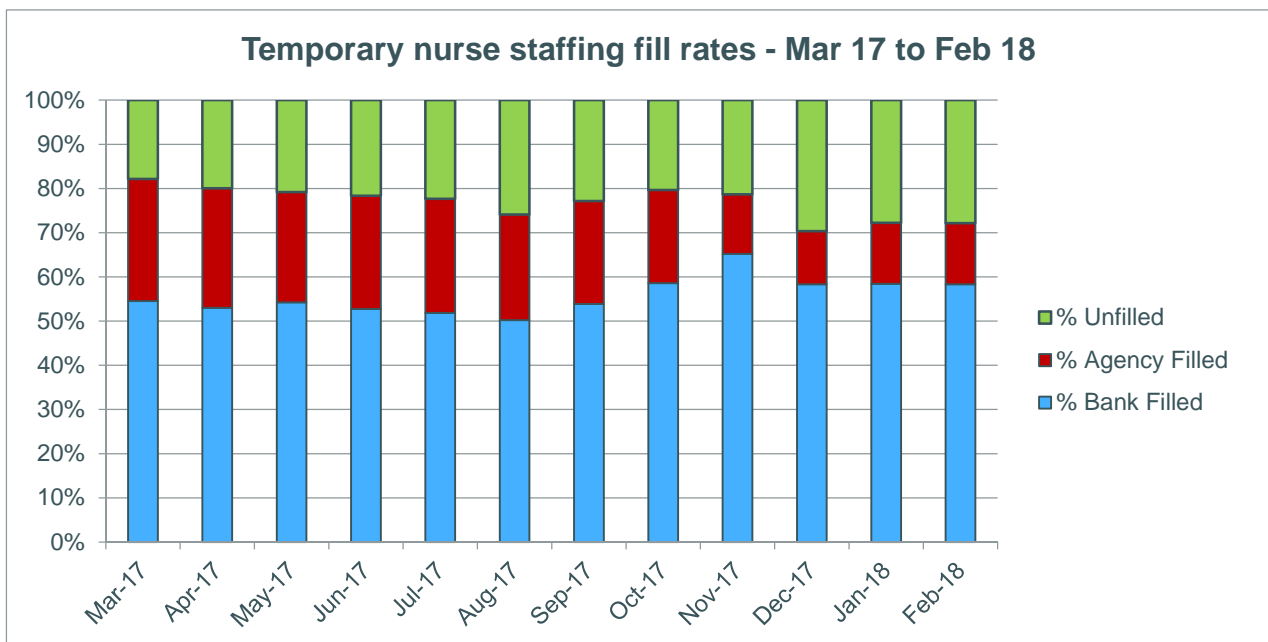


Graph 6 – Temporary Nurse Staffing Demand



Graph 7 shows the proportion of all shifts requested that were either filled by Bank, Agency or were unfilled. Overall, Bank fill-rates made up 58.35% of all requests in February 2018 whilst the Agency fill-rate was 13.81%.

Graph 7 – Temporary Nurse Staffing Fill Rates



2.6 Internal Audit – Staff Bank Management

In March, the Trust received an overall opinion of Significant Assurance from Internal Audit for its Staff Bank Management arrangements for nursing and medical staff. This confirmed that the Trust has strong governance arrangements in place which are working well. HR will now be following-up on the moderate and minor priority recommendations made within the report, including consideration for acquiring specialist software to support the management of the Medical Bank.

2.7 Management Competency Training

The HR Team are currently working with Organisational Development and the Freedom to Speak Up Guardian to develop a mandatory training package for managers within the Trust. The content will be guided and influenced by the Developing People Strategy (Embedding a culture of People Development), once it has been ratified. The training package will outline the Trust's desired leadership behaviours, with a focus on empowering managers to be more people-focused and exercise discretion where appropriate. The aim is for the training to be delivered to all managers and supervisors through a HR-led workshop, which will include input from Staff Side. The workshop will initially be delivered as a pilot, to allow it to be refined for use across the organisation.

2.8 Doctors in Training Streamlining Programme (Onboarding)

Health Education England's report 'Enhancing junior doctors' working lives: a progress report' has highlighted the need for improvement in employers' approaches to induction and mandatory training. The report states that recruitment and induction processes need to reduce duplication of pre-employment checks, mandatory training and induction when employees move from one NHS organisation to another, without any break in service. Currently, these processes tend to be repeated whenever a junior doctor enters or re-enters each Trust.

To address this, a national core working group was established to develop an efficient rotational process that could be applied across all NHS trusts. The key aim is to enable employers to establish streamlined processes regionally for recruitment and induction (a "perfect rotation process") by August 2018.

12 sites are currently piloting the perfect rotation process. The Trust has been chosen as one of 16 "Fast Follower" Trusts which will work to these principles as part of its April Changeover. Fast Followers have the opportunity to shape and influence the design of the Programme by supporting and providing input into the review and development of documents and process guides which will form the final national toolkit.

The full release of a national toolkit will be in May 2018 and Health Education England require all Trusts in England to have a streamlined process in place by August 2018.

2.9 Nurse Recruitment Event

The Trust will be running a Nursing Recruitment Event at York Hospital on 21 April. HR, in collaboration with the Chief Nurse Team, will be conducting a range of activities including:



- interviews for Staff Nurses;
- open session for people interested in Healthcare Assistant vacancies;
- information sessions on the Associate Practitioner and Apprentice Nursing Associate roles;
- directorate “marketplace” with information on a number of different specialties.

Previous recruitment events hosted by the Trust on weekends have been well-attended, and with a strong communications strategy in place, it is expected that the April event will be just as popular.

2.10 General Data Protection Regulations

The EU’s General Data Protection Regulation (GDPR) will apply from 25 May 2018 and brings about a number of changes which will impact on how employers process, manage and store personal data. This will have an impact on all staff that the organisation may hold personal data on, including contractors, volunteers, agency staff, applicants and staff who have left the organisation.

HR is auditing its current position to understand all data that is processed within the department and to identify any areas where processes may need to be improved. This work is being completed in conjunction with the Information Governance Team and will ensure that the Trust is working to comply with the new law by 25 May 2018.

3. Next Steps

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

3.1 Recommendation

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



Board of Directors – 28 March 2018 Developing People Strategy

Recommendation

- | | |
|--------------------------|-------------------------------------|
| For information | <input checked="" type="checkbox"/> |
| For discussion | <input checked="" type="checkbox"/> |
| For assurance | <input type="checkbox"/> |
| For approval | <input checked="" type="checkbox"/> |
| A regulatory requirement | <input type="checkbox"/> |

Current approval route of report

The report has been through the Workforce and Organisational Development Committee.

Purpose of report

To give the Board of Directors the opportunity to comment on the report and to give approval.

Key points for discussion

Any aspect of the report that the Board of Directors want to highlight.

Trust Ambitions and Board Assurance Framework

(https://www.yorkhospitals.nhs.uk/about_us/our_values/)

The Board Assurance Framework is structured around the four ambitions of the Trust.
How does the report relate to the following ambitions:

- Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.
- Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.
- People and Capability** - The quality of our services is wholly dependent on our teams of staff.
- Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

Reference to CQC Regulations

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

There are no direct references to CQC regulations.

Version number: 1

Author: Michael Proctor, Deputy Chief Executive

Executive sponsor: Michael Proctor, Deputy Chief Executive

Date: March 2018



Introduction, background and National Context

The Five Year Forward View (FYFW) identified three significant gaps that need to be closed:

- *The health and wellbeing gap*
- *The care and quality gap*
- *The funding and efficiency gap*

Unless organisations develop the capabilities of their senior and clinical teams, and individuals within them, then the long term outlook for the NHS as a whole, our own organisation, the population we serve and our staff is bleak.

Implicit within the direction set by FYFW is the requirement for better integration between professions, services and sectors. At present the NHS is engaging in a consultation process for a health and care workforce strategy for England to 2027. The working title of the document is: ***Facing the Facts, Shaping the Future***. What is anticipated to emerge from this publication is comprehensive, wide-ranging and aspirational changes focussed on:

- Increasing future workforce and supply from education and training (e.g.; increasing training numbers of all staff groups, targeted Health Career campaigns, improving career pathway options within and between professions)
- Reviewing and modernising education and training (e.g.; accelerated routes to registration, ensure areas like population and mental health are taught across all curricula)
- Widening participation in the workforce (e.g.; support clinical and non-clinical apprenticeships, improved opportunities for people with learning disabilities)
- Improving skill mix in the workforce (e.g.; develops credentialing across all professions, develop and implement consistent postgraduate nurse qualifications and the NLP framework).

All of this is welcome and important but we must acknowledge that the majority of the actions will take place at a national level with implementation locally and regionally developed through STP's and their Local Workforce Action Board's

As we need to contribute and positively respond to what is planned and what emerges and our organisations should take any opportunities to influence implementation we must, at the same time develop our own internal strategy for our workforce which makes best use of the controls that we have to recruit, retain and develop our staff and make them proud to be part of our own organisation within the NHS, to live our values and to be full of pride for what we do to care for our patients

This strategy therefore pulls together the various elements of individual and team development activity under a single over-arching framework. Each area is defined and activity identified but all are connected with the all-encompassing challenges identified above and are linked to our own organisations ambition to respond positively and creatively to the tests we face.

Specifically the significant work streams within this strategy are:

1. Culture and Engagement
2. Developing Leadership Capabilities - Organisational Development & improvement Learning (ODIL)
3. Talent Management

This document should also be considered a precursor to the development of 'The Institute' and help inform what that concept becomes. The Institute will align our activities to develop our people 'as leaders' with our ambitions to improve quality, safety and patient outcomes and further cultivate us as a Learning Organisation.



1. Culture and Engagement

Our culture is developed from our values and all our staff are expected to **'put our patients at the centre of everything we do'**. Our leaders and managers also need to demonstrate understanding of the people they lead and manage. They have to comprehend the day to day situation and pressures their staff face. They need to listen empathetically and help, support and challenge where necessary. They need to value diversity. In general terms they need to contribute to the maintenance and further development of a learning culture where staff at all levels feel able to contribute and their contribution is valued.

2. Developing Leadership Capabilities - Organisational Development Improvement Learning

The organisation needs to develop leaders who are able to see and understand the broad system within which our organisation works. They must be able to collaborate with partners within and outside our organisation and across professional and geographical boundaries. They need to develop trusting and honest relationships and be able to develop shared goals. They need to convince others of the need to change and to demonstrate to others that they too are open to new ideas and can be convinced by sound argument and evidence. They need to be able to hold others to account in line with our Personal responsibility Framework and Values. Our leaders need knowledge of improvement skills and how to use them at all levels.

Our Organisational Development & Improvement Learning (ODIL) team exist to provide corporate support and a planned, responsive, systematic, developmental or restorative approach to **improving organisational effectiveness** – one that aligns strategy, people and processes.

The ODIL team support the development of our **Leadership Capabilities** using the ODIL tools listed and specifically by providing a range of internal Leadership Development programmes & interventions and Quality Improvement learning opportunities. They support and signpost staff to external leadership opportunities by maintaining a close working relationship with our OD and Leadership strategic partners.

3. Talent Management

Our aim has to be to fill our current senior vacancies and develop a pipeline of progression with the right number of diverse, appropriately developed people. We need to support, retain and ensure the development of our precious workforce at all levels, developing our people to be the 'best they can be' and in doing so create opportunities for their further career development ('grow our own'). We also need to attract talent from other organisations and spheres to work for us and celebrate when our staff are offered and take development opportunities and promotions to work in other organisations.

Each of the 3 elements; will now be described in more detail:

1. Culture and Engagement

This element of our strategy has been developed in partnership with staff side representatives and is completely reflected in the Trust values. 'The way we do things around here' shapes the behaviour of everyone in the organisation, affects staff morale and directly affects the quality of care we provide. Poor standards of care can proliferate unless both patients and staff are listened to by the leaders of our health service and their concerns and ideas welcomed and acted upon.

It is widely acknowledged that what happened in Mid Staffordshire NHS Foundation Trust was caused by a range of factors, not least allowing a culture of fear and poor style of leadership to take hold. Sir Robert Francis highlighted the dangers of losing sight of human concerns in healthcare, the importance of engaging with patients and staff, and the risks to patients when the delivery of care becomes depersonalised. He insisted on the urgent importance of transforming the culture of NHS organisations away from one that is fearful and defensive and towards one that is open, honest and willing to listen. He called for a more open and transparent culture following the failures in patient care by having a 'professionalism of candour' which is set out in guidance of expected behaviour of healthcare professionals, including "saying sorry".

A crucial part of the culture change required to ensure this happens is that all who work in the service accept their responsibility to raise issues of concern and to support others who do so. Speaking up should be the norm, not a dangerous exception to a general practice of 'keeping one's head down'.

We all have a responsibility for making our Trust a place to be proud of; both in the healthcare we provide and as a place people want to work. In a caring environment like ours, behaviours of staff and the culture of the organisation directly impact on the care we provide and can colour the view our patients and visitors have on us.

We want our workforce culture to be inclusive, to allow staff to be themselves and be equipped and encouraged to deliver continuous improvement. Staff should gain pride and joy from their work.

The organisation will take a zero tolerance approach towards all forms of inequality, including bullying and harassment and continue to ensure our workforce has a voice that is listened to and acted upon.

1.1 Our Vision and Priorities

To be an excellent place to work – ensure our organisation continues to develop and be an employer of choice

- Creatively attract and maintain the right people to work in our Trust
- To enhance and improve the health and well-being of our staff
- To develop a learning environment that supports our current and future workforce development

1.2 Culture and Organisational Integrity.

What we want our culture to be:

Safe, open and transparent where there is no blame with lessons learned and staff feel engaged and empowered to appropriately challenge.

Our strong Trust values and Personal Responsibility Framework set out a level of expectation about the behaviours we expect of all of our staff. The national framework 'Developing People – Improving Care' is a helpful source reference developing compassionate, inclusive leadership at all levels.

Compassionate leadership means paying close attention to all the people you lead, understanding the situations they face, responding empathetically and taking thoughtful and appropriate action to help. It creates an environment where there is no bullying and where learning and quality improvement become the norm. Where leaders act with compassion, staff feel valued, engaged and enabled to show compassion themselves, as well as feeling obliged to speak up when something is wrong.

Every healthcare leader has to promote a culture where speaking up about legitimate concerns can occur without fear of harassment, bullying or discrimination. Culture must be seen as a two way process; it shapes the behaviour of all employees and they in turn shape the way the organisation performs. Different wards or departments may show cultural differences and it could be said that if all employees accept a culture that is inappropriate it will just continue. Evidence has shown that 'accepting' a poor culture may be because they are too scared to speak out.

To ensure the right culture and engagement with our staff, leaders at York Teaching NHS Foundation Trust will model high standards of behaviour and work with their teams to:

- Model support and compassion
- Value diversity and inclusiveness
- Ensure the appropriate level of accountability throughout the organisation
- Help people grow and lead
- Deliver effective performance through shared team objectives
- Enable learning and innovation
- Ensure necessary resources are available and used effectively.

What we will further develop and implement:

The following will be used to create an understanding of where the organisations culture and engagement levels are:

- Culture of Care Barometer Survey – We will carry out this quick and easy survey to help us gauge the culture of care we provide, creating an opportunity for staff to engage in discussions about the culture of the organisation, area or team. It can help highlight the early warning signs of cultural issues which could impact

on patient care. The tool is built around seven cultural factors: engagement, empowerment, leadership, values, roles, resources and teamwork.

- Staff Survey – This is completed every year and the questions will be used to map an understanding of any change in perceptions amongst the workforce.
- Staff Friends and Family Test – Running alongside of the Staff Survey, this gives an understanding of how our staff feel about the human concerns in the organisation.
- Employee Value Proposition focus groups

From the intelligence gathered above, the following work streams will be influenced and projects within them will be adjusted or new projects created to drive forward the desired change in culture, engaging our workforce through a very clear reflection of their collective opinions and needs.

1.3 Engagement Work streams

Staff engagement which includes motivation, involvement and advocacy, can be linked to patient satisfaction, patient mortality and overall performance indicators. Overall, patient outcomes are best when there is a climate of respect and dignity, where staff are clear about their goals and objectives and where there is effective people management practices. Cultures of engagement, positivity, caring, compassion and respect for all, are important factors associated with good quality of care.

1.4 The Employee Voice

The current work being undertaken includes:

- The ongoing Freedom to Speak Up Guardian Role – this role is values driven and is both novel and challenging, it has proactive, reactive, strategic and tactical elements and requires excellent partnership working; above all it requires the trust of workers throughout the organisation so that everyone feels supported and empowered to speak up. It also requires both independence and the skills to work alongside the Trust leadership team.
- The recent re-launch of the strengthened Fairness Champion role across the Trust to advocate our values, model desired behaviours, champion equality, diversity, fairness and to signpost staff with any concerns accordingly.

The new Emerging Bullying and Harassment Champion role. This allows not only another avenue for staff to voice any concerns but also is a way to link with Freedom to Speak Up Guardian to deal with anonymous concerns or overarching cultural issues, steering any further investigations or action plans as needed.

- Ongoing partnership working with our union colleagues informally and through the Joint Negotiation and Consultation Committee and Local Negotiation Committee.

1.5 Valuing People

The current work being undertaken includes:

To be a valued and trusted partner within our care system delivering safe effective care to the population we serve.

- The strong Organisational values, threaded through the every day recruitment and employment of all of our staff
- The recent relaunch of the Personal Responsibility Framework
- The Talent Management Strategy
- The corporate emphasis of the staff appraisal system
- Celebrating achievements through the Star Awards
- The range of staff benefits available
- The coaching, mentoring, apprenticeship, support staff programmes and leadership programmes available to our staff

1.6 Strategic Narrative

The current work being undertaken includes:

- Intensive work on Policy and Procedure development. We are working with staff side and other colleagues to revise our current policies and procedures. The aim is to promote a “restorative practice” approach and empower managers to be people focussed. It also encourages staff to make changes in their own work area, supporting them to ensure they have the optimum working environment.
- A management training and development programme is currently being created to run alongside the changes to policies. This will support our managers to be accountable and competent when making employee focussed decisions through our newly created policies and create a culture which enables people to commit to the organisational vision and priorities, providing clear evidence of accountability and consequences for staff on how they contribute to the Trust success.

1.7 Health and Wellbeing

- Staff Psychological Wellbeing Support Service – We recognise that our staff are our biggest asset and we are committed to continuing to provide staff with support to stay physically and mentally well.
- Schwartz Rounds - these newly implemented meetings provide a structured forum where all staff, clinical and non-clinical, have the opportunity to come together regularly at York and Scarborough Hospitals to consider the emotional and human dimensions of their work.

The approach is modelled on the idea of a Medical Grand Round, where a clinical team present a patient case, discuss their treatment plan and have an opportunity to have feedback from an audience of colleagues. However, in Schwartz Rounds the focus is turned on the healthcare staff themselves, allowing staff from all disciplines to share stories from their working lives- especially and challenging emotional or social issues they have faced in their day to day work. The purpose of Schwartz rounds is not to solve problems, but to explore the human reactions to the experience of delivering care and the demands that all staff working in health care face on a daily basis.

Schwartz Rounds have been shown to help staff because they reduce the feelings of stress and isolation which make it more difficult to provide compassionate care to [To be a valued and trusted partner within our care system delivering safe effective care to the population we serve.](#)

patients.

We will continue to measure staff engagement and utilise data to prioritise our workforce initiatives to improve productivity and retention across the Trust. This will also give us an understanding of the culture of the organisation

2. Developing Leadership Capabilities - Organisational Development & Improvement Learning

Great leaders enable great people to do great things

The Aims:

- To Provide first class learning & development opportunities enabling our staff to maximise their potential
- To Develop learning & promote innovation, create new knowledge through research & sharing this widely

The Organisational Development & Improvement Learning (ODIL) team support these aims by achievement of the following specific objectives:

- Creating an empowering culture of learning & development in our workforce
- Knowledgeable leadership

Progress against these specific objectives will be provided annually for the Workforce & Organisational Development Committee Board in an ODIL Update paper outlining all ODIL activity relating to: all ODIL

Development programmes, Leadership development, Coaching, Mentoring, Mediation interventions & OD Consultancy

In addition to supporting the achievement of our Organisational Strategic aims, ambitions & specific objectives relating to ODIL, we will ensure our ODIL interventions respond in a timely way to support the needs of the Organisation and those recommendations set out in current & future strategic papers; most notably the recent NHS Improvement: 'Developing People - Improving Care' (2016), Point of Care Foundation: 'Behind Closed Doors' (2017) & 'Year Forward Review' (2017).

All our ODIL internal development interventions are 'People' focused and are underpinned by our Organisational Values, Personal Responsibility Framework & the NHS Healthcare Leadership Model, Clinical Leadership Competence Framework & key National drivers including 'Five Year Forward' recommendations & support our Sustainability & Transformation Plans.

A longstanding component of our internal leadership development programmes and ODIL interventions is the development of our 'internal capability' using an organisational development approach in order to promote more 'awareness' of & 'development' of 'self' & others'.

Our ODIL approach to the development of leadership ‘capability’ and ‘capacity’ has been successfully developed over time. We aspire to further build and further refine on this approach in order to equip future leaders with skills and knowledge to tackle the leadership challenges that lie ahead.

All our interventions are underpinned using a Quality Improvement (QI) approach including QI learning interventions & assessment of QI application in Practice. This supports the recommendations of the ‘Developing people-Improving Care framework’ (NHSI 2017).

Our aim is to help all staff working in our organisation to become effective, compassionate & resilient leaders using what has been described as ‘the softer and more personal aspects of management style and behaviour (leadership) and thus being critical to the reputation of NHS organisations, the ability to recruit and retain good people and ultimately, therefore, to the quality of care on offer to patients’ (Patient Care Foundation ‘Behind Closed Doors’ 2017).

2.1 Summary of Range of Services Provided by Organisational Development & Improvement Learning team (ODIL)

- Internal leadership development programmes (working with our external strategic OD, QI & leadership partners, supporting & signposting to external Leadership, OD & QI learning opportunities)
- Short internal ‘bite size’ programmes that support specific leadership skills development. Conflict Resolution training
- Quality Improvement learning opportunities integral to and independent of internal leadership learning programmes
- Bespoke Organisational Development interventions and consultancy
- Coaching & Mentoring interventions that include 1:1; partnership and team coaching & mentoring programmes which support the development of coaching skills across the wider organisation that include team and health. Coaching supervision & coaching Continuing professional development (C.P.D.) for our internal Coaching faculty
- Continued development of longstanding relationships & reciprocal learning & development opportunities with local & regional external partners

Summary of ODIL Aspirations / Future Position

- Support the embedding of the Organisation’s Strategic Aims & Objectives, Values & Personal Responsibility Framework in all ODIL interventions
- Support the ‘Creation of an Empowering Culture of Learning & Development in our workforce’ through all ODIL interventions.

Develop ‘Knowledgeable leadership’ in our workforce through all ODIL development interventions. Develop an Organisation 360 leadership behaviours feedback tool

- Support the development of a Leadership Culture throughout the Organisation by further development of our internal Leadership, QI & Coaching Capability & Capacity
- Provide OD Consultancy (Proactive/Reactive) to support and enable staff to maximise their potential. Support the development of a ‘Restorative’ culture

To be a valued and trusted partner within our care system delivering safe effective care to the population we serve.

- Develop 'System' Leadership & 'System' Coaches through development of 'System' Leadership interventions
- Embed Team and Health Coaching model. Develop the Coaching service to include more access to Mentoring opportunities
- Embed Quality Improvement Learning, including inclusion into new staff Induction process
- Support the development of the Institute of Learning, Innovation & Research; Position & embed ODIL within the institute
- Support the internal Workforce Transformation agenda by providing ODIL facilitation (including Calderdale)
- Support the implementation of the Talent Management agenda
- Explore opportunity for Leadership & Coaching Apprenticeships supported by the Levy
- Explore development of a Local Graduate Management Trainee Scheme supported by the Levy
- Support local System ('Place) workforce transformation & development plans agenda, working with external partners
- Support regional HEE, LWAB & STP workforce transformation & development plans agenda
- Support the HEE Regional Leadership, Organisational development (Coaching) & QI agenda
- Continue & develop Strategic Partnership working with Local, Regional & National key Education, Leadership, Organisational Development, Quality Improvement partners; & other local Health & Social Care & local external organisations & partners

3. Talent Management

This aspect of the strategy sets out our vision to ensure effective and efficient talent management of employees in our organisation:

3.1 Our approach

The organisation will take a blended approach to managing talent – selective (exclusive) and inclusive elements.

This will support an intentional move away from the traditional hierarchical approach of talent management towards an organisational 'network' approach; seeing our people 'talent' as a 'community' with strong emphasis on attracting, recruiting, retaining, developing our talent and growing our own.

We aim to manage and engage our talent through conveying meaning and identifiable contribution at work for our staff (Turner 2015) and developing leadership potential at all levels. Talent management will be networked within the organisation.

Inclusive management of talent will be the prominent element however selection of talent for escalation will be identified and closely monitored through the appraisal process.

The aspiration to develop an Institute of Learning, Innovation and Research will further enhance opportunities to support staff engagement, development and networking. This strategy focusses on the development of the critical set of improvement and leadership capabilities identified to fill the gaps in the NHS Five Year Forward View:

- Systems leadership skills
- Improvement skills
- Compassionate, inclusive leadership skills

3.2 Business context

Health and social care is a fragile system experiencing increasing demands on a continuously reduced capacity to respond. Expectations of the public and professionals for patient care rightly so remain high and as an organisation we need to be able to deliver.

Managing talent is more important than ever to 'fulfil future leadership pipelines with the right numbers of diverse, appropriately developed people.' (Developing People – Improving Care)

This challenging climate of recruitment requires organisations to work harder at attracting talent when there are talent shortages and retaining talent when there is workforce and organisational uncertainty and unpredictability.

We want to develop an agile workforce who exhibits the key skills, knowledge, experience, values and behaviours to undertake their job roles effectively, whilst demonstrating their ability to deliver compassionate holistic care safely.

The organisation will take a blended approach to managing talent – selective (exclusive) and inclusive elements.

This will support an intent to move away from the traditional hierarchical approach of talent management towards an organisational 'network' approach; seeing our people 'talent' as a 'community' with strong emphasis on attracting, recruiting, retaining, developing our talent and growing our own.

We aim to engage and engage our talent through conveying meaning and identifiable contribution at work for our staff (Turner 2015) and developing leadership potential at all levels. Talent management will be networked within the organisation.

Inclusive management of talent will be the prominent element however selection of talent for escalation will be identified and closely monitored through the appraisal process.

The aspiration to develop an Institute of Learning, Innovation and Research will further enhance opportunities to support staff engagement, development and networking.

3.3 Talent management activity



4. Detailed Recommendation

The Board of Directors are asked to receive and discuss the report to approve its content.

Developing People Strategy

Embedding a Culture of People Development



Introduction

This strategy pulls together the various elements of individual, team, organisational and whole system development activity under a single overarching framework. Each area is defined and activity identified, all are connected with the challenges identified and are linked to our organisation's ambition to respond positively and creatively to the tests we face within the wider Health and Social Care system.

Specifically the significant work streams within this strategy are:

1. **Culture and Engagement**
2. **Developing Leadership Capabilities**
3. **Talent Management**

This document should also be considered a precursor to the development of '**The Institute**' and help inform what that concept becomes. The Institute will align our activities to develop our people 'as leaders' with our ambitions to improve quality, safety and patient outcomes and further cultivate us as a Learning Organisation.

National Context

Implicit within the direction set by The Five Year Forward View (FYFW) is the requirement for better integration between professions, services and sectors. At present the NHS is engaging in a consultation process for a health and care workforce strategy for England to 2027. The working title of the document is: ***Facing the Facts, Shaping the Future***. What is anticipated to emerge from this publication is comprehensive, wide-ranging and aspirational changes focussed on:

- Increasing future workforce and supply from education and training (e.g. increasing training numbers of all staff groups, targeted Health Career campaigns, improving career pathway options within and between professions)
- Reviewing and modernising education and training (e.g. accelerated routes to registration, ensure areas like population and mental health are taught across all curricula)
- Widening participation in the workforce (e.g. support clinical and non-clinical apprenticeships, improved opportunities for people with learning disabilities)
- Improving skill mix in the workforce (e.g. develops credentialing across all professions, develop and implement consistent postgraduate nurse qualifications and the ACP framework).

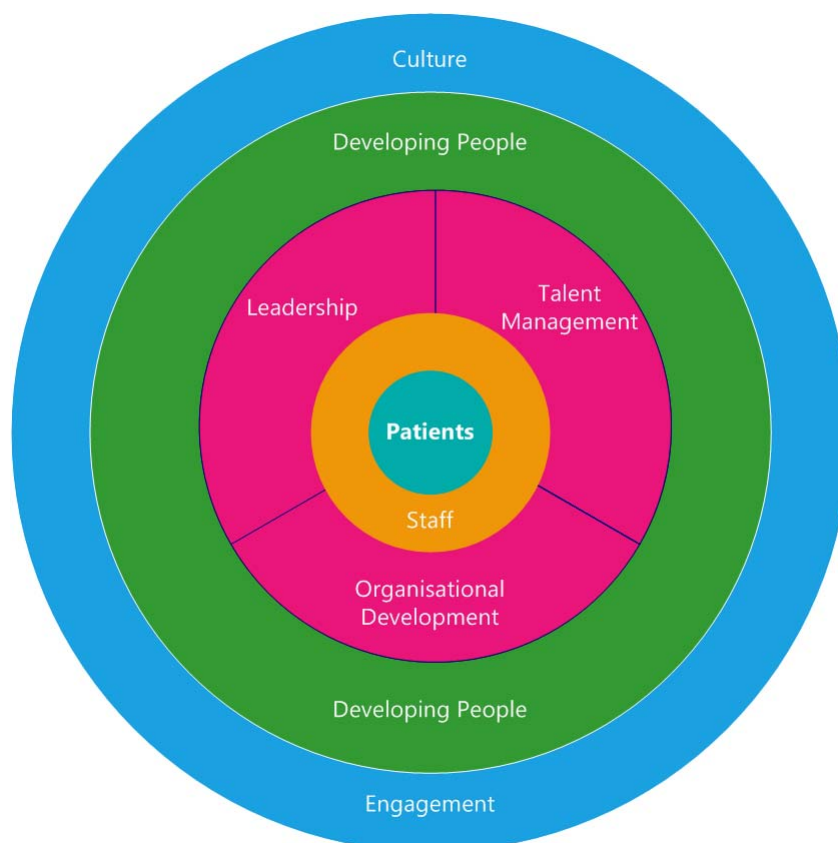
We must acknowledge that the majority of direction will be set at a national level with implementation locally and regionally developed through STP's and their Local Workforce Action Board's, for example responding to the requirements of NHS Improvement: 'Developing People - Improving Care' (2016), Point of Care Foundation: 'Behind Closed Doors' (2017) and Five Year Forward Review (2017) and 'Building Capacity and Capability for Improvement: embedding quality improvement skills in NHS providers' (2017).

We need to contribute and positively respond to what is planned and what emerges, and our organisation should take any opportunities to influence implementation. We must, at the same time develop our own internal strategy for our workforce which makes best use of the controls that we have to recruit, retain and develop our staff, and make them proud to be part of our own organisation within the NHS, to live our values and to be full of pride for what we do to care for our patients.

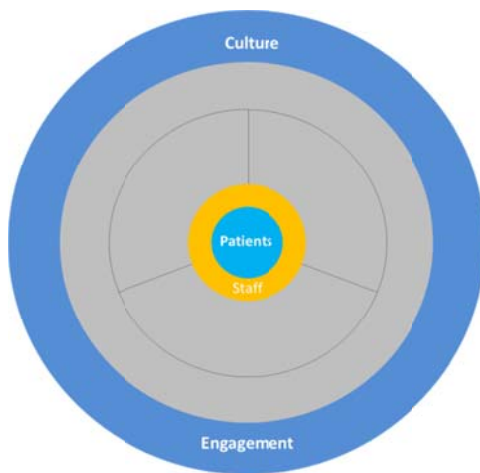
The FYFW identified three significant gaps that need to be closed:

- ***The health and wellbeing gap*** ***The care and quality gap***
- ***The funding and efficiency gap***

Unless organisations develop the capabilities of their senior and clinical teams, and individuals within them, then the long term outlook for the NHS as a whole, our own organisation, the population we serve and our staff is bleak.



Culture and Engagement



This element of our strategy has been developed in partnership with staff side representatives and is completely reflected in the Trust values. ‘The way we do things around here’ shapes the behaviour of everyone in the organisation, affects staff morale and directly affects the quality of care we provide. Poor standards of care can proliferate unless both patients and staff are listened to by the leaders of our health service and their concerns and ideas welcomed and acted upon.

It is widely acknowledged that what happened in Mid Staffordshire NHS Foundation Trust was caused by a range of factors, not least allowing a culture of fear and poor style of leadership to take hold. Sir Robert Francis highlighted the dangers of losing sight of human concerns in healthcare, the importance of engaging with patients and staff, and the risks to patients when the delivery of care becomes depersonalised. He insisted on the urgent importance of transforming the culture of NHS organisations away from one that is fearful and defensive and towards one that is open, honest and willing to listen. . He called for a more open and transparent culture following the failures in patient care by having a ‘professional duty of candour’ which is set out in guidance of expected behaviour of healthcare professionals, including “saying sorry”.

A crucial part of the culture change required to ensure this happens is that all who work in the service accept their responsibility to raise issues of concern and to support others who do so. Speaking up should be the norm, not a dangerous exception to a general practice of ‘keeping one’s head down’.

We all have a responsibility for making our Trust a place to be proud of; both in the healthcare we provide and as a place people want to work. In a caring environment like ours, behaviours of staff and the culture of the organisation directly impact on the care we provide and can colour the view our patients and visitors have on us.

We want our workforce culture to be inclusive, to allow staff to be able to be themselves and be equipped and encouraged to deliver continuous improvement. Staff should gain pride and joy from their work.

The organisation will take a zero tolerance approach towards all forms of inequality, including bullying and harassment and continue to ensure our workforce has a voice that is listened to and acted upon.

Our Vision and Priorities

- An excellent place to work – ensure our organisation continues to develop and be an employer of choice
- Creatively attract and maintain the right people to work in our Trust
- To enhance and improve the health and well-being of our staff
- To develop a learning environment that supports our current and future workforce development

What we want our culture to be:

Safe, open and transparent where there is no blame with lessons learned and staff feel engaged and empowered to appropriately challenge.

Our strong Trust values and Personal Responsibility Framework set out a level of expectation about the behaviours we expect of all of our staff. The national framework 'Developing People – Improving Care' is a helpful source reference developing compassionate, inclusive leadership at all levels.

Compassionate leadership means paying close attention to all the people you lead, understanding the situations they face, responding empathetically and taking thoughtful and appropriate action to help. It creates an environment where there is no bullying and where learning and quality improvement becomes the norm. Where leaders act with compassion, staff feel valued, engaged and enabled to show compassion themselves, as well as feeling obliged to speak up when something is wrong.

Every healthcare leader has to promote a culture where speaking up about legitimate concerns can occur without fear of harassment, bullying or discrimination. Culture must be seen as a two way process; it shapes the behaviour of all employees and they in turn shape the way the organisation performs. Different wards or departments may show cultural differences and it could be said that if all employees accept a culture that is inappropriate it will just continue, evidence has shown that 'accepting' a poor culture may be because they are too scared to speak out.

To ensure the right culture and engagement with our staff, leaders at York Teaching NHS Foundation Trust will model high standards of behaviour and work with their teams to:

- Model support and compassion
- Value diversity and fairness
- Ensure the appropriate level of accountability throughout the organisation
- Help people grow and lead
- Deliver effective performance through shared team objectives
- Enable learning and innovation
- Ensure necessary resources are available and used effectively.

What we will further develop and implement:

The following will be used to create an understanding of where the organisations culture and engagement levels are:

- Culture of Care Barometer Survey – We will carry out this quick and easy survey to help us gauge the culture of care we provide, creating an opportunity for staff to engage in discussions about the culture of the organisation, area or team. It can help highlight the early warning signs of cultural issues which could impact on patient care. The tool is built around seven cultural factors: engagement, empowerment, leadership, values, roles, resources and teamwork.
- Staff Survey – This is completed every year and the questions will be used to map an understanding of any change in perceptions amongst the workforce.
- Staff Friends and Family Test – Running alongside of the Staff Survey, this gives an understanding of how our staff feel about the human concerns in the organisation.
- Employee Value Proposition focus groups

From the intelligence gathered above, the following work streams will be influenced and projects within them will be adjusted or new projects created to drive forward the desired change in culture, engaging our workforce through a very clear reaction to their collective opinions and needs.

Engagement Work streams

Staff engagement which includes motivation, involvement and advocacy, can be linked to patient satisfaction, patient mortality and overall performance indicators. Overall, patient outcomes are best when there is a climate of respect and dignity, where staff are clear about their goals and objectives and where there is effective people management practices. Cultures of engagement, positivity, caring, compassion and respect for all, are important factors associated with good quality of care.

The Employee Voice

The current work being undertaken includes:

- The ongoing Freedom to Speak Up Guardian Role – this role is values driven and is both novel and challenging, it has proactive, reactive, strategic and tactical elements and requires excellent partnership working; above all it requires the trust of workers throughout the organisation so that everyone feels supported and empowered to speak up. It also requires both independence and the skills to work alongside the Trust leadership team.
- The recent re-launch of the strengthened Fairness Champion role across the Trust to advocate our values, model desired behaviours, champion equality, diversity, fairness and to signpost staff with any concerns accordingly.
- The Challenging Bullying and Harassment Champion role. This allows not only another avenue for staff to voice any concerns but also is a way to link with Freedom to Speak Up Guardian to deal with anonymous concerns or overarching cultural issues, steering any further investigations or action plans as needed.
- Ongoing partnership working with our union colleagues informally and through the Joint Negotiation and Consultation Committee and Local Negotiation Committee.

Valuing People

The current work being undertaken includes:

- The strong Organisational values, threaded through the every day recruitment and employment of all of our staff
- The recent relaunch of the Personal Responsibility Framework
- The Talent Management Strategy
- The corporate emphasis of the staff appraisal system
- Celebrating achievements through the Star Awards

- The range of staff benefits available
- The coaching, mentoring, apprenticeship, support staff programmes and leadership programmes available to our staff

Strategic Narrative

The current work being undertaken includes:

- Intensive work on Policy and Procedure development – We are working with staff side and other colleagues to revise our current policies and procedures. The aim is to promote a “restorative practice” approach and empower managers to be people focussed. It also encourages staff to make changes in their own work area, supporting them to ensure they have the optimum working environment.
- A management training and development programme is currently being created to run alongside the changes to policies. This will support our managers to be accountable and competent when making employee focussed decisions through our newly created policies and create a culture which enables people to commit to the organisational vision and priorities, providing clear evidence of accountability and consequences for staff on how they contribute to the Trust success.

Health and Wellbeing

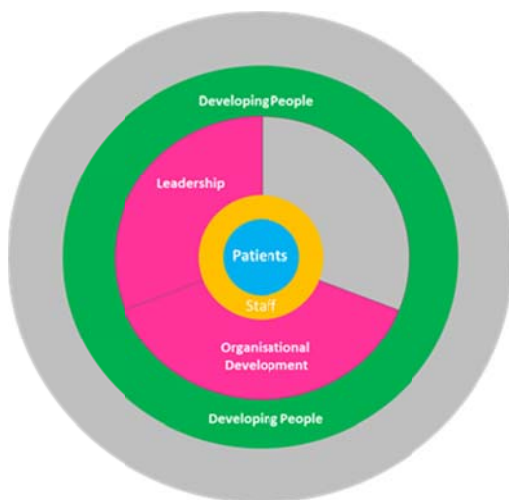
- Staff Psychological Wellbeing Support Service – We recognise that our staff are our biggest asset and we are committed to continuing to provide staff with support to stay physically and mentally well.
- Schwartz Rounds - these newly implemented meetings provide a structured forum where all staff, clinical and non-clinical, have the opportunity to come together regularly at York and Scarborough Hospitals to consider the emotional and human dimensions of their work.

The approach is modelled on the idea of a Medical Grand Round, where a clinical team present a patient case, discuss their treatment plan and have an opportunity to have feedback from an audience of colleagues. However, in Schwartz Rounds the focus is turned on the healthcare staff themselves, allowing staff from all disciplines to share stories from their working lives- especially and challenging emotional or social issues they have faced in their day to day work. The purpose of Schwartz rounds is not to solve problems, but to explore the human reactions to the experience of delivering care and the demands that all staff working in health care face on a daily basis.

Schwartz Rounds have been shown to help staff because they reduce the feelings of stress and isolation which make it more difficult to provide compassionate care to patients.

We will continue to measure staff engagement and utilise data to prioritise our workforce initiatives to improve productivity and retention across the Trust. This will also give us an understanding of the culture of the Organisation

Developing Leadership Capabilities



The organisation needs to develop leaders who are able to see and understand the broad system within which our organisation works. They must be able to collaborate with partners within and outside our organisation and across professional and geographical boundaries. They need to develop trusting and honest relationships and be able to develop shared goals. They need to convince others of the need to change and to demonstrate to others that they too are open to new ideas and can be convinced by sound argument and evidence. They need to be able to hold others to account in line with our Personal Responsibility Framework and Values. Our leaders need knowledge of quality improvement skills and how to use them at all levels.

Our Organisational Development and Improvement Learning (ODIL) team exist to provide corporate support and a planned, responsive, systematic, developmental or restorative approach to **improving organisational effectiveness** – one that aligns strategy, people and processes.

The ODIL team support the development of our **Leadership Capabilities** using recognised Organisational Development and Quality Improvement tools and specifically by providing a range of internal Leadership Development programmes and interventions and Quality Improvement learning opportunities. They support and signpost staff to external leadership opportunities by maintaining a close working relationship with our OD and Leadership strategic partners.

Great leaders enable great people to do great things

Our Vision:

- Provide first class learning and development opportunities, enabling our staff to maximise their potential.
- Develop learning and promote innovation, creating new knowledge through research and sharing this widely.
- Help all staff working in our organisation to become effective, compassionate and resilient leaders.

The Organisational Development and Improvement Learning (ODIL) team support these aims by achievement of the following specific objectives:

- Creating an empowering culture of learning and development in our workforce
- Knowledgeable leadership

This will be achieved through the following activities:

- All ODIL development programmes
- Leadership development
- Coaching
- Mentoring
- Mediation
- Bespoke OD interventions

In addition to supporting the achievement of the Organisational Strategic aims, ambitions and specific objectives relating to ODIL, we will ensure that ODIL interventions respond in a timely way to support the needs of the Organisation and those recommendations set out in current and future strategic papers; most notably the recent NHS Improvement: 'Developing People - Improving Care' (2016), Point of Care Foundation: 'Behind Closed Doors' (2017), Five Year Forward Review (2017) and 'Building Capacity and Capability for Improvement: embedding quality improvement skills in NHS providers' (2017).

All ODIL internal development interventions are 'People' focused and are underpinned by Organisational Values, Personal Responsibility Framework and support our Sustainability and Transformation plans. They reflect the behaviours identified in NHS Healthcare Leadership Model, and Clinical Leadership Competence Framework, and support the achievement of recommendations from key National drivers. All our interventions are supported by a Quality Improvement (QI) approach including QI learning and assessment of QI application in Practice.

A longstanding component of our internal leadership development programmes and ODIL interventions is the development of our 'internal capability' using an organisational development approach in order to promote more 'awareness' of and 'development' of 'self' and others'.

Our ODIL approach to the development of leadership 'capability' and 'capacity' has been successfully established over time. We aspire to build on this approach in order to equip future leaders, both within the Organisation and in collaboration with our partners in the wider Health and Social Care system, with skills and knowledge to tackle the leadership challenges that lie ahead. The aspiration to develop an Institute of Learning, Innovation and Research will further enhance opportunities to support staff engagement, development and networking. This strategy responds to the requirement of critical improvement and leadership capabilities as identified within the NHS Five Year Forward View:

- Systems leadership skills
- Improvement skills
- Compassionate, inclusive leadership skills

Talent Management



Health and social care is a fragile system experiencing increasing demands on a continuously reduced capacity to respond. Expectations of the public and professionals for patient care rightly so remain high and as an organisation we need to be able to deliver.

Managing talent is more important than ever – to ‘fulfil future leadership pipelines with the right numbers of diverse, appropriately developed people.’ (Developing People – Improving Care)

This challenging climate of recruitment requires organisations to work harder at attracting talent when there are talent shortages and retaining talent when there is workforce and organisational uncertainty and unpredictability.

We want to develop an agile workforce who exhibits the key skills, knowledge, experience, values and behaviours to undertake their job roles effectively, whilst demonstrating their ability to deliver compassionate holistic care safely.

Our Vision is to satisfy the current requirements for senior posts and develop a pipeline of progression with diverse, appropriately developed people and to ensure effective and efficient talent management of employees in our organisation:

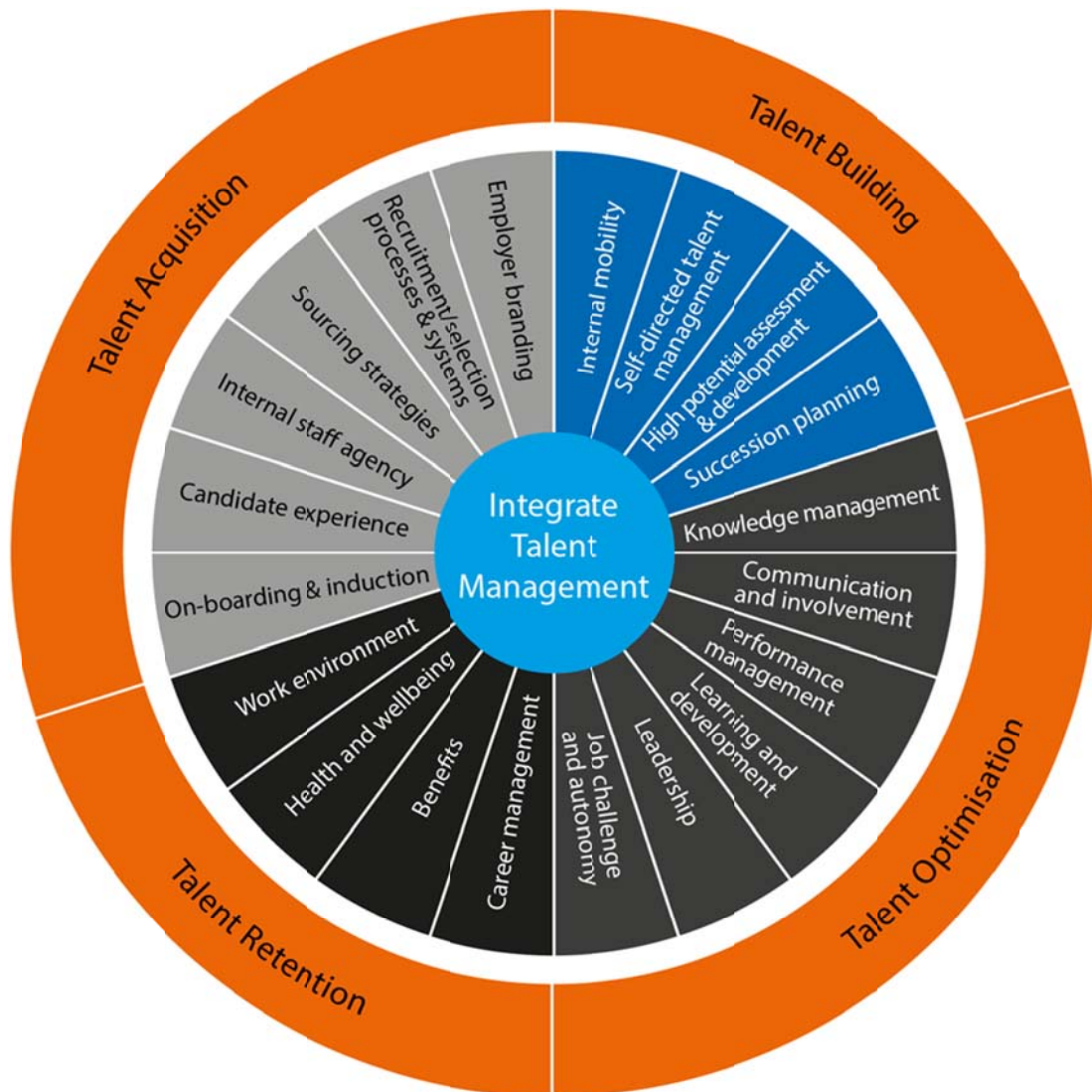
We need to:

- Support, retain and ensure the development of our precious workforce at all levels.
- Develop our people to be the ‘best they can be’
- Create opportunities for their further career development (‘grow our own’).
- Attract talent from other organisations and spheres to work for us
- Celebrate when our staff are offered and take development opportunities and promotions to work in other organisations.

We want an Organisation that will:

- Adopt a blended approach to managing talent – selective (exclusive) and inclusive elements.
- Support an intentional move away from the traditional hierarchical approach of talent management towards an organisational ‘network’ approach; seeing our people ‘talent’ as a ‘community’ with strong emphasis on attracting, recruiting, retaining, developing our talent and growing our own.
- Engage our talent through conveying meaning and identifiable contribution at work for our staff (Turner 2015) and developing leadership potential at all levels.
- Network talent management within the organisation.
- Select talent for escalation which will be identified and closely monitored through the appraisal process.

Talent management activity



Implementation

Specific delivery plans have been developed to support the implementation of this strategy, and its objectives. Progress reports and updated delivery plans will be submitted annually to the Workforce and Organisational Development Committee.

Embedding a Culture of People Development Delivery Plan

	Years 1 - 2	Years 3 - 4	Years 5 - 6
Culture and Engagement	Introduce the concept of Restorative Practice (RP) into leadership programmes and OD interventions (ODIL)	Implement, embed and evaluate RP approach (ODIL/HR)	
	Implement the Manager Training programme (HR)	Embed RP approach throughout all HR training programmes (HR)	
	Review and rewrite Employment Policies to integrate the RP concept (HR)	Continue to evaluate, review and rewrite Employment Policies to integrate the RP concept (HR)	
	Develop the concept of an RP faculty (ODIL/HR)	Develop the RP faculty (ODIL/HR)	Provide supervision/CPD to RP faculty (ODIL/HR)
	Train cohort of ACAS accredited mediators to provide sufficient capacity to meet organisational demand (ODIL)	Developing the mediator faculty (ODIL)	Provide supervision/CPD to mediation faculty (ODIL)
	Develop a robust process for prioritising and managing requests for bespoke OD interventions (ODIL)	Develop measures to evaluate the impact of bespoke OD interventions (ODIL)	Provide supervision/CPD to leaders and managers that are using OD tools and skills (ODIL)

	Years 1 - 2	Years 3 - 4	Years 5 - 6
Culture and Engagement continued	Develop further HR Training to enable and empower line managers to manage staff effectively and empathetically (HR)	Develop measures to evaluate the impact of HR Training (HR)	
	To consolidate current organisational position and develop a strategic approach to workforce transformation (ODIL)		Support local system (place) workforce transformation and development plans agenda working with external partners (ODIL)
	Develop a robust approach to Quality Improvement learning (ODIL) Quality Improvement learning is included in the organisations induction processes (ODIL)	Develop capacity for QI coaching (ODIL)	
	Continue to develop a strong leadership culture across the system by further development of our leadership programme portfolio (ODIL)		

	Years 1 - 2	Years 3 - 4	Years 5 - 6
Culture and Engagement continued	Develop and implement a “the way we do in York” management training programme. (HR/ODIL/ Freedom to Speak Up Guardian)		
	Tender for a new provider of the SFFT and Staff Survey in order to find innovative and timely ways of hearing the employee voice (HR)	Continue to use the employee voice forums to influence the work done under the culture and engagement workstream (HR)	
Developing Leadership Capabilities	Develop system leadership and system coaches through design of system leadership interventions (ODIL)	Progressing the development of a local Graduate Management Trainee Scheme (GMTS) development programme (ODIL)	
	Reviewing content of current leadership programmes to ensure compliance with DPIC requirements (ODIL)	Develop an organisational 360 leadership behaviours feedback tool (ODIL)	
	Continue to develop a strong leadership culture across the system by further development of our leadership programme portfolio (ODIL)	Support the development of the Institute (ODIL) Introduce basic OD tools and skills into leadership programmes (ODIL)	

	Years 1 - 2	Years 3 - 4	Years 5 - 6
Developing Leadership Capabilities continued	Explore the opportunity for leadership and coaching apprenticeships supported by the Apprenticeship Levy (ODIL)	Develop a system wide culture of coaching and development of skills of people throughout the whole system (ODIL)	
	Implement a system wide health coaching approach for health and social care professionals (ODIL) Implement a team coaching model (ODIL)		
	Develop a mentoring service	Develop the coaching service to include more access to mentoring opportunities (ODIL)	
	Develop a micro systems coaching approach		
	Develop leadership development opportunities for all staff at all levels of the organisation (ODIL)		

	Years 1 - 2	Years 3 - 4	Years 5 - 6
Talent Management	Coaching and mentoring activity (ODIL)	Coaching and mentoring activity (ODIL)	Coaching and mentoring activity (ODIL)
	CPD for existing coaches – career coaching (ODIL)		
	Access to ‘shadow coaching’ for leaders (ODIL)		
	Leadership development programmes (ODIL)	Leadership development programmes (ODIL)	Leadership development programmes (ODIL)
	Evaluate and make recommendations on the use of psychometrics (ODIL)		
		Evaluate and make recommendations on the use of development centres for talent management (ODIL)	

Blank page

Board of Directors – 28 March 2018

Gender Pay Gap Reporting

Recommendation

- | | |
|--------------------------|-------------------------------------|
| For information | <input checked="" type="checkbox"/> |
| For discussion | <input type="checkbox"/> |
| For assurance | <input type="checkbox"/> |
| For approval | <input type="checkbox"/> |
| A regulatory requirement | <input type="checkbox"/> |

Current approval route of report

Shared with Corporate Directors prior to publication on the Trust web-site; information will also be made available to Staff Side.

Purpose of report

This paper sets out the information on the Trust's gender pay gap which will be reported to the Government Equalities Office in line with mandatory reporting duties.

Key points for discussion

The paper make a distinction between equal pay and the gender pay gap, clarifies what the Trust is required to report and provides a review of the Trust's gender pay gap data.

Trust Ambitions and Board Assurance Framework

(https://www.yorkhospitals.nhs.uk/about_us/our_values/)

The Board Assurance Framework is structured around the four ambitions of the Trust. How does the report relate to the following ambitions:

- Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.
- Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.
- People and Capability** - The quality of our services is wholly dependent on our teams of staff.
- Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

Reference to CQC Regulations

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

Version number: 1.0

Author: Will Thornton, Senior HR Lead

Executive sponsor: Patrick Crowley, Chief Executive

Date: February 2018



1. Introduction and Background

Since April 2017, employers in Great Britain with more than 250 staff have been required by law to publish information about their gender pay gap. The law requires the Trust to provide information annually, both on its web site and on a government website, covering the following details:

- Gender pay gap (mean and median averages)
- Gender bonus gap (mean and median averages)
- Proportion of men and women receiving bonuses
- Proportion of men and women in each quartile of the organisation's pay structure

Publicly, there has been some confusion about the differences between gender pay and equal pay. It is important to emphasise that the gender pay gap deals with the difference between the average earnings of all women in an organisation compared to the average earnings of all the men. The focus is on analysing and understanding summary differences, unlike equal pay where employers are legally required to ensure parity of pay for men and women *doing the same or comparable job*.

The mandatory deadline for publication of gender pay gap data is 30 March 2018. The Trust intends to publish its gender pay gap information on 8 March 2018, on the same day as other NHS organisations in the Yorkshire and Humber region.

2. Detail of Report and Assurance

The Trust's analysis is based on data held on all staff in the Electronic Staff Record as at 31 March 2017. The data is based on a headcount of staff and does not identify differences in contracted hours or work patterns.

On 31 March 2017, the organisation's gender profile was 79% women and 21% men, with a distribution across the pay structure as follows:

	All Staff		Excluding Medical & Dental Staff	
	Male	Female	Male	Female
Upper	31.8%	68.2%	14.6%	85.4%
Upper Middle	14.2%	85.8%	14.3%	85.7%
Lower Middle	17.8%	82.2%	17.8%	82.2%
Lower	20.4%	79.6%	20.9%	79.1%

In regard to averages:

- The mean gender pay gap was 28.7% weighted towards men. Taking the mean average, men in the organization earned £5.65 per hour more than women.
- The median gender pay gap was 9.51% weighted towards men. Taking the median average, men in the organization earned £1.32 per hour more than women.



Information shared between 15 NHS Trusts in the Yorkshire and Humber area suggests that the Trust's mean gender pay gap was consistent with other organisations, with other Trusts reporting gaps of up to 30.6% weighted towards men.

Within the Trust, the concentration of Medical and Dental staff in the upper pay quartile had a strong bearing on the gender pay gap. The gender profile of the Medical and Dental Group was 38% women and 62% men. At Consultant level, this was 29% women and 71% men. Proportionately, more male doctors at the Trust were full-time. The average number of years' service for men in this group was also higher than for women, impacting salary values.

- When Medical and Dental staff were removed from the analysis, there was a 0.02% mean gender pay weighting towards women, with women earning £0.24 per hour more than men.
- Similarly, taking the median data for non-medical staff, the weighting towards women was 0.10%, equating to women in the Trust earning £1.13 per hour more than men.

The only bonus payments made by the organization were to Medical and Dental staff in connection with Clinical Excellence Awards, resulting in the following summary:

- Proportionately, more men received bonuses than women (159 out of 1,977 male employees [8.04%], compared to 47 out of 7,418 female employees [0.63%]).
- The mean gender bonus pay gap was 39.59% weighted towards men. Taking the mean average, men in the organization received £4,214.61 more than women in bonuses.
- The median gender bonus pay gap was 33.33% weighted towards men. Taking the median average, men in the organization received £2,983.55 more than women in bonuses.

It is worth noting that the number of men as a proportion of all staff who received a bonus was 77%. As a figure, this is not significantly different from the proportion of men who make up the Trust's Medical Consultant workforce.

3. Next Steps

One of the objectives of gender pay gap reporting is to create discussion around the reason for gaps, and to encourage more thinking about how these can be reduced. To an extent, the Trust is reliant on the wider system (e.g. for training doctors) to help reduce its own gap; but reinforcing a culture which is positive about flexible and part-time working within the organization would also help to support this objective.

The Trust's gender pay gap information will be published on its web site and on a government website on 8 March 2018.



Board of Directors – 28 March 2018

Associate Non-Executive Director Induction

Recommendation

- | | |
|--------------------------|-------------------------------------|
| For information | <input checked="" type="checkbox"/> |
| For discussion | <input type="checkbox"/> |
| For assurance | <input checked="" type="checkbox"/> |
| For approval | <input type="checkbox"/> |
| A regulatory requirement | <input type="checkbox"/> |

Current approval route of report

For information purposes only.

Purpose of report

The Board are asked to note the proposed induction plan for the Associate Non-Executive Directors (NEDs), Dr. Lorraine Boyd and Ms Lynne Mellor, who will be joining the Board for the first time next month.

The plan is constructed over 3 months and seeks to provide the Associate NEDs with an opportunity to familiarize themselves with the business of the Trust and their new colleagues.

I am grateful to the Board, in advance, for their support of Lynne and Lorraine during their induction period.

Key points for discussion

For information purposes only.

Trust Ambitions and Board Assurance Framework

(https://www.yorkhospitals.nhs.uk/about_us/our_values/)

The Board Assurance Framework is structured around the four ambitions of the Trust. How does the report relate to the following ambitions:

- Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.
- Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.

- People and Capability** - The quality of our services is wholly dependent on our teams of staff.
- Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

Reference to CQC Regulations

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

Version number: 1

Author: Susan Symington, Chair and Lisa Gray, Chief Executive's Office Manager

Executive sponsor: Susan Symington, Chair

Date: March 2018



1. Corporate Responsibilities

Date	Event	Time commitment
17 April 2018	Attend formal committee of the Board (Finance & Performance (9.30-11.30am) or Quality & Safety (10am-12pm)) Attend NED only monthly meeting (12-1.30pm)	1 day
25 April 2018	Board Meeting plus Board to Board with the Council of Governors	1 day reading and 1 day attendance
8 May 2018	Observe Audit Committee (9am-1pm)	Half day
22 May 2018	Attend formal committee of the board (Finance & Performance (9.30-11.30am), Quality & Safety (10am-12pm) or Workforce & Organisational Development (4-5.30pm)) Attend NED only monthly meeting (12-1.30pm)	1 day
30 May 2018	Board Meeting	1 day reading and 1 day attendance
14 June 2018	Council of Governors Meeting (4-6pm, Malton Rugby Club)	Half day
19 June 2018	Attend formal committee of the board (Finance & Performance (9.30-11.30am), Quality & Safety (10am-12pm) or Workforce & Organisational Development (4-5.30pm)) Attend NED only monthly meeting (12-1.30pm)	1 day
27 June 2018	Board Meeting (Scarborough site)	1 day reading and 1 day attendance

* Unless specified the meetings will take place on the York Hospital site.

2. Trust Induction

Lynne – 3 April 2018 Lorraine - TBC	Attend IT Induction	Half day
Lynne - 17 April 2018 (1.45pm) Lorraine – 17 April 2018 (2.00pm)	Obtain security card etc.	n/a
19 April 2018 (9.15am-4pm)	Attend Trust Induction (9.15am-4pm) York Hospital Social Club	1 day

3. Meeting your colleagues

I recommend that over the period of your Induction to the Trust, that you make time to meet with fellow unitary Board members for a one-to-one conversation. I recommend that you make initial contact personally and work together to find the best possible time/place to meet.

Patrick Crowley	Exec Chief Executive
Mike Proctor	Exec Deputy Chief Executive
Andrew Bertram	Exec Finance Director
Wendy Scott	Exec Chief Operating Officer
James Taylor	Exec Medical Director
Beverley Geary	Exec Chief Nurse
Brian Golding	Exec Director of Estates & Facilities
Sue Rushbrook	Exec Director of Systems & Networks
Libby Raper	NED Vice Chair Chair of Workforce Committee
Dianne Willcocks	NED Senior Independent Director Chair of Charity Committee
Jenny McAleese	NED Chair of the Audit Committee
Jennie Adams	NED Chair of the Quality & Safety Committee
Mike Keaney	NED Chair of the Finance & Performance Committee
Mike Sweet	NED Chair of the Estates & Environment Committee

4. Meetings with the Chair

Welcome meeting	5 April 2018 (email Lisa Gray to arrange time)
Review Meeting	28 June 2018 (email Lisa Gray to arrange time)

5. NED Mentor/Buddy

I have asked two of our senior NEDs Dianne and Libby, to provide you with support and mentoring during this 3 month period. My suggestion is that you seek to meet monthly (face-to-face or by telephone) for an hour or so. This will be at your own discretion and Dianne & Libby will be expecting a call.

6. Reading

You can read previous Board papers on the Trust website. This may be helpful as you acclimatise yourself to our environment.

It will be valuable to read the Five Year Forward View to familiarise yourself with the strategic aspirations of the NHS.

<https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

<https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf>

You will also find it useful to read about our local STP footprint.

<http://humbercoastandvale.org.uk/>

