York Teaching Hospital
NHS Foundation Trust

Board of Directors (Public Meeting)

31 March 2021

York Teaching Hospital
NHS Foundation Trust

BOARD OF DIRECTORS MEETING

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

On: 31 March 2021

In: via Webex

TIME	MEETING	LOCATION	ATTENDEES
09.30 – 12.15	**Board of Directors meeting held in public**	**Via Webex**	**Board of Directors Members of the public**
13.00 – 14.00	Board of Directors meeting held in private	Via Webex	Board of Directors

York Teaching Hospital
NHS Foundation Trust

Board of Directors (Public) Agenda

	SUBJECT	LEAD	PAPER	PAGE	TIME
1.	**Apologies for absence and quorum** To receive any apologies for absence.	Chair	Verbal	-	9.30 – 9.40
2.	**Declaration of Interests** To receive any changes to the register of Directors' declarations of interest or to consider any conflicts of interest arising from this agenda.	Chair	A	07	
3.	**Minutes** of the meeting held in public on the 27 January 2021, to approve as an accurate record.	Chair	B	11	
4.	**Outstanding actions** To discuss any actions arising from the action log.	Chair	Verbal	-	
5.	**Patient Story** To receive a patient story	Chief Nurse	Verbal	-	9.40 – 9.50
6.	**Chief Executives Update** To receive an update from the Chief Executive • Covid-19 Update • Integrated Care System • Recovery Plan	Chief Executive	C	19	9.50 – 10.00

Strategic Goal: To deliver safe and high quality patient care

Strategic Goal: To ensure financial sustainability

Strategic Goal: To support an engaged, healthy and resilient workforce

	SUBJECT	LEAD	PAPER	PAGE	TIME
7.	**Quality Assurance Committee Chair's report** To receive and note the minutes of the meetings held 16 February 2021 and escalation report on 23 March 2021.	Committee Chair	D D1	49 59	10.00-10.10
8.	**Nurse Establishment Review – follow-up report** To receive the report.	Chief Nurse	E	61	10.10-10.20
9.	**Resources Assurance Committee – Chairs Report** To receive and note the minutes of the meetings held on 16 February 2021 and escalation report held on 23 March 2021.	Committee Chair	F F1	91 101	10.20-10.30
10.	**Integrated Business Report** To receive and discuss the IBR, highlighting any areas of concern not already discussed or escalated by the Quality & Resources Assurance Committees.	All	*Separate Report*	-	10.30-10.40
11.	**Draft Income and Expenditure Plan – Quarter 1 2021/22** To discuss the report.	Director of Finance	G	103	10.40-10.55
12.	**Capital Programme 2021/22** To discuss and agree the Capital programme.	Director of Finance	H	111	10.55-11.10
13.	**YTHFM LLP Financial Plan 2021/22**	LLP Managing Director	I	119	11.10-11.20

Governance					
14.	**Audit Committee Chairs Reports** To receive and note the minutes of the meetings and escalation reports held on 9 March 2021.	Committee Chair	J J1	127 131	11.20-11.30
15.	**YTHFM LLP SFI's, Reservation of Powers and Scheme of Delegation** To receive and approve.	LLP Managing Director	K	145	11.30-11.35
16.	**Health and Safety Policy – YTHFM** To receive and approve .	LLP Managing Director	L	233	11.35-11.40
17.	**Trust wide Documents, and Service Level Documents – Development and Management of Policies** To receive and approve the policy.	Chief Nurse	M	241	11.40-11.45
18.	**Modern Slavery Act Board Statement** To receive and approve the Modern Slavery Act Board Statement.	FT Secretary	N	255	11.45-11.50
19.	**Standards of Business Conduct Policy** To receive and approve the amendments to the policy.	FT Secretary	O	259	11.50-11.55
20.	**Reflections on the meeting** • BAF	Chair	Verbal P	 261	11.55-12.00
21.	**Any other business**	Chair	Verbal	-	12.00

22.	**Items for information:**	Chair		-
	• Medical Directors Report		Q	281
	• Implementing Continuity of Carer in Midwifery Services		Q1	285
	• Head of Midwifery Annual Report 2020		Q2	289
	• To receive the March Star Awards booklet		Q3	319

23. Time and Date of next meeting

The next meeting will be held on 26 May 2021 via webex.

24. Exclusion of the Press and Public

'That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1(2), Public Bodies (Admission to Meetings) Act l960.

Additions:

A

Changes:

Lynne Mellor—Position with BT (telecom suppliers) removed

Deletions:

Director	Relevant and material interests					
	Directorships including non -executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation trust including but not limited to, lenders or banks
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
Jenny McAleese (Non-Executive Director)	**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 **Member**—Audit Committee, Joseph Rowntree Foundation	**Member of Court**—University of York	Nil
Dr Lorraine Boyd (Non-executive Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Ms Lynne Mellor (Non-executive Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mr Steve Holmberg (Non-Executive Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mr Jim Dillon (Non-Executive Director)	Nil	LLP—Members Representative	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil

Director	Relevant and material interests					
	Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation trust including but not limited to, lenders or banks
Prof Matt Morgan (Stakeholder Non-Executive Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	**Deputy Dean**—Hull York Medical School	Nil
Mr David Watson (Non-executive Director)	Battersea Dogs & Cats Home York University			**Act as Trustee** –on behalf of the York Teaching Hospital Charity		Hull York Medical School via York University
Mr Simon Morritt (Chief Executive)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity **Act as Trustee** Medi-cinema		Nil
	Other: Member of the Independent Reconfiguration Panel (Independent Committee advising the Secretary of State on contested health service re-configuration.					
Mr Andrew Bertram (Executive Director Director of Finance/ Deputy Chief Executive)	Nil		Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	**Member** of the NHS Elect Board as a member representative	Nil
Mrs Heather McNair (Chief Nurse)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil

Director	Relevant and material interests					
	Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation trust including but not limited to, lenders or banks
Mr James Taylor (Medical Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mrs Wendy Scott (Chief Operating Officer)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Ms Polly McMeekin (Director of Workforce & OD)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	HR Director—Nightingale Hospital (Yorkshire & Humber)	Nil
Mrs Lucy Brown (Director of Communications)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mr Dylan Roberts (Chief Digital Information Officer)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil

NHS
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Board of Directors – 31 March 2021
Public Board Minutes – 27 January 2021

The meeting was held via video conferencing and all attendees joined through Webex.

Present: **Non-executive Directors**

Ms S Symington	Chair
Mrs J McAleese	Non-executive Director
Dr L Boyd	Non-executive Director
Mr S Holmberg	Non-executive Director
Ms L Mellor	Non-executive Director
Mr J Dillon	Non-executive Director
Prof. M Morgan	Non-executive Director
Mrs J McAleese	Non-executive Director
Mr D Watson	Non-executive Director

Executive Directors

Mr S Morritt	Chief Executive
Mr A Bertram	Deputy Chief Executive/Finance Director
Mrs W Scott	Chief Operating Officer
Mr J Taylor	Medical Director
Ms P McMeekin	Director of Workforce & OD
Mrs H McNair	Chief Nurse
Mr D Roberts	Chief Digital Information Officer

Corporate Directors

Mrs L Brown	Director of Communication

In Attendance:

Mrs T Astley	Assistant to FT Secretary (note taker)

Observers:

Prof. J Baker	Aspiring Chair Programme
6 Trust Governors	
3 Members of the Public	

Ms Symington welcomed everyone to the abbreviated public Board meeting at York Hospital. The meeting was held in public via webex.

21/01 Apologies for absence

No apologies were received.

21/02 Declarations of interest

There were no changes to the Declarations of Interest.

21/03 Minutes of the meeting held on the 25 November 2020

It was noted that the minutes of the meeting held on the 25 November 2020 were approved as a correct record.

The Board:

- **Received and approved the minutes of the meeting held on the 25 November 2020.**

21/04 Outstanding Actions

Ms Symington noted that there were outstanding actions due to the Covid situation.

The Board:

- **Noted the action log**

21/05 Chief Executive Overview

The meeting opened with a short film recorded by the CE for all staff. The film coincided with the national news that 100,000 people have died in the UK as a result of the pandemic. Our trust has seen heightened mortality during the recent wave of the pandemic and it is well understood that our staff are very tired, saddened by the acuity and mortality of patients and many are personally challenged by the lockdown in their lives away from work too. The purpose of the film was to show empathy and consideration to staff of the impact of the virus. In the case of the board, it set the tone for the meeting ahead.

The Chief Executive provided an update on the following key areas:

<u>Covid-19 update</u>

Mr Morritt stated that as of Monday the Trust had over 200 Covid+ inpatients which had put significant pressure on the Trust, particularly on the York site where there was a high prevalence rate in the City of York. This could be due to the city being in Tier 2 restrictions when surrounding areas were in Tier 3. Forecasts suggest that this has now plateaued and the rate of admissions has started to reduce.

The vaccination programme is well established and to date 14,000 health care staff across York and North Yorkshire have been vaccinated at our trust. It was still a challenging situation and will be for some time.

Mrs Scott stated that the Trust still continues to operate within the context of a national level 5 incident. There were 157 Covid+ inpatients at York Hospital, 46 Covid+ inpatients at Scarborough Hospital and 13 Covid+ patients being treated in a community base. Out of those inpatients, 11 were in the Critical Care Unit at either York Hospital or Scarborough Hospital and 10 patients were receiving non-invasive intervention. As of yesterday, there were 242 Covid+ inpatients being treated in the Trust, the highest ever throughout the pandemic. As of 24 January 2021, there has been 479 Covid related deaths.

Mrs Scott advised that the Trust had enacted its Surge Plan and there were 7 dedicated Covid wards on the York site plus additional admitting beds, and 3 dedicated wards on the Scarborough site with Lilac Ward as the admitting ward.

Mrs Scott stated that managing the non-Covid activity during this time was very challenging and explained that during wave 1 of the pandemic, in line with national directive, the Trust stood down most of its services but this time round it has not happened and trying to manage all activity and referrals coming in to the organisation as well as treating Covid+ patients has taken its toll on staff. Some had to isolate; some were off with Covid related illnesses and staff were being redeployed to support the Covid inpatient areas and Critical Care.

WS confirmed that the Surge Plan was well developed and that planning is taking place for what will happen after the peak including starting to de-escalate some of the ward areas. The Third Wave has had a significant impact on elective activity and during December the Trust had to step down a number of routine cases, and in January, 99 elective cases were cancelled due to lack of beds, or staff shortages. She wanted to assure the Board that we are continuing to maintain cancer services and that patients who urgently needed surgery have access to surgery. A review takes place, with the oversight of the Medical Director, on a day-to-day basis.

Mr Morritt commented that he would like to thank the Trust's partners for supporting the Trust in maintaining patient flow throughout the pandemic. This included North Yorkshire County Council, City of York Council, other neighbouring NHS organisations and independent hospitals and he was grateful for their continued support.

<u>Integrated Care Systems (ICS)</u>

Mr Morritt stated that before Christmas the NHS consulted on the operating arrangements for ICS. The Trust ICS across Humber Coast & Vale (HCV) responded collectively. There was a broad agreement for Option 2: creation of a statutory body for the ICS, being the preferred option for HCV. Work was now underway to establish that body in shadow form from 1 April 2021. Discussions were now taking place throughout the City of York to ascertain how the place element of those changes might be managed. The objective is that with partners across the city, the Trust will be able to establish (in an interim form) a City of York alliance from 1 April 2021.

<u>Operational Planning</u>

Mr Morritt noted that at the beginning of 2020/21 the planning round was suspended. That had not been reinstated at all during the year and may not be for 2021/22 - at least for the first quarter of the year.

Mr Morritt asked for any questions.

Mrs Mellor said the video carried a very poignant message and praised the fantastic work from all the staff. She asked about the provision for Long Covid patients. Mr Taylor replied that the Trust will be setting up a clinic for Long Covid patients. Mrs Scott added that they have already received referrals from GPs regarding patients with ongoing issues. There was recognition that there would be an ongoing need to support these patients for a longer period of time hence the national funding to support these clinics.

Mrs McAleese paid tribute to Ms McMeekin and Ms Greenwood who were instrumental in setting up the vaccination centres. However, she was concerned with the reduction in levels of engagement by social care staff and by staff in the LLP. She felt there was an educational piece of work that still needed to be done.

Ms McMeekin replied that as of yesterday the trust had delivered 14,000 vaccines. The trust is monitoring really carefully how the vaccine was being used to ensure there is no wastage. She added that it had been really hard to engage social care staff given the eagerness of the Trust staff in having the vaccine. Around 700 social care employees have booked to have the vaccine within the next 4 days. We are now looking to reduce the centres' opening times to 3 days at Scarborough Hospital and 4 days at York Hospital in line with demand.

Mr Morritt referred to the lower take up of vaccination from the LLP staff and stated that we were doing some work with the LLP team to address this. Regarding social care staff, he has spoken with the City of York Council and North Yorkshire County Council who have replied that staff were able to access vaccination sites within their area to receive the vaccine.

Mr Dillon stated that at the LLP Board meeting on Tuesday it was highlighted that staff uptake may be low due to limited access to IT facilities to book a vaccine appointment. This has now been resolved and LLP staff can attend a vaccine centre on a walk-in basis.

Dr Boyd stated that across the Vale of York GPs were well on with the national target of over 70s being vaccinated by mid-February.

Mr Taylor stated that being vaccinated was about having personal protection from the virus but also it was about herd immunity in our communities and stated that as many people as possible need to be encouraged to have the vaccine to achieve herd protection level.

Ms McMeekin referred to the LLP walk-in vaccination provision, and commented that numbers were low. She was working with the Comms Team to focus on the educational messages to encourage vaccination through improved understanding.

The Board:

- **Received and noted the Chief Executive's Report including the Covid update**

21/06 Quality & Resources Committees – Items for escalation

Resources Committee – Mr Watson highlighted the following:

- Workforce – a grant has been secured to help roll out the medical e-rostering system.
- LLP – an excellent report was presented by the Managing Director, Mr Beverley, around the governance of the LLP and the interface of the Trust. It was agreed that Mr Bertram and Mr Beverley would jointly make recommendations to EPAM to move forward.
- IT – Mr Roberts presented a report highlighting the IT challenges faced by the Trust regarding outdated equipment, the necessity for a network upgrade, and the risks relating this, including cyber-attacks. He outlined a programme of upgrade which would cost £11m over 3 years. The Committee welcomed the report and supported the programme of upgrade as it processes through the various scrutiny committees of the Trust, and also to secure finances to do the work. In relation to that, Mr Bertram reported the huge demands for capital expenditure on the Trust in 2021/22 and the very significant gap in the amount of capital expenditure that had been requested against an expected budget of around £5m. AB confirmed that we are now looking at external monies to support the programmes and it is encouraging that Mr Roberts had identified an NHS programme which may support our aspirations and the Trust was also being supported by the ICS as a Digital Aspirant which may provide initial funding for consultancy support on the IT upgrade.

Mrs McNair referred to the nurse staffing ward unfilled rate which stood at 35%. There were currently over 100 nurses who have been redeployed throughout the Trust to cope with the pressures of the pandemic: these nurses have been required to develop new skills to care for Covid patients, often outside their usual areas of expertise and this created an additional pressure on the ward staff to support them. Mrs McNair advised the board that every day, it was a continual juggling act to ensure that the wards were safely staffed.

Quality Committee – Dr Holmberg highlighted the following:

- Nurse Staffing Review – Over time the Trust has fallen behind peer Trusts in terms of nurse staff investment, creating a £6m problem on the inpatient wards This figure did not include additional money which will certainly be required for maternity in order to ensure compliance with the recommendations within the Ockenden Report. Dr Holmberg alerted the Board to this very significant and concerning shortfall and emphasised the need to prioritise a plan for nurse staffing.
- CQC – the trust has been undertaking a review of our position in relation to the most recent CQC inspection. The review has been focused around a self-assessment of the Trust's progress to date against a new CQC modified regulatory framework in light of the pandemic,. While the review reveals some progress, the Trust rates itself as Requires Improvement. Dr Holmberg and there was a need to focus on this to improve the Trust's position as matter of great importance.

- Serious Incidents (Sis) – a review of the Si's had highlighted areas where it was felt that a shortfall in specialist nursing had contributed to harm to patients.

Mrs McNair gave an overview of the establishment review and stated this review should be carried out each year (but had lapsed during recent years) with the last full review being

done in 2015 and a shorter review being carried out in 2018 but not acted upon. A full review has now been carried out and a paper will be presented at the next Committee meeting in February.

Ms Symington noted that the board has many significant issues to understand and discuss, and one of the most significant of these is nurse staffing levels and their impact on patient safety.

Prof. Morgan identified a an emerging theme relating to issues which had 'drifted' and asked if the Trust/Board had a very clear focus on what should be being monitored, and if there was a plan to rectify these to prevent the Trust from falling into the same traps over the coming years? Ms Symington replied that the fact the Board were discussing the issues should give some assurance that the Board had that awareness. Mr Morritt agreed that the Trust did face some difficult challenges and the pandemic has hindered progress on some of these. He had discussed with the Board previously issues around staffing establishments, the robustness of IT and the challenges faced from an aging estate that requires additional investment. Mrs McNair confirmed that she had wanted to undertake an establishment assessment since she took up post, but did not have the capacity to do that until now. The aim now was to turn some of the diagnostic work that had been carried out into effective plans going forward and putting those issues right.

Ockenden Report

Mrs McNair explained that the report was the result of the investigation into the Shrewsbury & Telford baby deaths and was published in December 2020. It highlighted the need to strengthen assurance at Board level around maternity services and therefore the Board will be seeing a lot more reports on maternity services. There were 25 standards identified which were broken down into 7 categories, together with immediate and essential actions.

The report presented at Board today outlined areas where it was felt the Trust had potential issues and the Trust will need to submit it's baseline assessment by the 15 February. Some issues required a need to work differently but others required investment. She was confident that the Trust would become compliant in due course.

Mrs Mellor stated that she and Mrs McNair had had a series of meetings with the Maternity teams and she was assured that plans have started to be put in place. She has asked for milestones and actions to be devised around the list of items in the Ockenden report. There were also issues highlighted in the Ockenden report around workforce and leadership and discussions were taking place on how the Trust could comply with this and was waiting for further clarification.

The Board:
- **Noted the items escalated from the Committees**
- **Received and noted the report**

21/07 Integrated Business Report

Mr Taylor referred to the following:

- Duty of Candour – issue with a delay in the reporting of incidents. This had now been rectified.
- Medicines Management – improvement work was ongoing with high-risk medicines.
- Deteriorating performance with delirium and dementia screening – this piece of work was ongoing.

21/08 Reflections on the Meeting

Ms Symington stated that she had set out to chair an abbreviated meeting because of the challenges faced by the trust at the peak of Wave 3 of the pandemic. She drew her attention to the BAF which seeks to highlight the risks to the trust strategic objectives. Given the limited time for the meeting, the Board had not been able to cover all of the subjects in the BAF, but she noted that the most important issue was patient care, and this had been discussed in a number of ways.

Mr Watson commented that in relation to the BAF it was reassuring that during the course of the meeting concerns were expressed about many of the risks. He observed that it gave the Board significant comfort that the trust was aware of the risks, and that it was seeking to was seeking to act upon understanding, within the restraints of staffing and finance issues.

21/09 Any other Business

Mrs Mellor referred to the Star Awards which made wonderful reading in these hard times. She particularly referred to the excellent engagement with Teletherapy and wondered if further sharing with other trusts would be beneficial.

Prof. Morgan commented that despite everything that has been said about staffing pressures there had been no change in the quality of care and the mutual support was still there.

Ms Symington reminded the Board that Mrs Provins had retired on Monday. The Board wished her health and happiness in her retirement. She was very hopeful that an Interim FT Secretary will be in post by the time the next Board meeting took place in February.

Ms Symington recognised the effort and commitment given by the executive to the trust during this very difficult time, noting that they are working under extreme pressures and she thanked them for their professionalism and commitment.

No further business was discussed.

21/10 Items for Information

The Board noted the items for information including:

- Continuity of Care Report
- Medical Directors Report
- January 2021 Star Awards booklet

21/11 Date and Time of next meeting

The next public meeting of the Board will be held on 31 March 2021 via Webex. Details TBC.

Outstanding actions from previous minutes

Minute No. & month	Action	Responsible Officer	Due date
19/68	Consider in discussion with new CE, PCN presentation to board. Consider in 2021 after April.	Ms Symington	~~Oct 19~~ ~~Jan 20~~ ~~Jul 20 review~~
19/93	Mortuary to be kept under review on the action list.	Board	Until completed
20/11	Report front sheets to include items of real concern for Board discussion together with actions to address the concerns.	All	Feb 20 - ongoing
20/25	Invite Dr Jayagopal to provide an HYMS update to the Board in December 2020	Mrs Provins	Dec 2020
20/26	Clever Together feedback to the Board	Mr Morritt	~~Sept 2020~~ Oct 20 time out
20/40	IPC Presentation (every 6 months)	Mrs McNair	Mar 21

NHS
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Board of Directors – 31 March 2021
Chief Executive's Overview

Trust Strategic Goals:

☒ **to deliver safe and high quality patient care as part of an integrated system**
☒ **to support an engaged, healthy and resilient workforce**
☒ **to ensure financial sustainability**

Recommendation

For information	☒	For approval	☐
For discussion	☒	A regulatory requirement	☐
For assurance	☐		

Purpose of the Report

To provide an update to the Board of Directors from the Chief Executive on recent events and current themes.

Executive Summary – Key Points

The report provides updates on the following key areas:

- Covid-19 update
- Scarborough Urgent and Emergency Care Capital Scheme
- Regulatory updates
- Planning guidance
- System developments:
    - York Health and Social Care Alliance
    - Local government consultation
- New Trust name

Recommendation

For the Board of Directors to note the report.

Author: Simon Morritt, Chief Executive

Director Sponsor: Simon Morritt, Chief Executive

Date: March 2021

1. Covid-19 update

Since January we have seen a significant reduction in the number of Covid patients in our hospitals, as measures to limit the spread of the virus has taken effect. At the peak we had over 240 patients in our hospitals, far exceeding the previous numbers during the first wave.

We have also passed the milestone of a year since the first cases were confirmed in the UK, and a year since lockdown restrictions were first introduced.

There is however a reason for optimism in that we now have an understanding of how we will start to return to a more normal way of life, and when this might be able to happen. Our vaccination hubs at Scarborough and York have reopened and are giving second doses to our staff and those from wider health and social care organisations.

Our focus must now be on recovery, and how we can transition from the pandemic to more sustained 'business as usual', although of course it will inevitably look different for some time to come.

Our recovery focusses on two key areas; operational recovery and recovery from a workforce perspective. There are two main areas of focus for our recovery planning. The first is our operational recovery, i.e. how we return to delivering pre-pandemic levels of activity, and how we address the backlog of patients who have had their appointments or procedures postponed. The second is how we support our workforce, and the actions we should take to encourage staff wellbeing, in particular for those who have suffered trauma and/or mental ill health as a result of the pandemic, or will struggle to adjust as we return to a more normal way of working.

While we are yet to have confirmation of what the specific asks will be of us in terms of speed of recovery, or what the financial framework will mean for what we can do and how quickly, we are none the less building a plan based on a number of assumptions, that can be adjusted once we understand in more detail the parameters and expectations we are working with.

We are also in discussion with colleagues in the Humber Coast and Vale ICS about how we might collectively meet some of the challenges we all share, and use some of our individual trusts' resources more flexibly to serve the clinical specialties with the greatest need.

Our plans need to strike a balance between treating delayed patients as soon as possible and managing fatigue within the workforce. This will inevitably have an impact on the pace of recovery and the extent to which we may be able to increase our capacity, as well as other practical limitations such as the continuing of social distancing requirements and enhanced infection prevention measures.

In terms of our workforce, the ongoing wellbeing and welfare needs of our staff are a priority, and we are working up plans for how we can best support staff as we move to 'restart' the organisation and move away from the pandemic.

We already have in place a wide range of targeted wellbeing support, and we are looking at how we can invest in this further given the significant increase in demand that we have seen for this sort of help and support. Our organisational development team have

delivered resilience training for staff, and our chaplaincy teams have continued to provide input for staff as well as patients.

Further developments include increasing the resource we have available for bespoke, targeted psychological support and intervention to help staff recovery, and for organisational development support such as building team resilience, evaluating work-life balance, and restorative conversations.

We will also be delivering on the commitments made as a result of the large-scale staff engagement exercise, Our voice, our future, which will signal a fresh start for the organisation post-pandemic, and will see the rollout of the new values and behaviours that will provide a strong foundation for the organisation we want to become as we recover from the crisis and upheaval that the pandemic has caused this last year.

This will start to be communicated widely as we enter the new financial year, and we will be dedicating time to this as a Board in April.

2. Scarborough Urgent and Emergency Care Capital Scheme

This month we have received confirmation that the joint investment sub-committee of the Department of Health and Social Care and NHS England/Improvement has approved the Scarborough Outline Business Case for the multi-million pound investment to transform urgent and emergency care facilities at Scarborough Hospital.

This is excellent news and a testament to the huge amount of effort put in to this by all involved. This means that we can now progress to the next stage, which is the development and submission of the Full Business Case before the end of the year.

3. Regulatory updates

I have two positive updates for the Board regarding our regulatory scrutiny and oversight. The first is that I have received a letter from Richard Barker, Regional Director for NHS England and Improvement, detailing where we are placed in their segmentation of providers and commissioners, in line with the NHS Oversight Framework. This is attached in appendix 1.

NHS organisations are segmented based on the level of support they are deemed to require across the themes of leadership capacity and capability, quality of care, financial management, and/or operational performance.

We have moved from segment 3 to segment 2. The letter explains that this change has been driven by the improvements made to evidence compliance with the outstanding enforcements that were in place in relation to the previously identified issues into board and financial governance.

The second is that the the Quality Board for the Trust has been stood down, as confirmed in a letter from Margaret Kitching, NHSE/I's Chief Nurse for the North East (appendix 2).

The Quality Board was established to support improvements in quality, safety and performance across urgent and emergency care at the Trust and the wider York and Scarborough system.

Members of the Board, which include the Care Quality Commission, Clinical Commissioning Groups and other partner organisations have agreed that the purpose of the Quality Board is considered to have been fulfilled and that the specific concerns raised in relation to the delivery of urgent and emergency care by the Trust have been mitigated.

Both of these actions are important steps forward for us, and it is pleasing to see that we have made some progress in terms of patient safety, quality and performance, particularly in the current climate.

4. Planning guidance

The 2021/22 planning guidance has now been published. In terms of the financial settlement it is largely as expected, with the government allocating £8.1bn for covid-19 costs in the first half of the year. There is an additional £1.5bn funding for elective recovery, mental health and workforce development. The second half of the year will be agreed closer to the time.

The financial framework will build on a system-based approach to funding and planning, with system funding envelopes issued for the first half of the year. There will be a continuation of the system top-up and Covid-19 fixed allocation arrangement and the block contract approach for NHS providers.

We will be asked to focus on the following priories and to deliver them by working collaboratively through ICSs:

- Supporting staff health and wellbeing, and action on recruitment and retention
- Covid-19 patients and vaccination
- Restoration of elective and cancer care and managing increased demand for mental health services
- Expanding primary care capacity (improve access, experience and outcomes and address health inequalities)
- Redesign of community and urgent and emergency pathways

5. System developments

5.1 York Health and Social Care Alliance

Proposals to establish a Health and Social Care Alliance for York have been supported at a meeting of the City of York Council Executive earlier this month, essentially paving the way for the Alliance to run in shadow form until proposed reforms to health and care outlined in the recent White Paper take effect in 2022.

These proposals are the culmination of purposeful conversations between Health and social care organisations serving the City of York about how a more integrated approach could be formalised. Place-based working is key part of the future functioning of

Integrated Care Systems, and these discussions have focused on the potential scope of any devolved responsibility, principles and behaviours to be adopted by the collective organisations, and how the governance arrangements could work.

The aim of the Alliance is to strengthen health, care and public services in the city by building healthcare locally around residents, rather than around organisations.

Partners have set three 'areas of first focus' and seven other key priorities for the Alliance in 2021/22. These are the areas of service integration and change that the partners want to focus on together to achieve better outcomes.

The areas of focus for the next twelve months are:

- Diabetes prevention and healthy weight
- Learning disabilities and autism
- Integration of joint complex care packages

The other priorities are:

- COVID recovery
- Community Mental Health
- Dementia care and support across the whole pathway
- Loneliness, isolation and wellbeing
- Self-harm and suicide
- Childhood resilience
- Alcohol harm and substance misuse

The York Health and Social Care Alliance will run in shadow form during the 2021-22 financial year, in order to further develop governance and accountability structures. Once all partners have agreed to the yet-to-be-proposed terms of reference, the board will be formalised in 2022, when the new national legislation takes effect.

The first meeting of the Alliance took place last week, chaired by Cllr Keith Aspden, leader of City of York Council. I have been elected as vice chair. Attached to this report for information is a concord for the Alliance (appendix 3). Alliance partners have worked together to develop this and are supporting it, and I am recommending that we also sign it and continue to positively support the Alliance in its development.

5.2 Local government consultation

The Government is now consulting on the future of local government in North Yorkshire. Board members will recall in from my November 2020 report that North Yorkshire County Council submitted a proposal to the Government for a single unitary authority for North Yorkshire based upon the current county footprint, whilst retaining the existing City of York Council. This would be the first step towards devolution for North Yorkshire.

The proposal that is being supported by North Yorkshire County Council and City of York is being supported by North East and Yorkshire NHS regional office and Humber, Coast and Vale ICS. We will be supporting the proposals in our response to the consultation as they are entirely consistent with the direction of travel for Humber, Coast and Vale ICS in

terms of the development of the two geographic partnerships (North Yorkshire and York and Humber) and the two 'places' of City of York and North Yorkshire. Alternative proposals put forward by the District Councils would split North Yorkshire into East and West, and would create disruption at a critical time in the development of the ICS.

6. New trust name

Finally, I am delighted to say that from next month our trust will be known as York and Scarborough Teaching Hospitals NHS Foundation Trust.

The change officially takes effect from 1 April 2021, and much work has been undertaken to make the necessary updates and changes across the trust.

This has been a matter of great importance to me since I joined the organisation, as I heard frequently from staff, particularly those on the East Coast, that not being represented in the name of the organisation made them feel less valued and unrecognised as part of the wider organisation.

I believe that this change will send a strong, inclusive message to all of our staff, help us move forward as a single organisation, and better represent the communities we serve.

NHS (North East and Yorkshire)
6NE
Quarry House
Quarry Hill
Leeds
LS2 7UE

Tel: 0113 823508

04 March 2021

Simon Morritt
Chief Executive
York Teaching Hospital NHS Foundation Trust

Dear Simon

NHS provider segmentation

The NHS Oversight Framework sets out how we segment local providers and commissioners based on the level of support needs across the themes of leadership capacity and capability, quality of care, financial management, and/or operational performance.

The segmentation reflects our judgement of the seriousness and complexity of the issues each local organisation faces and the associated support need.

Based on this work, your trust has moved from segment 3 to segment 2. This change has been driven by the improvements made to evidence compliance with the outstanding enforcements that were in place in relation to the previously identified issues into board and financial governance. The relating compliance certificate to these enforcement undertakings was issued to the trust on 5 January 2021.

The NHS provider directory website will be updated to reflect the change in segmentation in due course.

Yours sincerely

Richard Barker
Regional Director
(North East and Yorkshire)

Cc:
Tim Savage, Regional Director of Finance, NHSEI
Foluke Ajayi, Locality Director, NHSEI
Stephen Eames, ICS Lead, Humber Coast and Vale

NHS England and NHS Improvement

Simon Morritt
Chief Executive
York Teaching Hospitals NHS Foundation Trust

Margaret Kitching
Chief Nurse North East
NHS England & NHS Improvement
6E26, 6th Floor
Quarry House
Leeds
LS2 7UE
Margaret.kitching@nhs.net

23 February 2021

Sent via email

Dear Simon,

Quality Board –York Teaching Hospitals NHS Foundation Trust

I am writing to formally confirm that a decision has been reached to stand down the Quality Board for York Teaching Hospitals NHS Foundation Trust.

The Quality Board was established to support improvements in quality, safety and performance across urgent and emergency care at the Trust and the wider York and Scarborough system, provide appropriate challenge to ensure that the most robust approaches are being considered, and obtain evidence and assurances that relevant milestones have been completed.

Following discussions with colleagues at the Care Quality Commission, Clinical Commissioning Groups and partner organisations, the purpose of the Quality Board is considered to have been fulfilled.

Members are satisfied that the actions taken by the Trust / across the system have sufficiently mitigated the specific concerns raised in relation to the delivery of urgent and emergency care by the Trust.

Please extend my thanks to your team for engaging with and participating in the Quality Boards, and congratulations for the progress made on your patient safety and quality improvement journey.

Yours sincerely,

M Kitching

Margaret Kitching
Chief Nurse, North East and Yorkshire
NHS England and NHS Improvement

cc. Heather McNair – Chief Nurse, York Teaching Hospitals NHS FT
James Taylor – Medical Director, York Teaching Hospitals NHS FT
Alison Smith, HCAV Director of Nursing, NHS England and NHS Improvement
Foluke Ajayi, HCAV ICS Director, NHS England and NHS Improvement
Paul Twomey, Medical Director, NHS England and NHS Improvement

York Health & Care System Alliance Concord

V1-7 – 4 March 2021

BACKGROUND

(A) The York Health and Care Alliance ("the **Alliance**") has been set up by the partner organisations ("**Partners**") who are signatories to this Concord as a place based partnership to help them deliver better health outcomes for the City of York Place, through more integrated working and improved use of data.

(B) City of York Place is the area covered by City of York Council plus the area covered by Pocklington Primary Care Network (PCN). (Most of the area covered by Pocklington PCN is in the area covered by City of York Council but there is part of Pocklington PCN that is in the area covered by East Riding of Yorkshire Council. As there is an increasing focus on work done by or in partnership with PCNs, the Alliance has decided that it would be preferable for City of York Place to cover all of this PCN area, rather than having some of the PCN in and some of the PCN out of City of York Place.) The services that are within the remit of City of York Place include public services provided by the Partners:

- to residents of City of York Place;
- within City of York Place; or
- to visitors and temporary residents of City of York Place.

(C) The key aims of the Alliance are:

- **People centred:** The development of public services and the right conditions for people and communities to stay well, enabling them to take increased responsibility for their own health and wellbeing

- **Integrated services:** The development of primary, social, voluntary and community care to support people and communities in the place they live and provide a point of on-going continuity, which for most people will be general practice

- **Timely and appropriate care:** The freeing up of mental and physical health specialists to be responsive to episodic events, to provide complex care and support, and to give specialist advice as part of multi-disciplinary teams ("the **Aims**")

(D) The shared purpose of the Alliance is to improve health outcomes and reduce health inequalities for the population of the City of York Place through the prevention of ill-health and provision of safe and high quality public services that work well together. Data, technology and innovation will be harnessed to achieve this ("the **Shared Purpose**").

(E) This Concord supplements and works alongside individual Partners' existing governance arrangements and their existing and future services contracts with the Vale of York CCG, NHS England and City of York Council, whilst respecting their individual sovereignty.

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This Concord sets out how the Partners will work together in a collaborative and integrated way in line with the Principles for the Shared Purpose and any outcomes defined by the Alliance.

(F) The Alliance is not a separate legal body so it is not able to make decisions in its own right. Each Partner retains responsibility for making its own decisions. The Alliance cannot require any Partner to act in a particular way, nor can any Partner or group of Partners "overrule" any other. However, it is hoped that through working together more closely Partners will make decision in a more co-ordinated way, with a better understanding of the implications for the overall health outcomes at City of York Place.

1 DEFINITIONS AND INTERPRETATION

1.1 In this Concord, capitalised words and expressions shall have the following meanings:

1.1.1 **Alliance Board** is the York Health & Care Alliance Board, as described at Clause 4;

1.1.2 **Areas of First Focus** means those projects and/or initiatives initially selected by the Partners and listed in Schedule 3;

1.1.3 **City of York** means the area covered by City of York Council plus the area covered by Pocklington Primary Care Network;

1.1.4 **Concord** means this document and any changes to it made in accordance with Clause 13;

1.1.5 **Commencement Date** means the date that the last signature was added to Schedule 1;

1.1.6 **Extended Term** has the meaning in Clause 10.2;

1.1.7 **Initial Term** has the meaning in Clause 10.1;

1.1.8 **Partners** means all those organisations set out in Schedule 1;

1.1.9 **Principles** has the meaning in Clause 2.4;

1.1.10 **Services** means the public services provided by the Partners to residents of the City of York; within the City of York; or to visitors and temporary residents of the City of York;

1.1.11 **Shared Purpose** means the vision described at paragraph (D) of the background section

1.1.12 **Values** has the meaning in Clause 2.3; and

1.2 In this Concord, unless the context requires otherwise, the following rules of construction shall apply:

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1.2.1 a person includes a natural person, corporate or unincorporated body (whether or not having separate legal personality);

1.2.2 a reference to the singular includes the plural and vice versa;

1.2.3 a reference to a statute or statutory provision is a reference to such statute or provision as amended or re-enacted. A reference to a statute or statutory provision includes any subordinate legislation made under that statute or statutory provision, as amended or re-enacted;

1.2.4 any phrase introduced by the terms "including", "include", "in particular" or any similar expression shall be construed as illustrative and shall not limit the sense of the words preceding those terms;

1.2.5 a reference to writing or written includes e-mails.

2 VALUES AND PRINCIPLES FOR THE ALLIANCE

2.1 The Partners recognise that achieving the Shared Purpose will depend on the Partners' ability to effectively co-ordinate themselves in order to deliver an integrated approach to the provision of the Services and the Areas of First Focus. This may include (if Partners choose) combining expertise, work force and resources.

2.2 The Partners also acknowledge the actions required following the "Integrating Care" guidance from NHS England around future collaborative working at place. The Partners wish to support each other in the development of a successful place based system for the City of York, which works as an effective part of the Humber Coast and Vale Integrated Care System.

2.3 The Partners embrace the following values:

2.3.1 always keeping service users at the centre of everything the Partners do;

2.3.1 supporting each other and working collaboratively to take decisions that are in the best interests of service users;

2.3.2 using the best available data to inform priorities and decision-making;

2.3.3 making time and other resources available to develop the Alliance and deepen working relationships between Partners at all levels;

2.3.4 being transparent with each other and the people of the City of York;

2.3.5 acting with honesty and integrity and trusting that each other will do the same;

This includes each Partner being open about the interests of their organisation and any disagreement they have with a proposal or analysis. Partners will assume that each of them acts with good intentions;

2.3.6 challenging constructively when required;

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2.3.7 implementing the priorities and decisions that have been agreed by all Partners through the Alliance Board and holding each other accountable for delivery;

2.3.8 sharing learning and making change through appreciative enquiry; and

2.3.9 working to understand the perspective and impacts of decisions on other parts of the health and social care system

(together these are the "**Values**").

2.4 The ways in which the Partners will put the Values into practice include:

2.4.1 having conversations about supporting the wider health and care system, not just furthering Partner organisations' own interests;

2.4.2 undertaking more aligned decision-making across the Partners and trying to commission and deliver services in an integrated way wherever reasonably possible;

2.4.3 routinely using insights from data to inform decision making;

2.4.4 encouraging and trusting front-line staff in Partner organisations to become more involved in the development of services and work jointly with staff from other Partner organisations;

2.4.5 ensure a co-ordinated approach to the delivery of Services, in particular where different Partners are involved in the provision of services to the same service user;

2.4.6 ensure that problems are resolved rather than being moved around the system;

2.4.7 developing multi professional teams from across the Partners to design solutions for the City of York, supported by Partner organisations' management and leadership;

2.4.8 taking a different approach to finance in order to make better use of individual organisation's budgets through improved coordination of health and care activities.

2.4.9 being accountable. Accounting to each other for performance of the respective roles and responsibilities set out in this Concord and the delivery of Services, in particular where Services delivered by different Partners interface with each other;

2.4.10 being open. Communicating openly about major concerns, issues or opportunities relating to this Concord and adopting transparency on all aspects of their Services, including through open book reporting and accounting, subject always to appropriate treatment of commercially sensitive information and competition law compliance if applicable;

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2.4.11 acting promptly. Recognising the importance of the Concord and responding to requests for support from other Partners;

2.4.12 deploying appropriate resource to support the Alliance and to meet the responsibilities set out in this Concord (each Partner retains ownership of its resources and is solely responsible for decisions about how those resources are used); and

2.4.13 always demonstrating that the best interests of population of the City of York are at the heart of the activities which they provide and the services they deliver under this Concord;

(together these are the "**Principles**").

2.5 Unless this Concord says differently, Partners shall each bear their own costs. By separate written arrangement, the Partners may agree to share specific costs and expenses (or equivalent) arising in respect of one or more initiatives or Areas of First Focus.

2.6 Each Partner shall remain responsible for fulfilling its statutory and contractual obligations and making decisions about its own budget.

2.7 The Partners will comply with applicable laws and standards including procurement rules, competition law, data protection and freedom of information legislation and nothing in this Concord shall require them to do otherwise.

3 PROBLEM RESOLUTION AND ESCALATION

3.1 The Partners agree to adopt a systematic approach to problem resolution, which recognises the Values and Principles.

3.2 The Partners commit to working cooperatively to identify and resolve any issues related to this Concord or the Alliance to their mutual satisfaction at an early stage so as to avoid such issues escalating into more formal disputes or litigation.

3.3 If a problem, issue, concern or complaint comes to the attention of a Partner in relation to the Areas of First Focus, the Services, or any matter in this Concord, such Partner shall notify the other Partners. The Partners shall then try to resolve the issue in a proportionate manner. If they are not able to do this or any Partner remains unhappy, the matter may be referred to the Alliance Board.

4 GOVERNANCE

4.1 Initially in the shadow year 2021/22, the governance structure for the Alliance in the City of York will consist of:

4.1.1 the Alliance Board; and

4.1.2 the City of York Health and Wellbeing Board.

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4.2 The Alliance Board is not a committee of any Partner or any combination of Partners. It will be for each Partner to take decisions for their organisation.

4.3 No Partner or group of Partners can take decisions on behalf of others through the Alliance Board.

4.4 City of York Council is not able to make decisions that have a direct effect on areas outside of the boundary of the Council.

Alliance Board

4.5 The Alliance Board will operate in accordance with its terms of reference set out in Schedule 2 (Terms of Reference).

4.6 The Alliance Board is the group responsible for leading the Partners' collaborative approach to the Services and Areas of First Focus, working in accordance with the Values and Principles to achieve the Aims and Shared Purpose across the City of York.

4.7 The Alliance Board is the forum through which the senior leadership of the Partners will meet and collaborate.

4.8 The Alliance Board is able to set up groups to support its work. This is done through agreement at an Alliance Board meeting.

Assurance and reporting

4.9 The Alliance Board will provide reports on its work to the Humber Coast and Vale ICS and to the City of York Council Health and Wellbeing Board.

4.10 It is the responsibility of each Partner to ensure that its representative on the Alliance Board reports back to their organisation about the work of the Alliance.

4.11 It is intended by the Partners that as these arrangements develop, the Alliance Board will review how it works with existing partnership engagement forums and the City of York Council Health and Wellbeing Board. The Partners will review the terms of reference of the Alliance Board at least once per year and this will include consultation with these groups about how the Alliance Board interacts with and reports to them.

5 AREAS OF FIRST FOCUS

5.1 The Partners recognise that by all focussing on the same areas they are more likely to achieve positive change. The Partners therefore agree to adopt the Areas of First Focus and that the provisions of Schedule 3 (Areas of First Focus) will apply.

5.2 Each of the Partners will commit to actively improving Services or the commissioning of Services in a way that:

5.2.1 responds to population need and takes a preventative approach;

5.2.2 better achieves the desired outcomes for the Areas of First Focus; and

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5.2.3 complies with the Values and Principles.

6 ENGAGEMENT BETWEEN THE PARTNERS

6.1 The Partners will communicate with each other clearly, directly and in a timely manner to ensure that the Alliance Board has all necessary information to perform its role.

6.2 The Partners shall each notify the Alliance Board of the level of delegation and authority of their representative at the Alliance Board and will agree to be bound by the actions and decisions of their respective representative taken at the Alliance Board provided those actions and decisions are carried out in accordance with their notification of authority and the provisions of this Concord.

6.3 The Partners will ensure appropriate attendance from their respective organisations at all meetings of the Alliance Board and that their representatives act in accordance with the Values, Principles and the Alliance Board Terms of Reference.

7 REPORTING REQUIREMENTS

Where appropriate and practicable, the Partners agree to develop consolidated reports and feedback responses for their organisations in respect of the work of the Alliance Board and the Areas of First Focus.

8 RESOURCES

The Partners will provide resources to support the Alliance as set out in the table below, with each Partner meeting the cost of the support they provide.

All Partners	Appropriate staff/ leadership time
Vale of York CCG	Administration support for the Alliance Board

9 INFORMATION SHARING AND CONFLICTS OF INTEREST

9.1 Subject to compliance with the law and contractual obligations of confidentiality, the Partners agree to share information relevant to the provision of the Services and the Areas of First Focus in an honest, open and timely manner.

9.2 The Partners agree to disclose all potential and actual conflicts of interest and ensure that such conflicts are managed in adherence with their organisation’s conflict of interest policies and statutory duties.

10 DURATION

10.1 This Concord shall take effect on the Commencement Date and will continue in full force and effect until April 2022 (“the **Initial Term**”), unless and until terminated in accordance with the terms of this Concord.

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10.2 The Partners agree to begin to review the impact of these arrangements in September 2021 in order to inform any changes to the Concord or extensions to the Initial Term. At the expiry of the Initial Term this Concord shall terminate automatically unless, no later than 2 months before the end of the Initial Term, the Partners agree in writing that the term of the Concord shall be extended for a further term agreed between the Partners (the "**Extended Term**").

11 TERMINATION IN WHOLE OR IN PART OF THIS CONCORD

11.1 This Concord shall terminate:

11.1.1 at the end of the Initial Term or Extended Term, whichever is the later; or

11.1.2 automatically and immediately where there exists just one Partner that remains party to this Concord.

11.2 Any Partner may exit these arrangements on not less than 3 months' written notice to the other Partners at any time.

12 LEGAL STATUS - NO LIABILITY

12.1 The Partners agree that except as regards this Clause 12 (Legal Status/No Liability), Clause 13 (Variation) and Clause 14 (Confidential Information), the terms set out in this Concord are not intended to create a legally binding relationship between the Partners.

12.2 The Partners do not intend that any liability will arise under this Concord and none of the Partners intend that any other Partner shall be liable for any loss it suffers as a result of adherence to the terms of this Concord by any Partner.

12.3 Without prejudice to Clause 12.2, each Partner will at all times take all reasonable steps to minimise and mitigate any losses or other matters to any other Partner under this Concord.

13 VARIATION

The Partners may agree to amend or supplement this Concord through unanimous agreement at an Alliance Board meeting or by email as set out in the Terms of Reference. However, any change to clause 12 will not be binding unless set out in writing, expressed to amend, waiver or vary this Concord and signed by or on behalf of each of the Partners.

14 CONFIDENTIAL INFORMATION

14.1 Each Party (a "Receiving Party") shall keep in strict confidence all technical or commercial know-how, specifications, inventions, processes and/or initiatives or other information which is marked as confidential which are disclosed to the Receiving Party by another Party (a "Disclosing Party"), its employees, agents or subcontractors, and any

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other confidential information concerning the Disclosing Party's business, its products or its services which the Receiving Party may obtain.

14.2 The Receiving Party shall only disclose such confidential information to its professional advisors, and those of its employees, agents or subcontractors who need to know the same for the purpose of discharging the Receiving Party's obligations under this Concord, and shall ensure that such professional advisors, employees, agents or subcontractors shall keep such information confidential.

14.3 The provisions of this Clause 14 do not apply to information which:

14.3.1 comes into the Receiving Party's possession directly from a third party other than as a result of a breach of confidence provided that third party was not under the same or similar duty of confidence;

14.3.2 is in or comes into the public domain other than as a result of a breach of Clause 14; or

14.3.3 the Partners in question agree in writing that the information is not confidential.

15 FREEDOM OF INFORMATION

Each partner retains their own legal responsibility to adhere to the Freedom of Information Act 2000. If any Partner receives a request for information relating to this Concord under the Freedom of Information Act 2000, it shall consult with the other Partners before responding to such request and, in particular, shall have due regard to any claim by any other Partner to this Concord that the exemptions relating to commercial prejudice and/or confidentiality apply to the information sought.

16 NO PARTNERSHIP

Nothing in this Concord is intended to, or shall be deemed to, establish any partnership between any of the Partners, constitute any Partner the agent of another Partner, nor authorise any Partner to make or enter into any commitments for or on behalf of any other Partner except as expressly provided in this Concord.

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Schedule 1

Signatories to the Concord

SIGNED by Duly authorised to sign for and on behalf of **CITY OF YORK COUNCIL**	))))	.... Authorised Signatory Title: [Chief Operating Officer] DATE: [ ]
SIGNED by Duly authorised to sign for and on behalf of **NIMBUSCARE**	))))	.... Authorised Signatory Title: [Chief Executive] DATE: [ ]
SIGNED by Duly authorised to sign for and on behalf of **ST LEONARD'S HOSPICE YORK**	))))	.... Authorised Signatory Title: [Chief Executive] DATE: [ ]
SIGNED by Duly authorised to sign for and on behalf of **TEES ESK AND WEAR VALLEYS NHS FOUNDATION TRUST**	))))	.... Authorised Signatory Title: [Chief Executive] DATE: [ ]
SIGNED by Duly authorised to sign for and on behalf of **VALE OF YORK CCG**	))))	.... Authorised Signatory Title: [Accountable Officer] DATE: [ ]
SIGNED by Duly authorised to sign for and on behalf of **YORK CVS**	))))	.... Authorised Signatory Title: [Chief Executive] DATE: [ ]
SIGNED by Duly authorised to sign for and on behalf of **YORK SCHOOLS & ACADEMIES BOARD**	))))	.... Authorised Signatory Title: [Chair] DATE: [ ]

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SIGNED by	)	....
Duly authorised to sign for and on	)	Authorised Signatory
behalf of **YORK TEACHING HOSPITAL**	)	Title: [Chief Executive]
NHS FOUNDATION TRUST	)	DATE: [ ]

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Schedule 2

Terms of reference of the York Health & Care Alliance Board

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1.	Purpose	The York Health and Care Alliance ("**the Alliance**") has been set up by the partner organisations (**"Partners"**) as a place based partnership to help them deliver better health and care outcomes for the City of York Place, through more integrated care and improved use of data. The key aims of the Alliance are: • **People centred**: The development of public services and the right conditions for people and communities to stay well, enabling them to take increased responsibility for their own health and wellbeing • **Integrated services**: The development of primary, social, voluntary and community care to support people and communities in the place they live and provide a point of on-going continuity, which for most people will be general practice • **Timely and appropriate care**: The freeing up of mental and physical health specialists to be responsive to episodic events, to provide complex care and support, and to give specialist advice as part of multi-disciplinary teams
2.	Area and population ("**City of York Place**")	The area of City of York Place is the area covered by City of York Council plus the area covered by Pocklington PCN. (Most of the area covered by Pocklington PCN is in the area covered by City of York Council but there is part of Pocklington PCN that is in the area covered by East Riding of Yorkshire Council. As there is an increasing focus on work done by or in partnership with PCNs, the Alliance has decided that it would be preferable for City of York Place to cover all of this PCN area, rather than having some of the PCN in and some of the PCN out of City of York Place.) The services that are within the remit of City of York Place include public services provided by the Partners: - to residents of City of York Place; - within City of York Place; or - to visitors and temporary residents of City of York Place

		The Partners acknowledge that there will not always be a neat fit between the relevant data and the City of York Place footprint, and the data that would be used in practice would depend on the question being asked/ problem being addressed.
3.	Workstreams	The Alliance has agreed that it will operate through a board of the Partners in accordance with these terms of reference (“**Alliance Board”**). The Alliance Board will choose the areas that the Alliance will prioritise. It is expected that these will be concerned with: - The commissioning, delivery and/ or design of public services that impact on outcomes for City of York Place - The development of the Alliance, including the deepening of trust and understanding between staff from different organisations - Improving the understanding and participation of citizens of the City of York Place, and engagement with other relevant organisations
4.	Membership and observers	**Alliance Board Members** The Alliance Board is made up of: • The Chair • NHS City of York Place Leader (chosen by the NHS Partners) or a deputy nominated by them • Partner Representatives These are the Board Members The Chair is in the first instance the Leader of City of York Council and attends in addition to the partner organisation representative(s) from City of York Council The NHS City of York Place Leader attends in addition to the Partner Representative from their organisation Partner Representatives The Partners of the Alliance are listed below. One representative from each Partner may attend the meetings of the Alliance Board, unless different arrangements are set out below. • City of York Council • Nimbuscare • St Leonards Hospice • Tees, Esk & Wear Valleys NHS Foundation Trust • Vale of York CCG • York Community & Voluntary Services • York Schools and Academies Board

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		• York Teaching Hospital NHS Trust There may be two Partner Representatives from City of York Council in addition to the Chair: the Director of Public Health, and one other Corporate Director. Partners nominate their Representative by emailing their name and contact details (including email address) to jo.baxter1@nhs.net. If a Partner Representative is unable to attend then a deputy may attend in their place, provided the deputy's name and contact details (including email address) are notified in advance to jo.baxter1@nhs.net by the Partner. If the Partner Representative from the City of York Council with responsibility for adult social care, children's social care and schools cannot attend then they may nominate up to two deputies if this is necessary to ensure that those attending on behalf of the Council have sufficient understanding of the areas being discussed by the Board. Citizen voice **Observers** The Alliance Board can agree to invite others to attend meetings to present, contribute to discussions or observe proceedings.
5.	Attendance	It is important that Partner Representatives from across the system attend Alliance Board meetings, to enable the Alliance Board to take a holistic approach. The Alliance Board can formally meet if: - The Place Leader or their deputy is present; and - The Leader of City of York Council or their substitute, the Executive Member for Health and Adult Social Care. If all these requirements are not met then the meeting can proceed but any outputs will be provisional unless or until they are approved by an Alliance Board meeting that meets the requirements. If a Partner fails to send a representative to the Alliance Board when the Alliance Board is due to discuss an item that directly concerns the Partner, then they shall provide the Alliance Board with an explanation for their absence. If a Partner fails to send a representative more than twice in any 12 month period without good reasons having been given for the absence then the remaining Board Members may choose to remove them from the Alliance. Attendance may be in person, by telephone or by video

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		link provided all Board Members attending are able to hear all other Board Members and appropriate security measures are in place If a Partner Representative does not attend a meeting at which changes or additions to the Concord or these Terms of Reference are discussed then they may give their agreement to those changes or additions by emailing jo.baxter1@nhs.net and stating unambiguously that they are agreed by the Partner Representative.
6.	Chairing arrangements	Meetings of the Alliance Board will be chaired by the Leader of City of York Council. If the City of York Council Leader is unable to attend then the Alliance Board meeting shall be chaired by the Deputy Chair. The Deputy Chair will be a Partner Representative from an NHS provider organisation, nominated by the Alliance Board at its first meeting.
7.	Status and authority	The Alliance is a group of organisations that have agreed to work together more closely, and to do this through participating in the arrangements set out in the Alliance Concord). Those arrangements include the senior leaders from each organisation meeting on a regular basis. When they meet together those leaders make up the Alliance Board. Neither the Alliance nor the Alliance Board is a legal body, and so they are not able to make decisions in their own right. Each Partner will continue to take its own decisions and implement them. The Alliance cannot require any Partner to act in a particular way, nor can any Partner or group of Partners “overrule” any other. However, it is hoped that through working together more closely – including by senior leadership meeting regularly at the Alliance Board – decisions can be made in a more co-ordinated way, with a better understanding of their implications for the overall outcomes at City of York Place. The aim is to reach consensus across all Partners over what action is best for City of York Place. Each Partner will decide for itself what level of authority it will delegate to its representative on the Alliance Board and will communicate this clearly to the other Partners. It is expected that the representatives on the Alliance Board will be senior leaders within their organisation, they will already have a significant decision-making responsibility for their organisation. If a representative is unable to agree to a proposal under consideration at an Alliance Board meeting without seeking approval from their organisation, they will

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		explain this at the start of the relevant agenda item. Before the first meeting of the Alliance Board, the each partner organisation will say briefly in writing what decisions their representative is able to make on behalf of their organisation and what decisions they would need to take back. These explanations will be collated and made available to all partner organisations. An organisation can update its statement at any time by emailing jo.baxter1@nhs.net It is the responsibility of each Partner to ensure that its representative on the Alliance Board understands the limits of their decision-making authority.
8.	Resources	As it is not an organisation in its own right, the Alliance relies on the Partners to provide the resources it needs to operate. The Alliance Board is supported by administration services provided by Vale of York CCG The Alliance Board is supported by a virtual data and analytics team ('Population Health Hub') made up of individuals spread across different Partners. It can ask this virtual team for: - Insights based on data - Input regarding the development of population health management capacity within City of York Place - Participation in Alliance Board meetings HCV ICS may allocate resources to be used by the Alliance. The Place Leader will be responsible for liaising with the HCV ICS and ensuring that such resources are spent in accordance with assurances provided to HCV ICS. The Alliance Board is able to set up groups to support its work. This is done through agreement at an Alliance Board meeting.

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9.	Ways of working	Board Members will: (a) Support each other to take decisions that are in the best interests of City of York Place; (b) Make time to deepen working relationships with other representatives (c) Work to understand the perspective and impacts of decisions on other parts of the health and social care system, and to use the best available data to inform decision-making (d) Ensure they are properly briefed about topics to be discussed at the Alliance Board (e) Participate in Alliance Board discussions in good faith and conduct discussions in a respectful way (f) Be open about their position and in particular if they disagree with a proposal or analysis, say so and explain why, rather than remaining silent (g) Be open about any interest their organisation has in an area being considered by the Alliance Board (h) Act as an ambassador for the Alliance within their organisation and the wider system Each Partner will ensure that: (a) It has a Representative at each meeting of the Alliance Board of appropriate seniority (b) Its Representative is appropriately briefed and authorised (in line with point 7), and that the representative understands the limits of their decision-making authority (c) Its Representative is given appropriate time and resources to enable them to participate meaningfully in Alliance Board meetings and to develop working relationships with people working in other parts of the system (d) Its Representative is familiar with these terms of reference
10.	Reporting	It is the responsibility of each Partner Representative sitting on the Alliance Board to report back to their Partner organisation about the work of the Alliance. The Alliance will need to report on its work to HCV ICS. Such reports will be made by the Place Leader, both in writing and by attending relevant meetings of the ICS. Written reports will be circulated to Partners in advance for comment. Any comments made will be reflected in the report. This may be done by adding the comments rather amending the original wording at the discretion of the Place Leader.] The Alliance Board will also report on its work to City of

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		York Council Health & Wellbeing Board. It is anticipated that the Place Leader will also sit on the Health & Wellbeing Board and so will be able to provide oral and written updates as desired by the Health & Wellbeing Board. The way in which the Alliance Board works alongside the Health & Wellbeing Board will be formalised as the Alliance develops. The Alliance Board will agree an annual report summarising its work that representatives can use to report to their organisation.
11.	Decision making	It will be for each Partner (and where decision-making has been delegated to them, each Partner Representative) to take decisions for their organisation. No Partner or group of Partners can take decisions on behalf of others. Therefore matters can be decided at the Alliance Board only if: - All Partners are represented at the meeting - Those Partner Representatives have the appropriate delegated authority from their organisation to make the decision - All Partner Representatives agree to make the decision
12.	Conduct of business	Meetings of the Alliance Board will be held regularly. It is anticipated that they will be held once a month but the Alliance Board may agree to a different meeting frequency if they wish, by doing so at a meeting of the Alliance Board. The Chair or the Place Leader may call extraordinary meetings of the Alliance Board at their discretion subject to providing at least five working days' notice to Board Members. If a Board Member wishes to add an item to the agenda they must notify jo.baxter1@nhs.net. Requests for agenda items will be passed to the Place Leader who will decide the content and order of the agenda. The Place Leader will also decide if any part of the meeting should be held in private. Circulation of the meeting agenda and papers via email will take place at least five working days prior to the meeting. Meetings of the Alliance Board will be held in public unless: - The Place Leader has determined that an

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		agenda item should be heard in private - Any partner organisation representative present requests that an item should be heard in private Agendas, papers and minutes will be published on the Vale of York CCG and City of York Council websites. Other Partners may also publish these documents on their websites if they wish. The minutes of Alliance Board meetings will be sent to Board Members within 10 working days of each meeting. The Alliance Board will have administrative support from Vale of York CCG to: - Collate items for the agenda - Circulate the agenda and any papers - take and circulate minutes of the meetings - maintain a record of actions and action owners

13.	Conflicts of interest	Board Members must refrain from actions that are likely to create any actual or perceived conflicts of interests.
		Board Members must disclose all potential and actual conflicts of interest and ensure that such conflicts are managed in adherence with their organisation's conflict of interest policies. Such conflicts should be declared at the earliest opportunity to jo.baxter1@nhs.net and at the start of any meeting discussing matters related to a conflict.
		If a conflict of interest is declared then:
		- The declaration will be noted in the minutes
		- The Place Leader may decide (either in advance or at the meeting) that the Board Member:
		  o can continue to participate as normal
		  o can attend but cannot contribute to discussions
		  o cannot attend
		  o cannot receive papers (including agendas and minutes) relating to the item
		for the relevant item
		
		The decision of the Place Leader will be noted in the minutes.
		
		Any Elected Member from CYC will be required to abide by the CYC Members Code of Conduct.

14.	Review	These terms of reference will be reviewed annually. They may be amended at a meeting of the Alliance Board by the agreement of the Partner Representatives.

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Schedule 3

Areas of First Focus

Early conversations with senior leaders have identified the need to start by concentrating on a small number of priority areas in order to channel our resources effectively in the initial stages of our joint working. Therefore, our first focus areas include:

- Prevention and early management of diabetes in vulnerable people
- High-cost complex packages, including CHC cases
- Learning Disabilities /Autism – specific topic tbc

These need to be refined by partners but there is a strong sense of support to take these forward.

There are also a number of areas where the work of Partners is so closely connected that it would be helpful for all of our teams to have some clarity, at least in terms of our commitment to work collaboratively. These include:

- COVID recovery
- Community Mental Health
- Dementia care and support across the whole pathway
- Loneliness, isolation and wellbeing
- Self-harm and suicide
- Childhood resilience
- Alcohol harm and substance misuse

Signalling our intention to develop a joint approach to these areas sends a strong message to our staff and partners. We anticipate that all Partners would take part in the process of aligning staff to these emerging programmes. This would be particularly important and helpful for those staff who will be affected by the likely process of NHS reconfiguration in 2021/22 We could also encourage teams to explore how best to come together to make this work happen.

We will work together in the areas set out above to deliver our Shared Purpose of improving health outcomes and reducing health inequalities for the population of the City of York Place, through the prevention of ill-health and provision of safe and high quality public services that work well together.

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NHS
York Teaching Hospital
NHS Foundation Trust

Board of Directors – 31 March 2021
Quality Committee Minutes – 16 February 2021

Members in attendance: Stephen Holmberg (SH) (Chair), Lorraine Boyd (LB), Heather McNair (HM), Jenny McAleese (JM), Wendy Scott (WS), James Taylor (JT), Lynette Smith (LS), Caroline Johnson (CJ), Rhiannon Heraty (RH) (minutes)

Attendees: Freya Oliver (FO), Jamie Todd (JT2), Sue Symington (SS)

Apologies for Absence: n/a

1. Welcome

SH welcomed everyone and declared the meeting as quorate.

2. Declaration of Interests

There were no declarations of interests declared.

3. Minutes of the meeting held on 19 January 2021

The minutes of the last meeting held on 19 January 2021 were agreed as a true and accurate record.

4. Matters arising from the minutes and any outstanding actions

Action 67 & 72 – LS confirmed this is part of a broader piece of work by Cancer Alliance across HCV. It has been raised internally and is linked to theatre prioritisation panel work to ensure robust pathways across theatre and cancer.

Action 74 – the Committee noted the new integrated approach to cancer harm that allows clinicians to record low level harm on CPD and moderate/high level harm on Datix. The Committee acknowledged the cultural work needed to encourage reporting and CJ gave assurance of a streamlined process to support timely incident reviews and avoid unnecessary SI declarations.

Action 83 – it was noted that the Committee will start to receive national reports/updates along with actions taken to align with national standards or address any issues identified.

Action 85 – the Committee noted the ARK paper circulated by JT prior to the meeting and discussed what was needed to improve function on the Scarborough (SGH) site. SGH now has a designated Deputy Chief Nurse and Deputy Chief Operating Officer and advert is to go out for a Deputy Medical Director.

Action 88 – the Committee noted the two elements being considered to address medical staffing shortfalls:

1. Capacity – what is needed for doctors to deliver capacity needs?
2. Quality and safety – how many doctors are needed to provide a safe quality service at SGH

The Committee acknowledged the plan to reinvigorate cultural work (e.g. Clever Together) on both sites to encourage more integrated working.

Action 86 – HM confirmed there is now a fully operational line team and closed the action.

5. Escalated Items

There were no items escalated from the Board or other Committees.

6. Focus on Patient Safety

- **Trust Response to the Ockenden Report**

FO gave an overview of the presentation. The Committee congratulated LB on her new role as NED safety champion and discussed the process for monthly reports. HM suggested that the Head of Midwifery be invited to discuss updates at Quality Committee level and LB should discuss at the Board of Directors as per the Ockenden expectation.

FO stated her main concerns as implementation of Saving Babies Lives V2, specifically around our capacity to open and offer risk-based scans, as well as getting training/support for specialties.

There was a discussion around post-partum haemorrhage. The Committee noted good progress from August 2020 to January 2021 and HM said this will continue to be monitored. SH questioned the RAG rating and FO confirmed this comes from our maternity dashboard and is set based on the national levels. The regional RAG rating is different so there is review needed to bring our dashboard in line with this.

The Committee acknowledged the Continuity of Carer and PMRT papers for information and noted clear lessons learnt from the PMRT report.

- **Medical Director's Report, incl. SI trends, Duty of Candour, Sepsis & 7 Day Service and Antimicrobial Stewardship in relation to IPC risks**

JT gave an overview of the report and noted slowed progress of clinical audit and effectiveness due to the pandemic but assured the Committee that this will become a focus again soon.

JT2 gave an insight into paediatric mental health and noted a stark increase in severity of presentation. However JT2 asked the Committee to note that we have started to develop

better links with partners (e.g. TEWV) and mental health and local relationships will be prioritised. Front door processes have also been improved including risk assessments held in ED and through paediatric ED nurses.

The Committee raised concern around restraint but was assured that training is being arranged and noted the opportunity for learning and QI work.

JT referred to SI 2021/437 and advised that there is a national conversation around all Covid-related nosocomial deaths being registered as individual SIs. However the conversation within the system is that this is unnecessary and would create an overwhelming amount of work. We are awaiting advice on this. The Committee noted the importance of using our learning from the third wave and implementing this in the event of a fourth wave, and also acknowledged social distancing as the cornerstone of all preventative measures.

- **GoSWH Quarterly Report**

JT gave an overview of the report and confirmed a plan to achieve senior support on the ward re the problems identified in Trauma & Orthopaedics. The Committee noted the positive news of the high fill rate (92.57%) in SGH, which is the highest it has been for a long time.

- **Escalation and Assurance Report from QPaS**

The Committee noted the improved governance and Duty of Candour (DOC) work, which is supported by the new process of recording harm on CPD and Datix. JT said there is also a separate piece of DOC work in Radiology, as historical errors are discovered in the REALM process. The Committee was assured that individual clinician performance can be tracked in this way but noted that discrepancies may not be identified until future scans were reviewed.

The Committee sought assurance on sepsis, noting the improved performance in ED and also on wards although the figures here still leave significant room for improvement. JT confirmed there are sepsis champions on the wards that recognise the issue, and said the Deteriorating Patients Policy has been improved, but improvements have been hindered by the pandemic. JM asked for a sepsis update every quarter and JT agreed to check as he thought there was already one in place.

HM confirmed that the DOC audit report will be shared at Audit Committee and the Committee noted all actions as complete and acknowledged the good progress.
The Committee agreed it was good to see the QPaS minutes but said it was still important to see items for escalation on the agenda from a governance perspective.

Action: JT to confirm quarterly sepsis update if not already in place and bring this to Committee

Action: CJ to ensure items for escalation are included on QPaS minutes

- **Infection Control Risks incl. Legionella Update, MSSA and C Diff Progress**

HM gave an overview of the report and highlighted key points. C. Diff progress is significantly better than last year - there has been work done around proactive cleaning and HM said she was more assured in our position.

MSSA requires further monitoring and there is work ongoing around reducing GNBSI. The Committee noted the significant pressure that the IPC team are under and noted there are currently two long-term sicknesses within the team. They are receiving psychological support and HM asked the Committee to support their work. HM noted the age profile of the team and said it would not be unreasonable to expect some retirements.

HM said we are working closely with the LLP around estates and environmental cleaning. There are issues with insufficient ventilation and IPC will likely extend the temporary fixes implemented for the pandemic.

Water safety is now being properly monitored and we have worked with Harrogate regarding the renal unit.

Action: HM to circulate paper around backlog maintenance to Committee members

- **Nurse Staffing**

HM gave an overview of the report. Nurse staffing remains a challenge but vacancy rates are low (6% in York and 13% in SGH). However the constant moving of nurse staffing to ensure patient safety has taken its toll on the workforce.

The Committee noted the appointment of two new clinical fellows in conjunction with the University of York.

There was a group discussion about whether nurse staffing will put recovery at risk and the Committee noted long term sickness, retirement and exhaustion as key factors. WS noted the extended shielding list and rollover of annual leave into 2021/22 will also affect our capacity to deliver the recovery plan. The Committee discussed buying back leave from willing staff and noted the financial burden of this but also debated whether the cost of staffing via bank and agency to cover leave may result in a false economy. The Committee agreed this was a debate to be held at the Board of Directors and would also link into a conversation on staff health and wellbeing.

The Committee noted the reason for delayed national planning guidance is the debate around what a reasonable expectation of staff should be, and the pace of recovery relies on balancing the needs of delayed patients and an exhausted workforce.

- **IBR Overview**

There was no further discussion needed around patient safety.

7. Focus on Effectiveness

- **CQC Report**

CJ gave an overview of the report and confirmed our registration has been amended due to the surge and use of Ramsay and Nuffield sites, which has been approved. CJ said the Quality & Regulations Group is being restructured using the transitional regulatory framework to a workshop style to consider the expectation of care groups and how to plan QI work.

HM asked the Committee to note that we are currently held to account monthly via a system-wide performance board meeting and have been recognised for the significant progress we have made. If approval is given to lift the breach of license, this meeting will be stepped down.

SH asked for an update on the self-assessment work and CJ said a QI plan needs to be developed to align with this with an aim to be ready by the end of spring 2021. There was a group discussion on ownership and it was agreed that the Executive Committee would prioritise work and provide assurance to the Quality Committee, who would also have a view on priorities and suggested focus.

- **Quality Account Priorities**

The Committee confirmed their support of the quality priorities for inclusion in the Quality Account.

- **IBR Overview**

There was no further discussion needed around effectiveness.

8. Focus on Patient and Carer Experience

- **Public Sector Equality Duty (PSED) Annual Report**

The Committee received the report for information and was assured of the agenda and work being done. The Committee agreed to escalate this to the Board of Directors.

- **Personalised Cancer Care Project**

The Committee received the report for information and no further discussion was required.

- **IBR Overview**

There was no further discussion needed around patient and carer experience.

9. Focus on Performance and Risk

- **Chief Operating Officer Report including Performance Update**

WS gave an overview of the Chief Operating Officer Report and confirmed the descalation of red Covid wards back to amber and return of staff to their substantive posts, including Endoscopy staff. The Committee noted the ongoing clinical prioritisation work and weekly reporting to NHSE/I around the number of patient cancellations and by category. NHSE/I have expressed significant interest in the number of patients classified as urgent and whether as an organisation and an ICS we are managing to see patients in a timely manner. WS confirmed ongoing conversations around mutual aid and added that JT has oversight of cancellations per week on a patient by patient basis.

52-week waits have increased but are still better than the original forecast position.

The Committee recognised that we managed to treat over 67,000 patients in January. WS shared a North East & Yorkshire Hospital Providers slide shared by NHSE/I detailing our January performance position – based on a 4 week rolling average (ranked 1st for first and follow-up outpatient delivery, 3rd for day case activity and 5th for ordinary elective) and noted the extraordinary efforts of staff. The Committee formally acknowledged this and stated their appreciation.

LS gave an update on the Urgent Care Transformation outlined on p105 and noted the clinical support. The Committee acknowledged this would lead to a big cultural shift and noted the opportunity for QI work. There was a discussion about areas of specialties with the most challenging waiting-list problems (e.g. Colorectal). The Committee acknowledged the importance of including prioritisation in the recovery plan.

Action: LS to look at DNA rates and consider any improvements for patient letters

- **Board Assurance Framework**

The Committee agreed the IBR and CRR need to be reviewed by Jill Hall (Interim Foundation Trust Secretary) and Bobby Anwar (Risk Manager) to appropriately reflect risk management.

- **Corporate Risk Register**

There was no further discussion required.

- **IBR Overview**

The Committee was assured that paediatric admissions are significantly reduced compared to last year. Ambulance handovers have increased in SGH but the Committee noted the good work done to sustain improvements and this is being monitored through emergency care discussions.

GP referrals are down by 30% mostly thought to be due to patients' lack of confidence to return to healthcare in a pandemic and the Committee noted the potential risk of unmet needs.

LS said they are considering a clinical assessment model for the IBR going forward.

- **Consider other potential new or emerging risks (IBR)**

There was no further discussion required.

10. Consideration of items to be escalated to the Board or other Committees

The Committee agreed the following items for escalation:

- PSED to demonstrate work
- Good news re our national position compared to other Trusts in the region

11. Any other business

There was no further business to discuss.

12. Time and Date of next meeting

The next meeting will be held on 23 March 2021 at 1pm by teleconference. Dial-in details will follow.

Action Log

Date of Meeting	Item No.	Action	Owner	Due Date
22.09.20	49	JT to bring sepsis report to Committee in c.4-6 months - date to be confirmed once data received	JT	Feb 21
22.09.20	52	HM to bring accreditation process report which relates to the Perfect Ward	HM	Mar 21
20.10.20	65	HM to bring audit report and results on why we are an outlier for post-partum haemorrhage to Committee	HM	Completed
17.11.20	67	LS to raise governance and decision-making principles at Cancer Delivery Group	LS	Completed

17.11.20	72	WS to speak to Yvonne Elliott about capturing patient harm across the system	WS	Completed
17.11.20	74	JT to update Committee on where patient harm (cancer and psychological) is being discussed	JT	Completed
17.11.20	77	CJ to provide an update on SI trends and incident report improvement work	CJ	Mar 21
08.12.20	80	HM to bring a dementia update to April Committee *Update: Work on this has started with a plan to do some engagement in Q4 to refresh the strategy and then launch in Dementia Awareness week May 2021.*	HM	May 21
19.01.21	83	CJ to include an alerts update re consolidated information streams in the MD Report	CJ	Completed
19.01.21	84	CJ to provide a standards update re consolidated information streams	CJ	Mar 21
19.01.21	85	JT to bring evidence of tracked ARK effectiveness to Committee	JT	Completed
19.01.21	86	HM to check status of line team with Liz Hill and update Committee on whether escalation is required	HM	Completed
19.01.21	87	JT to bring finalised statutory mandatory training process to Committee once completed	JT	TBC
19.01.21	88	JT to link with LS to discuss medical staffing shortfalls and ask care groups to RAG rate specialty workforce to correlate with capacity	JT LS	TBC
19.01.21	89	HM to bring PIR report for assurance	HM	Mar 21
19.01.21	90	CJ/Bobby Anwar (BA) to bring revised CRR to March Committee	CJ BA	Mar 21
19.01.21	91	LS to update Committee with new ECS standards	LS	Completed
16.02.21	92	JT to confirm quarterly sepsis update if not already in place and bring this to Committee	JT	Apr 21
16.02.21	93	CJ to ensure items for escalation are included on QPaS minutes	CJ	Mar 21

16.02.21	94	HM to circulate paper around backlog maintenance to Committee members	HM	Mar 21
16.02.21	95	LS to look at DNA rates and consider any improvements for patient letters	LS	Mar 21

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NHS
York Teaching Hospital
NHS Foundation Trust

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee/Group: Quality Committee	**Date: 23 March 2021**	**Chair: Steve Holmberg**

Agenda Item	**Issue and Lead Officer**	**Receiving Body, i.e. Board or Committee**	**For Recommendation or Assurance to the receiving body**
6 Update on Pre-natal Clinical Quality Surveillance (Ockenden)	Chief Nurse – Requirement to keep Board updated on progress	Board	Escalation
8 Community Services Update	Chief Nurse – To note excellent work by staff in the community during pandemic and effect of innovations in integration of care	Board	Information
10 Chief Operating Officer Report	COO – Verbal report on Clinical Summit in relation to patient safety concerns centered on Scarborough Hospital ED manifest by high number of 12 hour breaches	Board	Escalation

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NHS
York Teaching Hospital
NHS Foundation Trust

Board of Directors – 31 March 2021
Adult In-patient Wards Establishment Reviews – Options for projected investment 1-3 years

Trust Strategic Goals:

☒ **to deliver safe and high quality patient care as part of an integrated system**
☒ **to support an engaged, healthy and resilient workforce**
☒ **to ensure financial sustainability**

Recommendation

For information	☐	For approval	☒
For discussion	☒	A regulatory requirement	☒
For assurance	☐		

Purpose of the Report

The purpose of this follow-up report is to further raise awareness of existing staffing deficits in the current funded in-patient ward establishments following a full establishment review. The report also proposes investment in budgeted establishment to ensure safe nurses staffing on the adult in-patient wards for York Teaching Hospitals NHS Foundation Trust. In acknowledgement, following the discussion at the January Executive Committee, that an incremental approach is required, this paper sets out options for investment over 1-3 years, Appendix 1.

For ease of reference the full paper is attached at Appendix 2.

Executive Summary – Key Points

In January 2021, the nurse establishment review of the adult in-patient wards paper provided the Executive Committee with an updated position in relation to nursing workforce requirements needed to achieve safe staffing levels.

The Executive Committee acknowledged the content of the paper and requested a further piece of work to prioritise the required investment over 1-3 years.

The Executive Committee is asked to recognise that:

1. The risk identified in the initial paper remain
2. The complexity of trying to project investment with no indication of what is available in years 1-3

3. The financial post Covid-19 landscape; introduction of the ICS and detail of the Clinical Strategy may influence the staffing demands / opportunities for re-provision and modelling over the trajectory of this paper

There is no single approach that would achieve the investment required accept full investment in year 1; equally there are a multitude of opinions and views to balance in best planning the strategic approach to investment. It is recommended that the 2 year and if required 3 year investment is revisited based point 3 above.

The primary recommendation in this paper is to:

- Provide investment to deliver 3 days ward leadership time for every ward and to provide adequate headroom in order for ward managers to effectively manage within defined budget. This equates to £1.4M and is recommended in every option in year 1.

This option results in an equitable investment for all wards in year 1 and should set the benchmark for all frontline wards, units, departments and teams service re-design and skill mixing exercises in the future.

The options presented then have 1 additional guiding principle:

- That partial investment for increased establishment in any single ward is unhelpful as it does not allow effective roster planning. Therefore, the plans are based on individual wards receiving full investment either based on even distribution of money between York and Scarborough; priority wards based on the risk associated with the ratio work or the Trust adopting an 'east coast focus'.

Recommendation

- The Executive Committee is asked to consider uplift in funding for the adult in-patient wards to **a minimum of £1.4M** in year 1 to address ward leadership time and an appropriate level of headroom**.**
- To consider the options described and agree an approach for investment in years 2-3
- To support the work required to remove and re-build all ward rosters has been assessed as 1 x Band 4 administrator for 3 months full time which would equate to approximately £7,000
- To support associated recruitment activity, which may include further international recruitment, to meet the associated vacancy gap

Author: Helen Hey, Deputy Chief Nurse

Director Sponsor: Heather McNair, Chief Nurse

Date: March 2021

1. Introduction

Annual Nurse Establishment Review 2020 (presented January 2021)

A full staffing establishment review of the adult in-patient wards on the York, Scarborough and Bridlington sites was undertaken between August and October 2020 and presented to the Executive Committee in January 2021. The Executive Committee acknowledged the content of the paper and in principle supported the associated investment required. There was, however, explicit acknowledgement that achieving full investment in 2021/22 would be improbable and a further piece of work was requested to propose an investment plan over 1-3 years.

It is important to note that, without full investment, the risks outlined in the paper (Appendix 2) remain. However, there may be opportunities on the horizon with the development of the ICS and the awaited clinical strategy that result in service re-provision or re-design, where some Trust level efficiencies could be realised. Therefore, a further recommendation is to re-visit each ward detailed in the paper on the basis of any changes as they emerge and ensure these are developed by the ward leadership teams and signed off by the Care Group ACN / DCN.

The options, set out in Appendix 1, all have the same initial investment recommendation; that is to invest £1.4M in order to achieve adequate ward leadership time and adequate headroom to effectively manage each ward. This is a fair distribution of what is projected to be limited investment in year 1.

The paper then sets out 3 options, with options over 2-3 years, these are:

- To spread any investments evenly between the York and Scarborough sites, choosing some high risk areas on each site
- To invest first in the most high risk wards based on the work on ratios
- To focus investment and recruitment activity on the east coast first

The Executive Committee is asked to consider these options and set a strategic direction for future investment to 2024.

2. Detail

The plans set out below have not been easy to develop. With no indication of what might be achieved in 2021/22; the first priority has been set at a low level, assuming there will be minimal investment. Therefore, the most fair and impactful investment will be £1.4M investment to ensure every ward leader has the time to effectively manage his / her team and that with their team they can have the time necessary to achieve the requirements of the quality, governance, risk and patient experience agendas.

The remaining principles are set over both 2 and 3 year periods and will be subject to change dependent on emergent changes in service provision as a result of the

development of the ICS; re-provision of services post Covid and the Trust's clinical strategy.

In addition, there are a number of services that will, develop papers that review and propose amended nurse or midwifery staffing levels, namely; Scarborough Emergency Department; newly established Haldane Ward and midwifery services in response to the Ockenden Report. The Executive Team will not only have to balance across the proposals in this paper but in response to additional requests throughout 2021/22.

The Executive Committee should also note that this report has been developed in very high level detail to the nearest £.01M and that the projected investment options do not account for inflationary pay costs.

2.1 Investing in Ward Leadership and an appropriate headroom to effectively manage

This recommendation has been discussed widely with the senior nurses across all Care Groups and with the indication that any investment will probably not meet the requirements to respond to increase in numbers, then this is considered a positive and fair option.

This option requires £1.4M investment for the wards listed in this paper. The principle should set the benchmark for all future ward; unit and team reviews that are not encompassed in this paper.

This investment would allow ward leadership teams to achieve the requirements of a ward manager, which are clearly set out in the original paper in Appendix 2.

This investment would also release the time the teams in Human Resources take to support the administration of rosters, because the ward leadership team do not have time to effectively undertake their assigned duties, linked to effective rostering and staff management.

This investment, it is envisaged, would also set a clear standard and message that ward leadership is important and that the Trust respects the time is takes to undertake this important role; this will hopefully have a positive impact on how our nurse leaders feel about their roles and the Trust's commitment to them.

The 1 Year plan is achieving full investment of £5.8M in the first year. The following options are described over either 2 or 3 years and directly relate to the detail table in Appendix 1 and the list of Priority wards based on ratios in Appendix 3.

2.2 Evenly splitting investment between York and Scarborough sites

Option 1 (not necessarily achievable / the best) 2 year plan assumes the limited spend of £1.4m in year 1 and the remaining investment of £4.4M in year 2.

The 3 year plan attempts to (as evenly as possible) split the investment across both acute sites across all years, ensuring that each ward is fully (not partially) invested.

The principles set out align in part to the high risk wards based on ratios, however, some areas identified in the priority 3 category do not achieve investment until 2023/24.

This plan also assumes that the high risk priority 1 wards achieve investment in 2021/22 which takes the investment for this financial year to £2.38M.

2.3 Investing in the most high risk wards first based on the ratios

The original paper, Appendix 2, detailed where the Trust was in accordance with recognised ratios, which are a measurement used by regulatory authorities and which other Trusts in the ICS are invested to.

The 2 year option seeks the £1.4M ward leadership and headroom investment and seeks to fully invest in the establishments of all wards identified as red / amber when comparing the ratios to the region. This equates to £4.12M investment in 2021/22.

Leaving £1.68M for 2022/23 for further investment.

The 3 year option accepts the request for £4.12M in 2021/22 is probably unachievable and splits the investment over 3 years. The advantage over the option described above is that all high risk priority wards (on a scale) achieve investment by 2022/23, with the remaining wards achieving funding in 2023/24.

2.4 Focusing investment on the east coast

The final option is to consider whether focusing the initial investment on the east coast, alongside an east coast specific registered nurse recruitment program would provide more assurance aligned to some of our highest risk wards; the part of the Trust's geography that is most challenged for recruitment and the hospital wards highlighted in the 2019 CQC report.

The same recommendation would remain; that the investment delivered the £1.4m for all wards to have ward leadership time and headroom uplifted. The focus would then either be in year 1 or year 2 to focus all the investment on the east coast. This would mean that no wards in York achieved any increase in nursing numbers until 2023/24.

2.5 Delivery of £1.4M investment in 2021/22

Achieving the 3 days per week for every ward included in the paper would require an additional approximate **16** Band 5 registered nurses substantively.

Moving the 4% bank / agency line to substantive and uplifting from 20% (made up of 16% headroom and the 4% bank / agency line) to 22% headroom would require an

additional approximate **26** Band 5 registered nurses (although some consideration to establishing the identified nursing associates could be included in this work).

There would also be a requirement for approximately **40** Band 2 HCAs.

This would immediately increase the vacancy factor and require additional recruitment activity. The Trust is being closely monitored on the HCA vacancy level and if the investment is achieved the positive news of the investment would need to be explicit in the national returns, until full recruitment was achieved.

In addition, the paper asks for some initial enhanced support for the Human Resources team who support rostering. The investment is for **£7K** for some support to re-establish the rosters immediately. This would ensure that as the ward managers assume their 3 days per week management time they had a good starting place to manage well-designed rosters.

3. Conclusion

This nursing establishment review of the adult in-patient wards is overdue. The request for **£5,863,738** investment in 2021/22 is significant and therefore this paper makes the recommendation that, as a minimum**, £1.4M is invested in 2021/22** in order to achieve ward leadership time and an appropriate level of headroom. The principle of 3 days ward / unit / team leadership and 22% headroom should then be set as a principle for all future establishment review processes.

The paper sets out a range of options over 2 and 3 years. The associated decisions are complex. The recommendation is that, if full investment is not achieved in year 1 then the principles set out in this paper are revisited prior to further investment being assigned. This will allow for the investment to flex in accordance with any service re-provision or redesign work. The Care Groups should lead the workforce reviews with oversight and support from the Chief Nurse Team.

Finally, the Executive Committee should note that this paper does not reflect any inflationary pay rises and does not encompass any internal reviews underway that are not included in this paper or any emergent pressures that may come from national work, such as the impact of Ockenden, which may further influence future investment decisions.

4. Recommendation

- The Executive Committee is asked to consider uplift in funding for the adult in-patient wards to a minimum of £1.4M in year 1 to address ward leadership time and an appropriate level of headroom.
- To consider the options described and agree an approach for investment in years 2-3

- To support the work required to remove and re-build all ward rosters has been assessed as 1 x Band 4 administrator for 3 months full time which would equate to approximately £7,000
- To support associated recruitment activity, which may include further international recruitment, to meet the associated vacancy gap

Appendix 1

PLANS	OPTIONS
1 YEAR	2021/2022 All uplift, additional ward management time and revised establishments £5.8M

2 YEAR	OPTION 1 – limited year 1 spend		OPTION 2 – priority focus ratios		OPTION 3 - east coast focus	
	21/22	22/23	21/22	22/23	21/22	22/23
	£1.4M uplift / ward leadership time **£1.4M**	£4.4M All establishment and skill mix uplifts **£4.4M**	£1.4M uplift / ward leadership time £2.72M Fund priority wards (1,2,3) **£4.12M**	£1.68M Fund remaining wards **£1.68M**	£1.4M uplift / ward leadership time £1.7M Realign budgets on east coast and fund all other east coast wards **£3.1M**	£2.7M Fund all York site wards **£2.7M**

3 YEAR	OPTION 1 – even split / cost and site			OPTION 2 – priority focus ratios			OPTION 3 – east coast focus		
	21/22	22/23	23/24	21/22	22/23	23/24	21/22	22/23	23/24
	£1.4M uplift / ward leadership time £0.98M Fund high risk priority wards (1) **£2.38M**	£1.33M Fund priority (2) Wards **£1.33M**	£2.09M Fund priority (3) wards and all remaining wards **£2.09M**	£1.4M uplift / ward leadership time £0.98M Fund high risk priority wards (1) **£2.38M**	£1.73M Fund remaining priority wards (2+3) **£1.73M**	£1.68M Fund remaining wards **£1.68M**	£1.4M uplift / ward leadership time **£1.4M**	£1.7M Realign budgets on east coast and fund all other east coast wards **£1.7M**	£2.7M Fund all York site wards **£2.7M**

Appendix 2

York Teaching Hospital
NHS Foundation Trust

Executive Committee – 2 December 2020
Adult In-patient Wards Esatblishment Reviews

Trust Strategic Goals:

☒ **to deliver safe and high quality patient care as part of an integrated system**
☒ **to support an engaged, healthy and resilient workforce**
☒ **to ensure financial sustainability**

Recommendation

For information	☐	For approval	☒
For discussion	☒	A regulatory requirement	☒
For assurance	☐		

Purpose of the Report

The purpose of this report is to raise awareness of existing staffing deficits in the current funded in-patient ward establishments following a full establishment review and to request consideration of investment in budgeted establishment to ensure safe nurses staffing on the adult in-patient wards for York Teaching Hospitals NHS Foundation Trust; acknowledging an incremental approach will be required due to the level of investment being requested.

The baseline budget is currently £40,755,510. The review has been based on the ward structures, functions and total spends in 2019/2020, thus largely eliminating the impact of Covid-19. The total spend, including bank and agency, in 2019/2020 was £44,443,508. The required uplift following the establishment reviews and incorporating uplift to both substantive headroom and substantive non-clinical ward leadership time is **£5,863,738** from total spend to £50,307,246.

This significant request for financial approval will provide parity with other Trusts in the ICS; meet national evidence based recommendations and ensure compliance with safe nurse staffing standards.

If approved there will be five associated risks which are:

-Increased vacancy factor until recruitment target can be met.

-Increased bank and agency spend to meet ratified new establishments until recruitment target can be met.

-Increased regulatory scrutiny of recruitment and retention activity until recruitment target can be met

-Delegated responsibility to minimize agency spend to negligible levels and only in exceptional defined circumstances to Care Groups and ensure effective rostering and line management principles are adhered to.

-Requirement for the health roster team to take down all existing rosters and re-build them with the new establishments

Executive Summary – Key Points

This nurse establishment review of the adult in-patient wards provides the Executive Committee with an updated position in relation to nursing workforce requirements needed to achieve safe staffing levels.

Professional judgement discussions alongside assessing Care Hours Per Patient Day (CHPPD); staffing ratios and quality indicators performance have formed the evidence base for this work. Good practice would deliver up-to-date benchmarking data from Model Hospital, however, as referenced in the paper the relevant data has not been refreshed since April 2019, so whilst the data is presented, its relevance could be disputed.

Recommendations are presented throughout the paper with an Appendix which provides ward level detail which informs the proposed amendments required to both the establishments (staffing levels / skill mix) and the infrastructures (headroom / ward management time). There is scope for considering incremental investment, acknowledging the level of investment being requested and a consideration of priority areas included.

There are a number of specific risks associated with achieving the funding in total or in part that are described. The risks specifically link to a potential immediate increase to the registered nurse vacancy position; this will be more acutely noted on the east coast.

In order to meet all recommendations would require an uplift funding of **£5,863,738.** There are recommendations for partial investments and associated priorities. If investment is not achieved the first associated risk is that the Care Quality Commission undertake an inspection and form the same or similar views about wards that did not achieve investment following their inspection in June 2019. Secondly, whilst nurse staffing levels has been rarely associated as a primary factor root cause in the majority of patient harm events it is often cited as a contributory factor. Thirdly, whilst the Trust will not know the impact of Covid-19 on how nurses feel from staff survey results, previous results have indicated that a lack of substantive staff impact of how people feel about their roles; having appropriately established wards with substantive staff recruited will have a positive impact on staff survey results.

Recommendation

- The Executive Committee is asked to consider an uplift in funding for the adult in-patient wards to **£5,863,738.** Incremental or partial investment options are included in the paper for consideration
- To support the work required to remove and re-build all ward rosters has been assessed as 1 Band 4 administrator for 3 months full time which would equate to approximately £7,000
- To support associated recruitment activity, which may include further international recruitment, to meet the associated vacancy gap
- Through Operational Performance and Management governance structures ensure compliance with good roster management and human resource management practices are embedded and effectiveness is monitored

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Director Sponsor: Heather McNair, Chief Nurse

Date: January 2021

Introduction

Annual Nurse Establishment Review 2020 (presented January 2021)

A full staffing establishment review of the adult in-patient wards on the York, Scarborough and Bridlington sites was undertaken between August and October 2020. It is important to note that the establishment reviews should have taken place annually; however, a full review of the adult in-patient wards has not been effectively undertaken and reported since 2018. Following the review in 2018, the previous Head of Nursing for Workforce embarked on a significant piece of work to improve health roster compliance and management as the principle action from the review; the view being that if roster compliance and management was improved this would form the basis of the next establishment review, but without good roster compliance the teams were running inefficiently. This piece work did not deliver the planned outcomes. In spring / summer 2019, there was insufficient capacity in the Chief Nurse Team to coordinate and respond to a full establishment review. The lack of formal review lead to exposure, by the Care Quality Commission, in June 2019 of inadequate registered nurse staffing levels on the Scarborough site and the requirement to immediately invest specifically in the medical wards.

Undertaking an annual review is a mandated requirement and the Trust Board should be confident that the Trust has reviewed ward establishments in order to be assured that the right staff are in the right place at the right time. Equally, any staffing challenges are understood and addressed through appropriate investment. If finances are not sufficient to meet the staffing requirements this needs entering onto the Corporate Risk Register to ensure that there is monthly oversight against any nurse staffing gaps and patient or staff safety concerns.

The section below summarises the evidence based guidance that has been issued to Trusts since 2013. This paper just covers adult in-patients. For transparency, it is fair to acknowledge, that whilst some smaller scale reviews / proposals / business cases have been developed, presented and funded in the past few years, there was limited appetite to present a full adult in-patient review. This has now been rectified through this work and will, alongside all wards, units and departments form part of an annual review cycle.

1. Developing Workforce Safeguards

1.1 Developing Workforce Safeguards (NHSI 2018) set out a clear accountability framework for NHS organisations in relation to expectations for the delivery of best practice standards for workforce deployment and planning.

1.2 The workforce safeguards included 14 recommendations that are assessed as part of the Single Oversight Framework (SOF) information analysed as part of the Trust’s annual governance statement.

1.3 The document recommendations build on previous safe staffing publications from the National Quality Board (NQB) and were intended to enhance governance processes that support effective and informed decision making regarding workforce issues. It is expected that organisations can demonstrate and evidence actions taken

to provide assurance of safe staffing and by definition the associated compliance with CQC Fundamental Standards.

1.4 A workforce establishment review and analysis has taken place to ascertain compliance with the recommendations in relation to the nursing workforce. The current position, narrative case for change and proposed new establishments for nursing are outlined in Appendix 1.

2. National Quality Board Safe, Sustainable and Productive Staffing

2.1 The National Quality Board published a series of improvement guides to support safe, sustainable and productive staffing, in the context of acute hospital service provision. This review focusses solely on the adult in-patients, but the Executive Committee should be aware of the framework and the application of principles across all areas of practice. The NQB documents listed below, form the framework for all establishment reviews:

- How to ensure the right people, with the right skills, are in the right place at the right time – A guide to nursing, midwifery and care staffing capacity and capability (2013).
- Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – Safe, sustainable and productive staffing (2016).
- Safe, sustainable and productive staffing – An improvement resource for adult inpatient wards in acute hospitals (Edition 1, 2018).
- Safe, sustainable and productive staffing – An improvement resource for urgent and emergency care (Edition 1, 2018).
- Safe, sustainable and productive staffing – An improvement resource for neo natal care (Edition 1, 2018).
- Safe, sustainable and productive staffing – An improvement resource for children and young people's inpatient wards in acute hospitals (Edition 1, 2018).
- Safe, sustainable and productive staffing – An improvement resource for the deployment of nursing associates in secondary care (Edition 1, 2018).

2.2 The National Institute of Clinical Excellence published their guidance, Safe staffing for nursing in adult inpatient wards in acute hospitals in 2014. This guidance is separate, but intrinsically aligned to the principles set out in NQB improvement resource guidance.

2.3 All referenced NQB publications directly triangulate with the relevant recommendations from Lord Carter's 2016 review of operational productivity and performance in NHS acute hospital trusts.

2.4 The NQB have determined three core components that make up the framework of guiding principles for safe staffing (figure 1).

Figure 1: Principles of safe staffing

2.5 Supplementary to safe staffing principles, the NQB have also presented a triangulated approach to staffing decisions that describe expectations that contribute to the achievement of having the right staff, with the right skills in the right place at the right time.

Figure 2: Triangulated approach to staffing decisions

Safe, Effective, Caring, Responsive and Well-Led Care		
Measure and Improve - patient outcomes, people productivity and financial sustainability - - report investigate and act on incidents (including red flags) - - patient, carer and staff feedback -		
- Implementation Care Hours per Patient Day (CHPPD) - - develop local quality dashboard for safe sustainable staffing -		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

2.6 NHS Improvement has developed complimentary guidance to support effective implementation and sustainability of the triangulated components. This includes;

- Care hours per patient day (CHPPD): guidance for acute and acute specialist trusts (2018)
- Nursing and Midwifery e-rostering: a good practice guide (2018)

3. Right Staff, Right Skills, Right Time and Place Adult Inpatients – Current Position

3.1 This NQB improvement resource for adult inpatient wards in acute hospitals includes ten recommendations that form a governance framework in relation to safe, sustainable and productive staffing in acute adult wards.

4. Detail

4.1 Evidence base introduction

There are a number of specific ways the Trust monitors safe nurse staffing levels both dynamically and strategically. This paper presents the data for the associated Care Groups using nursing ratios; CHPPD (Care Hours Per Patient Day) and professional judgement.

It would be good practice to make reference to model hospital data in order to support the Trust to benchmark against peers. Unfortunately, model hospital has not delivered refreshed data for nurse staffing since the beginning of 2019, for the 2018/2019 period, and therefore any benchmarking would be subject to significant disparity, due to changes in functions of wards / units and acuity and dependency over more than 24 months.

The Trust's Efficiency Analyst Team, produced the information from 2018 / 2019, presented in the table below. This indicates that the Trust WAU (weighted activity unit) is significantly below both the national median and the recommended peer group at £761 WAU for nursing staff. This does not necessarily mean this is good / efficient practice as it is only one measure: cost. This information needs using alongside Key Performance Quality Indicators and Care Quality Commission reporting to determine if the Trust has the correct staffing and skill mix models in place. It is assumed that if the model hospital data was refreshed, with no comprehensive staffing review in 2019/2020, that the comparative position would be unchanged.

Table 1 – Opportunity Scanner for staffing taken from Model Hospital data 2018 / 2019 from Model Hospital

4.2 Data: Care Hours Per Patient Day (CHPPD)

CHPPD was developed, tested and adopted to provide a single, consistent and nationally comparable way of recording and reporting deployment of staff on inpatient wards.

- It produces a single comparable figure that represents both staffing levels and patient requirements, unlike actual hours or patient requirements alone.
- It enables wards within a trust, and wards in the same specialty at other trusts, to be compared. As CHPPD is calculated after dividing by the number of patients, the value does not increase due to the size of the ward, enabling comparisons between wards of different sizes.
- It offers the ability to differentiate registered nurses and midwives from healthcare support workers for reporting purposes, ensuring skill-mix is well-described and the nurse-to-patient ratio is taken into account in staff deployment, along with an aggregated overall score.

Comparing CHPPD reflected by the set establishment with CHPPD available on the roster can support ward leaders in managing the workforce to meet patient need. This data, particularly if tracked over time, provides an informative picture of staff deployment. It can be used in productivity and efficiency discussions as well as highlighting areas that may require establishment setting or skill-mix review.

CHPPD is therefore valuable because it consistently shows how well patient care requirements are met alongside outcome measures and quality indicators.

The care hours per patient day required to deliver safer care can vary in response to local conditions, for example the layout of wards or the dependency and care needs of the patient group it serves. Therefore, higher levels of CHPPD may be completely justifiable and reflect the assessed level of acuity and dependency. Lower levels of CHPPD may also reflect organisational efficiencies or innovative staffing deployment models or patient pathways.

It is evident that the movement of ward functions and staffing throughout 2020 has resulted in using the CHPPD benchmark between the same specialties in other peer trusts problematic. However, the trust is still able to identify specific specialty areas within the trust to ensure that there is consistency of approach across wards, especially similar wards in Care Groups 1 and 2 that are on different sites.

In addition, as described above CHPPD was a key measure in the model hospital. The latest data in model hospital was produced in April 2019 from 2018/2019 data when the average CHPPD nationally was 8.1.

Based on the numbers in Table 2, but eliminating spurious results for the wards identified the Trust average is 8.0 which is just below the national average from April 2019. However, within this there are specific wards which fall well below national average figures. There are recognised national differences in how the data is collected and what is included, but these figures directly relate to the internal ratios presented below and professional judgements for the Trusts' adult inpatient areas, fundamentally linking directly to the level of investments requested in this establishment review.

Table 2, below represents a rolling 3 month average of current relevant CHPPD figures from Unify submitted report with associated narrative and a RAG rating. There are a number of associated developments that need to be considered in 2021 that will influence the understanding of the CHPPD data and ensuring it is more reflective of ward based staffing, specifically more accurately capturing the apprenticeship posts; nursing associates; associate practitioner and the work / inclusion of allied health professionals.

Additionally, the impact of Covid-19 and the requirement to change the ward bed base and staffing models will continue to influence how the CHPPD data is captured and used for assurance / escalation.

Table 2 – CHPPD per Ward and Care Group Averages

Care Group 1 – average 8.3		
Ward	Overall CHPPD	Narrative
AMB	10.1	Acute admitting area. Higher staff levels
CCU	16.7	High acuity area. Higher RN skill mix
Ward 23	8.4	
Ward 26	7.7	
Ward 32	6.2	

Ward	Overall CHPPD	Narrative
Ward 33	6.5	
Ward 35	5.7	Not assured on undertaking workforce review. Significant uplift identified to meet patient care requirements
Ward ASU	6.9	Not assured on undertaking workforce review. Significant uplift identified to meet patient care requirements
Ward 25	19.9	Data consistency and activity on ward needs checking. Data eliminated from average
Ward 37	7.7	
Ward 39	6.5	
AMB	9.6	Acute admitting area. Higher staff levels
Care Group 2 – average 8.0		
Ward	Overall CHPPD	Narrative
Lilac	9.3	Acute admitting area. Higher staffing levels
Oak	6.7	
AW	NA	Data not relevant. New 11 bedded unit opening
Beech	11.7	
CCU	9.4	
Cherry	6.5	Not assured on undertaking workforce review. Significant uplift identified to meet patient care requirements
Chestnut	6.5	Not assured on undertaking workforce review. Significant uplift identified to meet patient care requirements
Stroke	8.5	
Graham	NA	Data not relevant. New SDEC / HFU open
Ash / Aspen	NA	NA newly combined unit data not yet relevant
Johnson	5.9	Not assured on undertaking workforce review. Significant uplift identified to meet patient care requirements
Care Group 3 – average 7.1		
Ward	Overall CHPPD	Narrative
Holly	5.5	Not assured on undertaking workforce review. Significant uplift identified to meet patient care requirements
Maple	8.2	
Kent	19.0	Low activity in Kent results in the CHPPD being high. Data eliminated from average
Ward 11	5.3	
Ward 16	8.0	
G1	NA	Due to the changes on G1 throughout the year data not relevant
25	8.0	
Ward 26	7.7	
Ward 29	7.8	Due to the changes on Ward 29 throughout the year data not relevant. Data will need collecting when elective orthopaedics resumes and comparing to peers. Data eliminated from average
Care Group 4 – average 8.6		
Ward	Overall CHPPD	Narrative
Ward 31	8.6	

4.3 Data Ratios

The evidence base that sits behind CHPPD is well-established and based on a systematic approach to undertaking daily census checks of acuity and dependency. This process supports an understanding of CHPPD benchmarking and fully informs daily dynamic decision making in relation to the best deployment of staffing each day.

It must be noted that the opportunity to effectively use this data in 2020 and now into 2021 has become more of a challenge and there is some confidence or level of assurance to revert to a more traditional view of register nurse to patient ratio. It is also noted that regulators, such as the Care Quality Commission and more recently the Royal College of Nursing have asked the trust for the registered nursing ratios rather than referring to CHPPD.

As a basis, within the ICS the other acute trusts have also continued to use registered nurse ratios as a basis for monitoring safe staffing levels. In the next table, and in reference to the proposed uplifts in Appendix 1, is a recommended registered nurse staffing to patient ratio, mapped alongside the current registered nurse to patient ratio and the proposed option. The table has been RAG rated to indicate the level of associated assurance with the current and proposed statuses, with a narrative comment where the inclusion of registered nurse associate is considered.

Table 3

	Care Group 1						
	Peer / ICS Ratio		Current Ratio		Proposed Ratio		Narrative
	Day	Night	Day	Night	Day	Night	
AMU	1:6	1:6	1:6	1:7.5	1:5.1	1:6	Uplift achieves N ratio. D ratio above recommendation to accommodate higher Late shift activity
CCU	1:2	1:2	1:2.6	1:2.6	1:2	1:2	Uplift will achieve D and N ratio
Ward 23	1:7	1:10	1:7.5	1:15	1.7.5	1:10	Skill mix review on days. Current reliance on 2 RN and 2 NA change to 3 RN and 1 NA. Uplift achieves N ratio
Ward 26	1:7	1:10	1:7.5	1:15	1:7.5	1.10*	Skill mix review on days. Current reliance on 2 RN and 2 NA change to 3 RN and 1 NA. Uplift achieves N ratio with 1 NA
Ward 32	1:7	1:10	1:6.7	1:14	1:5.6	1:14	Day shifts elevated to support Angio lists dependent on consultant job planning. Professional judgement 1:14 with uplift to 3 HCAs safe for night shifts
Ward 33	1:7	1:10	1:7	1:14	1:5.6	1:9.3	Acuity and dependency / professional judgement indicates need to increase staffing. The judgement is that encompassing 1 NA role per shift would be safe
Ward 35	1:7	1:10	1:7	1:14	1:7	1:9.3	Skill mix review on days. Current reliance on 2 RN

							and 2 NA change to 3 RN and 1 NA. Uplift achieves N ratio
Ward 23	1:4	1:10	1:4.2	1:7.6	1:3.8	1:7.6	Assured
Ward 25	1:7	1:10	1:8.3	1:12.5	1:5	1:8.3	Acuity and dependency / professional judgement indicates need to increase staffing. The judgement is that encompassing 1 NA role per shift would be safe
Ward 37	1:7	1:10	1:8.75	1:10.5	1:7	1:10.5	Assured
Ward 39	1:7	1:10	1:6.6	1:10	1:6.6	1:10	Assured
AMB	1:6	1:6	1:6	1:7.5	1:6	1:7.5	Assured for RNs. The Ward (frailty) has requested an uplift of HCAs to support dependency
Ward 34	1:7 (NIV)	1:10	1:7.5	1:10	1:6	1:10	An uplift of RN on day shifts has been requested to support acuity
	Care Group 2						
	Peer / ICS Ratio		Current Ratio		Proposed Ratio		Narrative
	Day	Night	Day	Night	Day	Night	
Lilac	1:6	1:6	1:6.4	1:8	1:6.4	1:8	Uplift of NA on E and N and Twilight requests to meet acuity and activity
Oak	1:7	1:10	1:8.25	1:11	1:6.6	1:8.25	Uplift requested to meet dependency and environmental challenges
AW	1:7	1:10	1:4	1:4	1:4	1:4	Assured. Small unit. Undertake further review in 6 months
Beech	1:7 (NIV)	1:10	1:6.4	1:6.4	1:6.4	1:6.4	Assured post CQC funded. Ward proposed replacing 1 RN with 1 NA to support apprenticeship model – local staff development
CCU	1:4	1:4	1:4	1:4	1:4	1:4	Assured posts CQC funded needs putting in place. Uplift of NA and HCAs to meet dependency and clinic needs
Cherry	1:7	1:10	na	na	1:7	1:9.3	New facility new model (from 'old' Cherry budget)
Chestnut	1:7	1:10	1:9.3	1:14	1:7	1:9.3	Significant uplift needed to meet staffing requirements
Stroke	1:7	1:10	1:8	1:8	1:5.3	1:8	Assured. Small unit under new management. Uplift of D requested to meet dependency. Undertake further review in 6 months
Graham (SDEC)	?1:6	?1:6	1:5	1:10	1:5	1:10	Assured. New management and new facility. Undertake further review in 6 months
Aspen / Ash	1:7	1:10	1:5.25	1:5.25	1:4.2	1:4.2	Assured. Across 2 units so necessarily inefficient for costs. Addition of a NA requested
Johnson	1:7	1:10	1:9.3	1:14	1:7	1:14	Increased dependency since change in stroke pathway. Increase in HCAs requested or N to meet dependency
	Care Group 3						
	Peer / ICS Ratio		Current Ratio		Proposed Ratio		Narrative
	Day	Night	Day	Night	Day	Night	
Holly	1:7	1:10	1:9.3	1:14	1:4.6	1:9.3	Uplift requested although

							day shift requires further review to understand acuity and dependency modelling
Maple	1:7 (hob)	1:10	1:4	1:6.6	1:5	1:10	Assured. Model proposed is staffing reduction
Kent	1:7	1:10	1:11.2	1:14	11.2	1:14	Breaches standard but activity and CHPPD would not suggest a requirement for uplift. Review is more activity is proposed
Ward 11	1:7 (NEU)	1:10	1:7.5	1:14	1:6	1:10	Inclusion of NAs in staffing proposal to meet ratios and ensure sufficient cover for NEU
G1	1:7	1:10	1:6.2	1:11	1:5.5	1:11	Inclusion of NAs in staffing proposal to meet requirements for care. Releasing RNs for complex surgery (head and neck)
Ward 16	1:7	1:10	1:4.5	1:6.25	1:4.5	1:6.25	Assured
Ward 26	1:7	1:10	1:6.25	1:12.5	1:6.25	1:8.3	Revise model to include NAs and uplift RN on N
Ward 29	1:7	1:10	1:7.6	1:11.5	1:5.75	1:7.6	Based on elective orthopeadics. Support model but suggest further review elective orthopaedic strategy / annual planning
	Care Group 4						
	Peer / ICS Ratio		Current Ratio		Proposed Ratio		Narrative
	Day	Night	Day	Night	Day	Night	
Ward 31 (onc)	1:4	1:10	1:4	1:9	1:3.6	1:9	Assured. Request plan to uplift L shift to meet demand

4.4 Professional Judgement

The nationally recognised methodologies for collecting and benchmarking adult in-patient safe nurse staffing levels are described above. However, as described in the Principles of Safe Staffing above, the Trust also uses professional judgement of senior nurses working in the areas. All the establishment reviews undertaken have been directed by the Ward Managers and Matrons, signed off by the Assistant Chief Nurses and overseen by a member of the Chief Nurse Team.

It is important to taken into account the judgement of the very experienced nurses who know the ward and the patient's level of need rather than simply using statistical tools or fixed ratios in isolation.

In Appendix 1, where relevant, a narrative summary for professional judgement has been included to explain any lack of assurance / request for uplift in funding.

4.5 Quality Indicators

Two successful and specific developments in 2020 will be used to more effectively align safe nurse staffing levels to the quality of care on the adult in-patient wards. These are the nursing dashboard and the introduction of Perfect Ward. The Chief Nurse Team have appointed a specific post, which commences in February 2021, to

examine the use of the data and quality indicators and to align this to a refreshed approach to governance and a ward accreditation process.

There are a number of quality indicators that specifically align to care being safe, effective and of high quality when linked to safe nurse staffing, these are included in the nursing dashboard. The intention is to further develop the dashboard in 2021, based on feedback from the nurses who manage the wards, units, departments and community teams.

Specific to ward areas this will assist in developing an approach to refreshing the use of 'red flags' for nurse staffing levels, associated risks or harms.

As an example, Table 3 sets out the 3 month average scores (Jan-Mar 2020 pre Covid-19) for the adult in-patient units included in this review. There is a new monthly operational review of nursing workforce with each care group where the dashboard is monitored. Not all measures have an associated target, but where possible the information is RAG rated.

With improved nurse staffing levels the targeted aim through the Care Groups governance meetings and operational performance meetings would be to achieve improvements across the quality indicators.

This information, alongside the staffing ratios, CHPPD and professional judgement collectively informs where nurse staffing levels may be impacting safe care. The information should not be taken in isolation, for example, the relatively poor fill rates on Kent Ward, but good quality performance is directly correlated to very low activity on this ward and that there is no requirement to fill the planned shifts most weeks. In addition, there are some wards where the information collected is not applicable, for example, Ward 29, elective orthopaedics changes from elderly / winter pressures to elective orthopaedics and then to COVID-19 ward in this 3 month period.

	Care Group 1							
	RN fill rate 80-105%		FFT response rate	News Compliance	Medicines administration errors	Category 3 or 4 Pressure Ulcer	Fall with serious or severe harm	Reportable infections
Ward	Day	Night	30 %	90%				
AMU	74.3%	94.9%	11.5%	87.6%	2.6	0	0	0.6
CCU	88%	87.4%	11.8%	85.2%	0.3	0	0	0
Wd23	70.7%	88.9%	29.6%	83.8%	1.3	0.3	0.3	0.3
Wd26	83.6%	99.2%	6.6%	86.3%	0.3	0.3	0.3	0
Wd32	92.6%	97.8%	8.2%	84.9%	0.6	0	0	0.6
Wd33	73.5%	100.9%	2.7%	90.2%	0.6	0.3	0	1
Wd35	65.1%	101.7%	31.2%	83.9%	0.3	0.3	0	0
ASU	74.6%	104.2%	0%	85.8%	1	0	0	0.3
Wd25	68.4%	102%	25.9%	80%	0.3	0	0.6	0.3
Wd37	91.1%	100%	11.2%	88.9%	0	0	0	0
Wd39	79.4%	99%	50.3%	80.7%	0.6	0	0	0.3
AMB	75.5%	91%	17.6%	88.4%	0	0	0	1
Wd34	92.2%	126.4%	41.8%	93.%	0.3	0	0	1
	Care Group 2							
	RN fill rate 80-105%		FFT response	News Compliance	Medicines administration	Category 3 or 4	Fall with serious	Reportable infections

			rate		errors	Pressure Ulcer	or severe harm	
Ward	Day	Night	30 %	90%				
Lilac	90.1%	161.6%	25.5%	88.8%	1.6	0	0	1
Oak	78.9%	103.5%	25.3%	90%	1.3	0	0	1.6
AW	103.2%	101.6%	21.9%	92%	0.6	0	0	0.3
Beech	155.4%	163.5%	27.2%	95%	0.3	0	0	0.6
CCU	107.7%	116.3%	38.1%	94.8%	1	0	0	0.6
Cherry	69.7%	81.6%	10.4%	97.8%	1.6	0	0	0.3
Chestnut	99.2%	115.7%	16.4%	94.2%	0.6	0	0	0.6
Stroke	75.8%	100.7%	52.2%	92.8%	0	0	0	0.6
Graham	NA	NA	NA	NA	NA	NA	NA	NA
Ash/Aspen	NA	NA	NA	NA	NA	NA	NA	NA
Johnson	97.4%	105%	43.6%	77.7%	0.3	0	0	1
	Care Group 3							
	RN fill rate 80-105%		FFT response rate	News Compliance	Medicines administration errors	Category 3 or 4 Pressure Ulcer	Fall with serious or severe harm	Reportable infections
Ward	Day	Night	30 %	90%				
Holly	76.2	102.6%	13%	93.8%	0.6	0	0.3	0.3
Maple	91.9%	109.1%	1.2%	90.3%	1	0	0	0.3
Kent	57.2%	48.5%	100%	99%	0	0	0	0
Wd11	95.5%	101.5%	16.5%	94.5%	0.6	0	0	1
G1	87.2%	98.9%	26%	91.1%	1.3	0	0	0
Wd16	88.3%	97.1%	11.2%	89.3%	0	0	0	0.6
Wd26	NA	NA	NA	NA	NA	NA	NA	NA
Wd29	NA	NA	NA	NA	NA	NA	NA	NA
	Care Group 4							
	RN fill rate 80-105%		FFT response rate	News Compliance	Medicines administration errors	Category 3 or 4 Pressure Ulcer	Fall with serious or severe harm	Reportable infections
Ward	Day	Night	30 %	90%				
Wd31	96.2%	142.3%	30.4%	91.2%	1	0.6	0	2.3

4.6 Health roster management compliance

A significant benefit of achieving the right staff and skill mix and allowing the ward managers adequate time to discharge their roles effectively will be to improve compliance with health roster management.

Undertaking the establishment reviews has highlighted the limited time and resource the ward managers have to effectively review their budgets and skill mix and that the information the team now received from Allocate Insights is poorly understood and utilised.

The Assistant Chief Nurses in each Care Group have been specifically tasked with reviewing the unavailability data at the start of 2021. A corporate high level review of this data has revealed that, whereas over a 4 week period wards are afforded 30 hours ward management time, the actual time being taken is much higher, but recorded under a range of different subjects, namely: ward management; administration day; interviewing day; roster creation day, with one ward totaling 150 hours over 4 weeks. Discussions with the Matrons have revealed that this will not accurately reflect clinical activity and that senior nurses may take 2 hours doing the health roster and then work for the remaining hours of the day on the ward, but they

are not changing duties mid-shift. The system does allow for duties, wards and roles to be altered in the moment, this helps with more accurate data collection. This work needs to be managed at Care Group level, reporting through the operational governance meetings. Conversely, the limited official allowance for ward management time may be leading to more inefficiency, in that people work in an unfocussed way on the full range of ward management and leadership duties.

5. Headroom

The use of 'headroom' (uplift or mark-up) percentage refers to the allowance included within establishments to cater for managing unavailability such as annual leave, bank holidays, study leave and sickness/absence. In most trusts, this does not include maternity leave, which is treated separately due to its ad-hoc nature. It is important to set the headroom allowance accurately and in accordance with the needs of the organisation. Typically, it is set between 21-23% of net establishment in most trusts. If the allowance is too high, this can result in overspending for the patient care requirements. If the allowance is set unrealistically too low, this also results in the ward/department overspending as it represents a false position to manage against.

Table 5. Current Headroom for Adult In-patient Wards

Component	Number of days allocated per annum	Percentage mark up on net establishment
Annual Leave (AfC average)	30	11.5%
Bank Holidays (in-year)	8	3.0%
Sickness allowance (usually set at Trust's target. E.g. 3.9%)	10	4.0%
Education and Training requirements	4	1.5%
Total allowance per wte	**52**	**20%**

Table 5, describes the current headroom for adult in-patient wards. However, this is split with 16% in headroom that ward managers can substantively recruit to and 4% in a bank / agency budget line, not to be substantively recruited to, but with an expectation that bank and agency will be used 4% of the time, all the time.

The first recommendation is to remove the 4% bank and agency budget line and move to substantively recruit to the headroom required to effectively recruit to the establishment required to effectively run each ward.

The second recommendation is to increase the headroom by 2% to 22% substantively. The Allocate Insights report indicates and average unavailability of 24-26% (prior to the impact of Covid-19 when the Trust has seen an increase in unavailability to 33%). The other acute provider trusts in the ICS support higher headroom than York Teaching Hospitals NHS Foundation Trust (Hull 21.6% and NLAG 22%) meaning this recommendation would bring ICS alignment.
In Appendix 1 cover sheet, an option to increase to 24% has been included which would meet the current unavailability requirement. However, there is opportunity through effective rostering and human resources management to successfully bring

this within 22% and through Care Group governance and financial performance management structures this should be managed and monitored.

Table 6. Recommended Headroom for Adult In-patient Wards

Component	Number of days allocated per annum	Percentage mark up on net establishment
Annual Leave (based on ward age profile)	31	12.3%
Bank Holidays (in-year)	8	3.1%
Sickness allowance (usually set at Trust's target. E.g. 3.9%) + Carers / Compassionate leave	11	4.3%
Education and Training requirements	4	2.3%
Total allowance per wte	**54**	**22%**

The Trust is in a good position moving into 2021 to pursue a position of full recruitment for both registered nurses and healthcare assistants on the York site and health care assistants on the Scarborough site. The associated risk will be recruiting to registered nurses on the east coast if the substantive establishment is increased.

6. Ward Management / Non-clinical Supervisory Time

Following the Francis Report (2013), a suggested change to the Ward Manager role was to make the role supervisory and to change the focus of the role to ensure the Ward Manager was not part of the nursing 'numbers' or care delivery team, and to move them fully into a leadership position with authority and time to monitor care standards and lead (Francis, 2013 and Pegram, 2014). The rationale being that the Ward Manager is supported with sufficient resource (time) to lead, supervise and support staff, and ensure effective high-quality care is delivered within their ward or unit.

The Royal College of Nursing (RCN) advocates that the Ward Manager should be 100% supervisory (Seers, 2009), however, there is no specific definition of the role. What is determined is that the role is multifaceted and requires adequate time to discharge effectively.

For insight the Ward Manager role includes:

- Knowing their patients and the associated care plans on a ward. Oversight of Board Rounds and operational patient flow activities
- Using feedback from patients through FFT, complaints and compliments to improve the experience of patients on their ward
- Using staff feedback through formal and informal routes to ensure staff well-being; retention and recruitment is excellent
- Understand staffing capacity and skill mix to ensure dynamic delivery of staffing each day to maintain patient safety and high quality care
- Monitor the quality of care and associated risks. Investigate risks and incidents and ensure the associate learning is adopted and embedded on the ward
- Monitor cleanliness and infection control compliance and address deficiencies

- Understand the internal mechanisms to monitor quality through audit and accreditation that lead to the best possible outcomes for patients
- Understand the external regulatory framework and the requirement to achieve CQC standards
- Demonstrate leadership by working alongside staff who are new or in phases of development (either clinical or managerial)
- Be aware of the 'lived experience' of staff and whilst adhering to all aspects of Human Resource Policy ensure staff well-being is maintained.
- Undertake a Training Needs Analysis annually and ensure through appraisal that staff are trained in the correct competencies; are able to achieve their objectives and their ambitions
- Provide an excellent learning environment for non-medical learners and ensure staff are competent in undertaking the roles of clinical assessor and clinical supervisor
- As budget holder be responsible for the management of a pay and non-pay budget.

Currently the time allocated to undertake 'Ward Management' is 7.5 hours / week. This is insufficient to effectively discharge Ward Management duties and is not in line with other Trusts in the ICS; (Hull and NLAG allocate 15 hours / week, however, the Chief Nurse in NLAG has indicated an intention to request full time supervisory status for their Ward Managers in 2021).

An option for 15 hours has been included in Appendix 1 of the paper; however, the requirements set out above clearly demonstrate the complexity and breadth of this pivotal role. The recommendation is that this is increased to 22.5 hours and that it is retitled non-clinical leadership time that can be allotted to anyone in the team to undertake leadership duties on the ward.

7. Conclusion

This nursing establishment review of the adult in-patient wards is overdue. The request for **£5,863,738** in 2021 is significant. The assumption is that if a full review had taken place annually since 2018 the changes in acuity and dependency of patients and ward activity would have resulted in a more incremental change to budgeted establishments.

The investment will reduce risks associated with nurse staffing. However, it is acknowledged that the investment only forms part of a bigger picture and the requirements to recruit to additional vacancies over-time remains a significant challenge, specifically on the east coast. This presents the Executive Committee with the consideration of realistic options to only part fund in 2021based on projected recruitment potential and look to further fund in 2022.

The Chief Nurse Team, recommendation would be to support the increase in headroom to 22% and the increase in non-clinical leadership time to 22.5 hours per week as a fundamental minimum for all wards in 2021. The associated cost for this is £1.2M. This principle should be applied to all other wards, units, departments and nursing and midwifery teams in the community as we undergo an ambitious schedule of reviews throughout 2021.

If partial or incremental investment in the establishments is achieved the Chief Nurse Team would make a judgement to first invest in the elderly wards on both sites and then specifically Lilac Ward and Chestnut Ward on the Scarborough sites. The uplifts across the elderly wards only equates to £2.3M. There are a number of newly established / revised wards where a further review in 6 months is recommended, namely, the combination of Ash / Aspen; reopening of Ann Wright and a review of Ward 29 once it is re-established as an elective orthopaedic ward.

If further investment is achieved there are recognised and associated risks, namely, a potential immediate increase in the reported vacancy position; the requirements for increase recruitment activity; the requirement to undertaken health roster revisions and a potential for increased bank and agency bookings until substantive recruitment is achieved. These are predictable risks which have been discussed with the recruitment team; health roster team and finance prior to the submission of this paper.

If none or only partial funding is supported the Executive Committee should consider the associated risks and update the appropriate risk registers to acknowledge and then monitor the related patient harm, patient experience and staff experience reports through the appropriate Care Group and Corporate governance structures.

8. Recommendation

The Executive Committee is asked to consider and paper and approve an incremental approach to investment in front line adult in-patient wards areas.

Appendix 3

Ward budgets to realign (housekeeping) and priority wards based on ratios

The following wards were identified as requiring significant realignment of budget.

Lilac / Cherry – changed functions

CCU – Scarborough

Stroke – Scarborough

Ash / Aspen – reconfigured

Graham – Conversion to SDEC / HFU

Anne Wright – amended bed base

Priority Wards

This is a subjective prioritisation based on ratios. These wards do have some associated risks, but this is not more than reported risks on other wards, for example, Beech Ward is a higher risk ward, but for the purpose of this exercise is not a high risk ward as its staffing establishment was immediately invested in following the 2019 CQC visit, therefore it has already achieved a revised and compliant staffing and skill mix.

Please note that the realignment required in Care Group 2 complicates the prioritisation, for example, Lilac Ward appears to require significant investment, but at the time of review it was working to the previous Lilac Budget but functioning as an acute admissions unit. Conversely, Cherry ward appeared over-established as is had converted from an admissions unit to a downstream ward. Therefore, financial re-alignment (right budget in the right place) may slightly influence the prioritisation.

Priority 1 Wards

Chestnut

Holly

Johnson

Priority 2 Wards

Oak Ward

Ward 23

Ward 26

Ward 35

Ward 25

Priority 3 Wards

Ward 32

Ward 33

Ward 11

Priority 4 Wards

All remaining wards

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NHS
York Teaching Hospital
NHS Foundation Trust

Board of Directors – 31 March 2021
Resources Committee Minutes – 16 February 2021

Attendance: David Watson (DW) (Chair), Lynne Mellor (LM) Jim Dillon (JD), Andrew Bertram (AB), Polly McMeekin (PM), Delroy Beverley (DB),), Penny Gilyard (PG), Adrian Shakeshaft (AS), Joanne Best (minute taker)

Apologies: Dylan Roberts (DR)

The following staff were stood down from attending due to the Covid 19 situation: Graham Lamb, Steven Kitching

1. Welcome

DW welcomed everyone to the Resources meeting and declared it quorate.

2. Declaration of Interests

There were no changes to the declarations, and no declared conflicts of interest arising from the agenda from either a Trust or an LLP prospective.

3. Minutes of the meeting held on 19 January 2021

The minutes of the meeting held on 19 January 2021 were approved as a correct record and the following noted in respect thereof:

PG, item 40 on the action log should read HPV Hydrogen peroxide vapour.

4. Matters arising from the minutes and any outstanding actions

Item 8 – Will move to new management for new financial year – complete

Item 18 – Meeting arranged – complete

Item 20 – Operational issue – complete

Item 28 – Operational issue – complete

Item 31 – LM, noted there had been email correspondence outside of the Resources meeting but assurance of the process to allow patients access to tablets was still required.

The Committee discussed patient access agreeing this item should be escalated to the Board and moved to the Quality Committee with the Digital team liaising with Patient Experience team to resolve any issue.

Action 31: PM to raise with Heather McNair, Chief Nurse.

5. Executive Reports

YTHFMLLP

Compliance Report

DB, noted the Compliance Report had not been seen by the appropriate LLP Boards prior to submission to the Resources Committee.

Action 45: DB Governance with AB

PG, performance had improved slightly in the previous month although sickness absence within the domestic team had increased. Recruitment of Bank Staff and their return rate had proved challenging.

Item 4.4 - Staff attending Trust Health and Safety Training - The Trust's HR Business Partner supported significant improvements to the process which should reflect in the February figures. The LLP is continuing to address approximately 60 long term sickness absence cases which are currently impacting on KPi's.

JD reiterated his previous concerns that the majority of LLP papers submitted to the Resources Committee relate to operational matters and are not appropriate for this Committee.

The group discussed which Trust Board the LLP should report into and appropriate data for reports.

DW, following the LLP's review of Governance if Resources Committee is deemed not the appropriate Board to receive certain LLP's reports, this outcome should be included on the Resources Committee agenda for discussion and agreement by the Committee.

EPAM Minutes

Page 19 – LM referred to the £3m Capital Programme underspend, requesting assurance this would be spent before the end of this financial year.

AB, the backlog maintenance scheme is not an issue of concern but noted his concern in relation to two capital schemes, York Emergency Department spend of £2m and the Critical Care spend of £1.7m both schemes are progressing well. The modular ICU which will create an additional 6 critical care beds at York is being built off-site by Portakabin. Spend difficulties relate to the time funds were released, but is continually reviewed.

DB confirmed a real time update would be delivered to the LLP's Board next week, he will then update the Resources Committee NEDs.

Action 46: DB
Page 22 - LM highlighted concern in relation to patient safety issue raised due to lack of auditing of routine maintenance of ventilation at SGH theatres.

DB will respond to LM's concerns outside of this meeting.

Action 47: DB

Culture Report

PG delivered an overview of the report highlighting that it is central to the LLP's 5 year strategic plan and addresses cultural transformational changes which are required to ensure the LLP becomes a respected organisation with efficient and effective processes.

LM acknowledged the programme supported an understanding of requirements and indicates clear future milestones. Referring to the previously submitted ACAS Report which had highlighted need for cultural change within the LLP, LM noted that it would be good to see a direct correlation between the LLP's plan and the outcomes of the ACAS report along with how the LLP's plan links directly to Trust's strategy and cultural behaviours.

Action 48: PG

PM, the LLP's action plan links closely with the Trust's Values and Behaviours plan. The LLP had been included in this piece of work as a directorate, noting the deadline has slipped from March to May 2021.

Community Stadium update

DB briefly discussed the report noting the assumption it had been read.

LM noting the time slippage for the handover of the project, asked how this had impacted on the benefits highlighted in the business case, also referring to a number of risks highlighted in the report, e.g. equipment, loss of revenue, potential legal claim and car parking issues asking what steps had been put in place to mitigate these issues.

DB to discuss these issues with LM outside of the meeting.

Action 49: DB

The group discussed issues which had occurred during the development of the Community Stadium and if the Trust should be involved in a review after completion.

AB confirmed the contract with the lease company will be signed at the end of this week.

In response to LM's request to review the Business case - AB agreed we should do this and discussed the Trust's post implementation business case review process confirming he would trigger it for the Community Stadium..

Action 50: AB

Domestic Report – operational report

Items for Escalation to the Board

- Follow-up re patient access to tablets most appropriately managed by Heather and Quality Committee. Correspondence exchanged has identified this is an area where the Patient Experience Team are active.
- Debate re issues (and level of detail) regarding LLP to be brought to Resources Committee to be addressed in joint Delroy/Andy proposal to EPAM
- Concerns whether two capex projects (York ED and York ICU) will be completed by year-end.
- Very positive response from Committee to presentation of the Culture report and the Road Map for the Change Programme
- Community Stadium project plagued with delays and challenges. Andy to trigger post-implementation review process to ensure that the space will deliver the benefits that we initially sought. Formal PIR to be invoked at month 6 (September 2021) and month 12 (March 2022) and reported into Resources Committee.

The LLP representatives left the meeting.

Finance

IBR Overview

I&E position - AB, at the end of month 10 the Trust is reporting an I&E position of £1.7m deficit against a planned deficit of £2.9m, delivering a positive variance of £1.2m against the plan submitted to NHSE/I.

Operational expenditure for elective activity is behind plan as a result of the pandemic noting funding for Covid response is continuing.

Presently the Trust is showing a forecast outturn of £6.9m deficit against a plan of £5.4m which is a deterioration against plan of £1.5m, this relates to an increase in the annual leave provision due to staff carrying forward annual leave. Further guidance is expected before the end of the week. AB discussed the shortfall noting the Trust will be compensated with a cash back payment for 'other income' which is £4.5m of the £6.9m deficit.

Cash – Under the current regime of advance payment the Trust would have received a 13th payment in March but NHSE/I have confirmed this will not be issued, but with receipt of the compensation payment covering 'other income' on 15th March it is envisaged the Trust will not experience cash flow problems at the end of the financial year.

AB discussed the income stream and guidance received from NHSE/I to support annual leave which is carried forward, noting involves a cash payment and will be received before 15th March.

Under the Elective Incentive Scheme the Trust also expects to receive approximately £1m from the Treasury as more than expected elective work was carried out between September and December 2020.

The Trust also accessed additional Orthopaedic capacity and is seeking approximately £1m from NHSE/I to cover these costs, confirming this had not been included in the Trust's financial position.

The additional funding expected by the Trust and noted above supports an expected surplus forecast outturn of approximately £3m.

Business Planning - AB confirmed the I&E plan for 2021/22 has been delayed as NHSE/I are still negotiating funds with the Treasury. The draft I&E plan will be submitted to the Board at the end of March.

BAF / CRR

AB discussed both the Trust and System Plan noting the expectation both will be achieved, but confirmed the uncertainty of next year's finance remains a risk.

LM asked how much annual leave staff are able to carried forward.

PM discussed the Trust's policy, noting Government Emergency Legislation was announced at the start of the pandemic which allows individuals who are unable to take annual leave due to the pandemic to roll over up to 20 days leave over a 2 year period. The Trust has encouraged staff to take their leave.

The group discussed the possible total number of annual leave hours which Trust staff may carry forward. The expectation is a set number of days per staff member will be supported financially by NHSE/I.

Items to be escalated to Board

- Currently, £1.2m ahead of plan to end January primarily because we have not been able to undertake all the elective work planned for 20/21
- Forecast for the year is a deficit of £6.9m (primarily due to need for unused staff leave accrual and a shortfall in other income; both of these issues accepted by NHSE/I as allowable deficits). However, the latest information from NHSE/I indicates that some central reimbursement expected for staff leave accrual, for the "other income shortfall" and for the Elective Incentive Scheme linked to extra elective work completed in Autumn. These issues, coupled with better than plan performance on core spending, are likely to result in a surplus position of around £3m.
- No definitive news on income regime for 21/22 save that Trust will not receive April's income in March. However, no cash-flow issues forecast at this time.
- Huge disparity between "capex wish-list" and capex available for 21/22. Management currently minded to focus on back-log maintenance and IT though ICS funding may in-part support both of these demands. How do we measure relative merits of different capex candidates given the massive shortfall in available spend?

- Need to re-assess risks in relation to eg renal if certain key capex projects cannot be funded
- Assets potentially surplus valued at c. £8m; options to be delivered in respect of each saleable asset

Draft Capital Planning information – for information only

DW requested further information as to how capital expenditure projects are selected.

AB, explained previously the expanding NHS had supported most projects and discussed how the Trust will support future projects e.g. next year's Digital investment with a requirement of £4.3m, noting possible support from other investments such as the Digital Aspirant programme and ICS funding which would be used to support back log maintenance plans.

LM, originally Digital had request £4.8m but now it has been reduced to £4.2m, asked for clarification.

AB, follow a review of the paper the amendment made related to revenue, the remaining £4.2m is capital.

LM referred to point 8 of the Capital Planning Report, noting the number of significant issues which had been highlighted as risks asking if these had been considered in relation to the BAF. AB confirmed he would review these risks but noted support from the ICS would be required for these projects.

LM, referring page 60 of the pack and the table of potential asset sales, asking if these will be sold or could the Trust re-purpose them?

AB and DB will review the list of potential asset listed for sale noting the Board had already agreed to the sale of the York Social Club and had previously approved a paper to develop marketing options for Cherry Tree Avenue, staff accommodation at Scarborough.

Action 51: AB / DB

DW, referring to page 57, is the Trust able to continue to expand its lease portfolio where appropriate prior to the IFRS16 changes being implemented.

AB confirmed when appropriate the lease portfolio could continue to be expanded allowing the Trust access to the latest technology.

LM, previously she had requested a report as to where additional income could be generated using the LLP as a vehicle for the Trust. DB said a list exists and he would share.

Action 53: DB

The group discussed the expectation that the LLP will eventually provide a commercial benefit to the Trust, but agreed the need to ensure the service delivered to the Trust is first class before they are able to market themselves to other agencies.

Workforce

Staff Survey

PM gave an overview of the report, noting the CQC had moved the Trust a larger group of 128 Trusts for benchmarking purposes. The uptake of this census was 36% of all staff compared to 43% in the previous year, with the 2nd wave of the pandemic impacting on participation.

The report covered 10 themes, noting when compared to its self in 2019 the Trust deteriorated in 4 of these themes, Equality and Diversity, Health and Wellbeing, Line Management and Team Working but improved marginally in Safety Culture. But when compared to other benchmarking groups the Trust is just above the benchmark in 1 theme, Equality and Diversity.

Although morale across the NHS for 2020 had shown an improvement the Trust's score had stayed static and is behind the benchmark average, noting this is a key indicator for organisational culture.

Statistically the Trust changed in 2 aspects, Equality and Diversity and Team Working, but deteriorated in Equality and Diversity. With regard to Team Working, it is broken down into classifications with the Trust below benchmarking average in all classifications.

Next Steps – the report refers to Trust staff only and a further report which will be broken down into Directorate groups will be received, which will allow individual teams to receive the more bespoke support.

PM noted the clever together work steam had been paused due to the pandemic, but will support the implementation of the values and behaviours work across the Trust from April 2021, along with the underlying behaviours framework.

LM noted a number of BAME staff had not appreciated the attention of the BAME labelling. How will this be addressed?

PM, due to the pandemic risk assessments were carried out for all staff with the priority being for staff who were seen to be highly clinically vulnerable to Covid. The Trust experienced a low number of staff who had issue with having risk assessments, but supported these staff acknowledging the Trust's duty of care to move them to alternative work area if this was required following an assessment.

PM, discussed the poor uptake from the BAME community with regard to the Covid vaccination programme, noting 59% of Trust BAME staff had received their first vaccination; ways to support a higher uptake are being explored.

Imperial College London Disciplinary learning (Improving our People Practices)
PM highlighted changes made by the Trust and noting the aim of this paper is to provide continued assurance with regard to ongoing developments in the progression towards achieving these recommendations.

PM noted in 2017 the Trust suspended 19 individuals and conducted 69 disciplinary hearings, confirming numbers of both have continued to reduce due to the Trust's different approach with only 2 individuals being suspended in 2020 and 12 disciplinary hearings.

DW acknowledged the background of the report, but noted the requirement of these disciplinary processes to address behaviours which should not be tolerated.

LM, IBR indicates during the pandemic period the number of grievances was extremely low but this number appears to be rising, does this correlate to expectations following the staff survey report?

PM, discussed the importance of investigating grievances in a timely manner and agreed with LM's view.

Items for Escalation

- Staff survey showing declines in Diversity, Health, Managers and Team Working measures. In relation to Team Working, we are below peer group average. This excludes LLP. Need to progress "Clever Together"
- Only 59% of BAME staff eligible have been vaccinated
- Paper on Disciplinary Processes to ensure we are compliant with best process. Further presentation arranged for Board in due course

Digital

Digital Report

This report was taken as read

LM discussed the origin of the report noting the aim was to support the suggestion that a higher than planned spend for IT and Networking was necessary, using model hospital data to support this claim. LM, stated that her preference would be to benchmark against the Global Digital Exemplars Programme (GDE) measures i.e. those Trusts who had received funding a couple of years ago and those who had taken the lead on Matt Hancock's more recent Digital Aspirant programme be used for this benchmark data

The group discussed financial and cultural challenges required to support an improved IT system, highlighting the importance of offering supporting evidence of efficiencies and benefits of updates to support a case for change.

It was agreed benchmarking data is not always recorded in the same way, but suggested the benchmark report is re-run using the Trusts who have already accessed the Digital Aspirant programme.

Action 52: AS / DR

Digital Aspirant Initial Bid

AS confirmed no update had been received.

Items for Escalation

- No news yet on Digital Aspirant Programme

6. Any other Business

No other business was discussed

7. Time and Date of next meeting

The next meeting will be held on 16th March 2021 at 9am via webex. Dial in details are within your diary invite.

Action Log – Resources Committee

Item number	Meeting date	Action	Owner	Due Date	comment	last update	status
53	16.02.21	DB to share list of possible areas which could generate additional income for the Trust in the future	DB	Mar-21			GREEN
52	16.02.21	AS to re run benchmarking report using digital aspirant hospitals	DR/AS	?		16.02.21	green
51	16.02.21	AB / DB to review potential assets for sale - could they be re purposed	AB/DB	Apr-21	Underway	16.02.21	green
50	16.02.21	AB to raise Post Implementation BC review process for Community Stadium	AB	Mar-21	Actioned for 6 & 12 months PIRs post live date.	16.02.21	green
49	16.02.21	DB to discuss Community Stadium slippage risk with LM	DB	Mar-21		16.02.21	green
47	16.02.21	DB to contact LM and update re ventilation at SCH Theatres	DB	Mar-21		16.02.21	green
46	16.02.21	DB to update RC NED's on Capital Spend situation after LLP Board meeting	DB	Mar-21		16.02.21	green
45	16.02.21	DB /DW discuss submission of LLP Compliance Report to appropriate LLP Board prior to RC meetings	DB	Mar-21		16.02.21	green
42	19.01.21	People Plan update to RC	PM	May-21		19.01.21	Green
40	19.01.21	DB to share HSE report it appropriate - 2019 HPV incident	DB	Mar-21	No report from the HSE	19.01.21	Green
22	17.11.20	Digital – section to be included on the IBR	DR	Mar-21			Green

NHS York Teaching Hospital NHS Foundation Trust

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee/Group: Resources Committee	Date: 23 March 2021	Chair: David Watson

Agenda Item	Issue and Lead Officer	Receiving Body, ie. Board or Committee	For Recommendation or Assurance to the receiving body
HPV HSE incident (Delroy)	So as to avoid duplication, it was agreed that Audit Committee under the leadership of Jenny should take the lead in relation to our review of policies and procedures (HR and H&S), lessons learned and follow-ups in relation to the Scarborough HPV incident. Jenny informed.	Audit Committee Board	FOR ACTION FOR INFORMATION
Schedule of Work (Jill)	Proposed, subject to Board approval, that RC will undertake an initial review of capex and expenditure forecast with a view to making recommendations to the Board for spend approval	Board	FOR APPROVAL
TOR in respect of LLP attendance at RC (Jill)	Proposal from Andy/Delroy in relation to role of RC in respect of LLP approved. RC's ToR to be updated in respect of RC's ongoing role in relation to LLP so as to avoid future duplication of scrutiny	Jill, Delroy, Andy Board	FOR ACTION FOR INFORMATION
Safety of staff at work and around commute (Polly, Delroy, all)	23.5% of our staff have experience harassment, bullying or abuse from patients or service users at work in the past 12 months. What can we do to improve culture and safety of all of our staff at work and around their commute (and avoid another Sarah Everard tragedy)? Focus on culture and physical environment	Board	FOR APPROVAL AND ACTION
Progress of COVID vaccination for Trust staff (Polly)	On-going work to persuade those not yet vaccinated to do so	Board	FOR ACTION
IT capex (Dylan/Andy)	Likely that c. £2m of capex will be allocated towards basic IT upgrade as part of £10m+ 3 year programme. Can we do more?	Board	FOR ACTION
Finance	Expected outcome for 20/21 will be £2.4m deficit after accounting for £4.3m of holiday accrual (part of which may yet be re-imbursed centrally). Negative issues impacting this outcome are known and accepted by NHS Centre	Board	FOR INFORMATION

Finance	Still no certainty on our income plan for 21/22!	Board	FOR INFORMATION
Finance	Proposed that we undertake a COVID-spend review and ascertain lessons learned (Andy)	Board	FOR INFORMATION
Finance	What more can we do as a Trust to generate more income (to invest back into our core infrastructure and people) (Andy)	Board	FOR INFORMATION
Sue/Governors(Sally)	Request by observing Governors to attend committee meetings more regularly	Sue/Governors	ESCALATION
All	Should we have a "staff member story" at RC and other committee meetings	Board	FOR DECISION

G

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 31 March 2021
Draft Operational Financial Plan 2021/22

Trust Strategic Goals:

☒ **to deliver safe and high quality patient care as part of an integrated system**
☒ **to support an engaged, healthy and resilient workforce**
☒ **to ensure financial sustainability**

Recommendation

For information	☒	For approval	☒
For discussion	☒	A regulatory requirement	☐
For assurance	☐		

Purpose of the Report

To report on, and seek Board approval on the Trust's draft Income & Expenditure (I&E) plan 2021/22.

Executive Summary – Key Points

Following the emergency financial regime in operation during 2020/21, as part of the NHS response to the Covid-19 pandemic, the publication of national planning guidance for 2021/22 is still awaited. Pending publication of the guidance, a draft I&E plan for 2021/22 has been developed based on briefings received from NHSE&I.

Because of the absence of national planning guidance, a financial framework and details of the Trust's emergency budget allocation, this draft plan is speculative at this stage and subject to revision.

This report presents the draft version of the I&E plan for 2021/22. A further report on the full and final version of the operational financial plan 2021/22 will be presented for approval to the Board at its April meeting, assuming national guidance and detail of the Trust's emergency financial budget are received.

Recommendation

The Board of Directors is asked to note and approve the Trust's draft operational I&E plan for 2021/22.

Additionally, the Board of Directors is asked to note that, following the eventual receipt of the national planning guidance and allocations to be issued by NHSE&I, a final version of

the full operational financial plan will be prepared for presentation to the Board for approval.

Author: Graham Lamb, Deputy Finance Director

Director Sponsor: Andrew Bertram, Finance Director

Date: March 2021

1. Introduction

The Board is aware of, and has previously received reports on, the emergency financial framework that was been put in place by NHSE&I for 2020/21. This was one measure to support the NHS in meeting the challenge presented by the Covid-19 pandemic. The emergency financial framework substituted for the draft financial plan for 2020/21 approved by the Board at its March 2020 meeting.

It is clear that as we enter into the financial year 2021/22 the emergency financial regime will continue. Normal NHS contracting arrangements will continue to be suspended.

At the time of writing this report, we are still awaiting the national planning guidance and notification of allocations for 2021/22 under the continuation of the emergency regime. The draft plan for 2021/22 is therefore constructed on the basis of national briefings, detailed in the section below, given by Julian Kelly (NHSE&I Chief Financial Officer) and his team. As part of this briefing the following broad timeframes were presented:

- Mid-March 2021: National planning guidance and notification of revenue / capital allocations issued. Still awaited.

- Mid-April 2021: system and organisational plans submitted to NHSE&I.

The Board is asked to consider and approve the draft version of the 2021/22 plan. Following receipt of the national planning guidance, notification of the allocations, and following discussion and agreement with system partners, a further report on the final version of the plan will be presented to the April Board meeting, before its expected submission to NHSE&I during April 2021.

2. Draft Planning Assumptions Based on the National Briefing (25 February 2021)

The following issues are the key points presented at the recent national briefing, together with some local interpretation on areas not covered.

- It was confirmed that current emergency financial regime will continue into quarter 1 (Apr, May & June) 2021/22. There was a strong indication that this will continue into quarter 2, and reference was made that discussions with the Treasury are underway to seek to keep this regime in place for the full 2021/22 financial year. This would mean the eventual post-covid financial reset would occur from 1 April 2022. However, other than the arrangements for quarter 1, the later quarter and full-year arrangements are still subject to confirmation.

- The Trust's funding will remain on the basis of fixed resource envelope going into 2021/22, with the value being reset to reflect our actual spending in October, November and December 2020 (quarter 3 of the 2020/21 financial year). This will be adjusted for inflation and any anomalies in the new reference period, although this will not initially in quarter 1 cover any cost of living pay inflation, as a decision on this is not expected until quarter 2 at the earliest. Once a cost of living award has been made, this will be backdated and funding made available to cover this in later quarters.

- It is not clear from the briefing what will happen with covid funding going beyond quarter 1, but we should expect downward pressure as the Treasury seeks to reduce the level of additional spending seen on Covid measures during 2020/21.

- The final position in relation to recovery activity funding has not been agreed with the Treasury but the ICS will get an additional allowance to support organisations that can go further. Further details are expected in the national planning guidance. At the moment this plan assumes activity in quarter 1 of 2021/22 is the same as activity in quarter 3 of 2020/21.

- It is expected that there will be no formal efficiency requirement in place for quarter 1, although the NHSE/I have indicated that they will be seeking productivity gains that improve and enhance elective activity recovery.

- There will be no growth funding for increases in emergency activity levels, as the expectation from the DHSC is that with the continuation of funding at recent 2020/21 quarter 3 levels, and including covid funding, this will most likely cover any pressures.

- The absence of growth funding means that our business planning process will remain suspended in the main part, certainly in the short term. Depending on the period on which the framework outlined for quarter 1 is extended over the rest of the financial year, it may be that the business planning process is suspended for the full year, especially if the regime continues and financial reset in not implemented until April 2022. The management of the message throughout the Trust, that we are unlikely to have any development funding during 2021/22, is going to be important.

- Any incremental investment that the Trust chooses to make will have to be matched with an equal and opposite expenditure reduction elsewhere in our spend plans. Rather than incremental investment we are going to need to manage a period of recycling existing spend to deal with the real priorities we feel we need to take forward.

3. Income & Expenditure (I&E) Plans

The Trust's draft I&E plans are based on the details from the national briefing described above. In summary the Trust's draft I&E plan for 2021/22 is presented in **Appendix A**. An indicative full year is presented, although alongside it is the illustrative draft plan for quarter 1, on which the most certainty exists of the likely planning framework into 2021/22.

<u>Income</u>

Using the information from the draft briefing, income is based on an assessment of the Trust's actual spend in quarter 3, 2020/21. Other income, which excludes expected allocations for work commissioned from the Clinical Commissioning Groups (CCGs) and NHSE, is based on the underlying rate reported in quarter 3. The assumed allocation from CCGs and NHSE is the balancing figure between the two. All income figures have been inflated by 1% over the quarter 3 levels. This is deliberately low in recognition that any allocations received for quarter 1 2021/22 will not cover pay awards.

Expenditure

Expenditure is based on the following:

- Base budget and reserves in 2020/21, to which are added cost pressures experienced during 2020/21 and those anticipated to arise during 2021/22.
- Inflation is included to meet primarily non-pay expenditure only. At this stage no provision is included for cost of living pay awards as per the briefing, however once awarded it is expected that additional funding over that assumed will be made available to cover the additional cost.
- Additional provision is included to meet the unavoidable costs of pre-committed business cases.
- No efficiency target is included in the draft plan. The briefing received confirmed there would be no target for quarter 1 2021/22; with any ask for the remaining quarters being dependant on whether, and for how long the regime proposed for quarter 1 is extended throughout the rest of the year.
- At this stage no additional income or expenditure is assumed to meet activity beyond the underlying levels experienced during quarter 3 2020/21.

4. Comparison of the Draft Plan to Underlying Run Rate

In order to test the robustness of the draft plan, a comparison has been made with the actual run rate in Q3 2021/21 (the reference period being used by NHSE&I), and the 2021/22 year to date (April 2020 to February 2021), with both increased by 1% for comparable inflation to 2021/22 levels. The table below illustrates that for both income and expenditure the draft plan 2021/22 is broadly in line with the adjusted underlying run rate experienced during 2020/21.

	Average Monthly Run Rate		
	2021/22 Plan	**Q3 20/21**	**YTD 20/21**
	£000	**£000**	**£000**
NHS Clinical Income	44,684	44,619	42,363
Non-NHS Clinical Income	168	160	181
Other Income	4,840	3,932	5,639
	49,692	48,711	48,183
20/21 Q3 and YTD plus 1% inflation	**49,692**	**49,198**	**48,665**
Expenditure Above EBITDA	-48,020	-47,677	-46,443
Expenditure Below EBITDA	-1,654	-1,524	-1,511
	-49,673	-49,201	-47,954
20/21 Q3 and YTD plus 1% inflation	**-49,673**	**-49,693**	**-48,433**

5. Recommendation

The Board of Directors is asked to note and approve the Trust's draft operational I&E plan for 2021/22.

Additionally, the Board of Directors is asked to note that, following the eventual receipt of the national planning guidance and allocations to be issued by NHSE&I, a final version of the full operational financial plan will be prepared for presentation to the Board for approval.

Appendix A. Draft Income and Expenditure Account for 2021/22

YORK & SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRUST
SUMMARY DRAFT INCOME & EXPENDITURE POSITION 2021/22

	Full Year £000	Q1 £000
INCOME		
NHS Clinical Income		
Clinical Commissioning Groups and NHSE	531,506	132,877
Local Authorities	4,703	1,176
	536,209	**134,052**
Non-NHS Clinical Income		
Private Patient Income	260	65
Other Non-protected Clinical Income	1,756	439
	2,016	**504**
Other Income		
Research & Development	2,468	617
Education & Training	19,889	4,972
Donations & Grants received of cash to buy PPE & Intangible Assets	703	176
Other Income	35,019	8,755
	58,079	**14,520**
Total Income	**596,304**	**149,076**
EXPENDITURE		
Baseline Expenditure	-528,391	-132,098
Prior Year Cost Pressures	-10,000	-2,500
Pay and Inflationary Pressures	-6,698	-1,674
Investment in Activity Related Developments	-2,434	-609
Covid-19 Costs	-22,390	-5,597
Quality & Risk Management	-1,412	-353
Other Costs	-4,911	-1,228
Business Developments	0	0
Less: CIP	0	0
Total Expenditure	**-576,236**	**-144,059**
EBITDA	**20,068**	**5,017**
Profit/ Loss on Asset Disposals	0	0
Fixed Asset Impairments	0	0
Depreciation on purchased and constructed assets	-11,890	-2,973
Depreciation on donated assets	-455	-114
Depreciation on donated assets - right of use re: peppercorn leases	-25	-6
Depreciation on right of use assets	0	0
Interest Receivable	10	3
Interest Expense on Non-commercial borrowings	-516	-129
Interest Expense on Uncommitted loans	0	0
Interest Payable on Leases	0	0
PDC Dividend	-6,969	-1,742
NET SURPLUS/ DEFICIT	**223**	**56**
PERFORMANCE AGAINST FINANCIAL IMPROVEMENT TRAJECTORY		
Net Surplus/ (Defciit)	223	56
Add Back		
Remove capital donations/grants I&E impact - Income	-703	-176
Remove capital donations/grants I&E impact - Depreciation	480	120
ADJUSTED FINANCIAL SURPLUS/(DEFICIT)	**-0**	**-0**

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NHS
York Teaching Hospital
NHS Foundation Trust

Board of Directors – 31 March 2021
2021/22 Capital Programme

Trust Strategic Goals:

☒ **to deliver safe and high quality patient care as part of an integrated system**
☒ **to support an engaged, healthy and resilient workforce**
☒ **to ensure financial sustainability**

Recommendation

For information	☒	For approval	☒
For discussion	☒	A regulatory requirement	☐
For assurance	☒		

Purpose of the Report

The purpose of this report is to propose stage 1 of the Trust's 2021/22 capital programme.

Executive Summary – Key Points

Details of all capital requests against the Trust's available resources were presented to the Executive Committee at its meeting on 20 January 2021 and £5m was identified as discretionary in terms of available funding. The Executive Committee discussed and agreed a back to basics programme, providing capital funding for essential backlog maintenance and improvements to our digital infrastructure as the two main priorities for the 2021/22 financial year. This debate was shared with the Resources Committee who also supported the back to basics programme.

This paper proposes a first release of funding going into the new financial year and proposes a second review of priorities during quarter one.

Recommendation

The Executive Committee at its meeting on 17 March 2021 approved the programme as described in this paper. The Executive Committee is recommending to the Board of Directors that this programme is approved. The Board of Directors is specifically asked to:

- Discuss and agree the capital programme at table 1.

- Discuss and agree the recommendation from the Executive Committee that in addition to the commitments in table 1 a further £2m is released for digital improvements (against the requested £4.3m), £1m is released for essential backlog maintenance, £0.4m is released for continuation of the ward refurbishment

programme and that we retain £1.657m for further consideration during quarter 1 of the new financial year.

- Establish project teams to scope the work in relation to: air handling at York Theatres, York SCBU, Scarborough Radiology backlog maintenance, dialysis capacity and the development of the child development centre at York. In addition work continues to secure a development partner to provide HYMS teaching facilities.

Author: Andrew Bertram, Finance Director

Director Sponsor: Andrew Bertram, Finance Director

Version: Version 1

Date: March 2021

1. Introduction and Background

The table below summarises the current position in terms of the known availability of capital funds and any commitments made against the capital programme.

Table 1. Working Draft 2021/22 Capital Programme

Sources of Funding in 2020/21:	£m	Programme Expenditure:	£m
Depreciation Funding (our own funds)	12.370	York – HV Infrastructure	0.475
Existing Loan/Lease Repayments	(3.150)	York – HV Infrastructure Contingency	0.250
		ICU – Modular Build contingency	0.500
		Community Stadium – Small Lantern	0.668
		Minor Schemes	0.500
		Medical Equipment (MERG)	0.350
		Fees (Feasibility for new schemes)	0.300
		Capital Staff	0.770
		SNS Staff	0.350
New PDC Funding – Scarborough Fees	1.365	STP Wave 4 Fees for Scarborough ED	1.365
Charitable Funding	0.380	Charitable funds Butterfly Scheme/ Other charitable	0.380
*New PDC Funding York ED Phase 2	13.000	York ED Phase 2 Scheme*	13.000
VIU – Loan funding	6.900	VIU/PACU	6.900
		Unallocated Capital Programme	**5.057**
TOTAL	**30.865**	**TOTAL**	**30.865**

* Note: Funding has not yet been confirmed for the York ED Phase 2 scheme.

The programme will be updated accordingly as any new externally funded schemes come on line with secured funding and as any contingencies are released.

It should be noted the depreciation funding figure, which is the core of our capital programme funding, remains estimated and will be updated in due course. It is not expected to change significantly.

As can be seen in table 1 above, after all capital pre-commitments are taken into account, the remaining unallocated capital resource available is currently **£5.057m**.

We should also note that in support of the Scarborough ED, Critical Care and backlog maintenance business case, the Trust, along with the ICS, has made a commitment from its own capital programme. The current outline business case (recently approved) confirms £40m from the DHSC supplemented by £4m from the ICS and £3m from the Trust. In the case of the Trust and ICS contribution we will look to smooth these charges across the three financial years that the construction period touches. The scheme is due to start in quarter 4 of 2021/22 and so we should expect to make a contribution of up to £0.5m from the 2021/22 capital programme.

2. Capital Programme Priorities

It is important to remind the Executive Committee that the depreciation generated capital programme funding should be used for maintenance and replacement of existing assets. Discussions surrounding the working draft of the capital programme with the Executive Committee, at its January 2021 meeting, confirmed two real priorities; those being continuing the backlog maintenance programme and updating/improving the Trust's digital infrastructure. The views expressed by the Executive Committee being directly aligned to the CleverTogether staff engagement feedback work and the principle ask of staff to "sort the basics".

The demands on the capital programme have also been discussed in detail with the Resources Committee (sub-committee of the Board of Directors) and at summary level with the full Board of Directors. Both the Resources Committee and the Board of Directors fully endorse this fix the basics principle.

2.1 Backlog Maintenance

YTHFM LLP has recently undertaken a full site condition survey in order to identify and prioritise backlog maintenance issues across the whole Trust. The 2020 ERIC return confirmed a total outstanding backlog maintenance requirement of £32m. Of this, the report identified £4m of critical backlog maintenance work, most of which will be completed as part of the 2020/21 capital programme. Our estates and facilities partners are currently assessing the 2021/22 critical backlog maintenance requirement. At this stage we are continuing to make an assumption that this will be around £2m. Confirmation of a final figure from the LLP is awaited.

In addition to this programme of work the Board, the IPC Team and the Chief Nurses office have previously requested a separate allocation be identified and protected for ward refurbishment. This has previously been set at £0.4m. The work programme for this refurbishment has been managed through the Chief Nurses office.

2.2 IT Infrastructure Investment

The Trust's Digital and Information Service (DIS) has, under the leadership of the new Chief Digital Information Officer, been reviewing its capital investment requirements going forward. The team have prepared an Essential Information and Communications Technology (ICT) investment programme and have prepared a separate and specific paper for the Executive Committee in order to provide detail.

Table 2, overleaf, summarises the key investment requirements for the 2021/22 capital programme.

Table 2. IT Capital Requirements for 2021/22

Project	**2021/22 £m**
End User Computer Replacement Programme	1.6
Network Infrastructure – edge switches	0.5
Network Infrastructure – core data centre	0.3
Network Infrastructure – wireless network	0.5
Telephony Infrastructure	0.05
Video Conferencing	0.08
Bleep System Replacement	0.075
Server Software	0.18
Computer Storage and Backup	0.8
Cyber Security Tools	0.2
TOTAL PROGRAMME	**4.285**

3. Known Equipment Replacement Requirements for 2021/22 (Source: Care Group Business Planning Work)

The Trust would typically lease many medical equipment items instead of purchase outright. This allows the Trust to expand the reach of the capital programme. It is this area particularly that will eventually be impacted by the IFRS16 changes. However, for the 2021/22 capital programme we can continue with lease arrangements where appropriate and we anticipate being able to afford a total leasing provision of £4.56m in our revenue position, which will represent an increase of £0.7m from 2020/21.

We continue to work through the replacement requirements in order to finalise the revenue implication details. We do not expect difficulty in managing known key and essential medical equipment replacement.

4. Other Care Group and Directorate Requests Against the Programme

We hold on record all the detail provided by Care Groups of anticipated additional capital requirements going forward. This list comprises completely un-scoped schemes with no feasibility work having been undertaken right through to schemes with documented initial feasibility and planning work. This list will be maintained as the active capital requirement list and will be used alongside the eventual clinical strategy work to support and plan for future developments; it will be used in conjunction with the developing ICS capital support programme and will be used to support any external bidding opportunities that might arise in year.

5. Other Considerations Against the Programme

There are several significant issues in relation to the Capital Programme that the Executive Committee are aware of. Following presentation of the draft plan and summary Care Group information at the January Executive Committee a request was made for any

further issues to be added to this programme list of urgent schemes requiring further work up. No further additional representations were made.

Of note, the January list included work in relation to electric vehicle charging points on the hospital sites, but following discussion at the January Executive Committee this has been removed from the urgent requirement list. No work is progressing at this stage.

Areas identified as urgent capital priorities are:

- York hospital main theatre environment has significant backlog maintenance issues, specifically in relation to the air handling plant. Our estates and facilities partners are concerned over the ability to keep the air handling plant running as this is significantly outside of its expected useful life. Any interruption to air handling could result in significant theatre down time. Consideration is suggested to the formulation of a project group to consider how this work can be taken forward. This will most likely result in a major multi-million pound project with some fees costs expended against the 2021/22 capital programme. This is most likely to be a case where support from the ICS would be necessary as the total cost is likely to be beyond the reach of our own internal capital programme. No ICS funding is yet known about for 2021/22 and beyond.

- York SCBU environment is essentially the original 1970s build environment with very limited update or improvement work over the years. The unit has, in the past, been the subject of a number of MRSA events with a potential link being the age of the environment and the cleaning challenges this presents. Again consideration is suggested to the formulation of a project group to consider how this work can be taken forward but also to consider the necessary clinical model and size and configuration of any replacement unit. This will most likely result in a major multi-million pound project with some fees costs expended against the 2021/22 capital programme. This is most likely to be a case where support from the ICS would be necessary as the total cost is likely to be beyond the reach of our own internal capital programme. No ICS funding is yet known about for 2021/22 and beyond.

- Scarborough Radiology Backlog Maintenance totaling £3m has been identified as part of a review of the estate. This is necessary to undertake before any equipment replacement or expansion of service can be undertaken. This work is increasingly becoming a priority and is going to be a problem, if not addressed, as we have a number of replacement schemes imminently necessary. This is most likely to be a case where support, either in full or in part, from the ICS would be necessary as the total cost is likely to be beyond the reach of our own internal capital programme. No ICS funding is yet known about for 2021/22 and beyond.

- York Renal Dialysis design work was approved by the Executive Committee as part of the 2020/21 capital programme. This work will be presented to the Executive Committee in due course. The York main dialysis unit facilities are inadequate and no longer fit for purpose. The same can be said for the Easingwold satellite dialysis facilities too with the current environment being in an extremely poor state of repair. It is expected that this design work will confirm the need for a multi-million pound combined York and Easingwold dialysis unit in the currently void space underneath the York Endoscopy unit (the current dialysis facility and the old physiotherapy

space). This is most likely to be a case where support from the ICS would be necessary as the total cost is likely to be beyond the reach of our own internal capital programme. No ICS funding is yet known about for 2021/22 and beyond.

- HYMS Teaching Facility design work has identified a solution on the spare land opposite Park House. This is a £25m-£30m build project providing a complete teaching and education facility. The business case has already been presented and approved that described the student population growth and revenue investment requirements to support expanded teaching and this case showed a contribution from the income received to service any necessary loan to finance the build project. A Prospectus from the design work has been prepared and the identification of an investment partner is the next step forward. Teaching space is going to rapidly become an issue as student numbers grow in the next year.

- Design work has been undertaken to expand the outpatient clinic space in the Child Development Centre at the York site. This is an aged building no longer fit for purpose in terms of configuration, capacity and the environment. The stage 1 completed report suggests a scheme capital cost of £4.5m. This is most likely to be a case where support from the ICS would be necessary as the total cost is likely to be beyond the reach of our own internal capital programme. No ICS funding is yet known about for 2021/22 and beyond.

6. Proposed Capital Programme

Even with the pandemic-related uncertainty in terms of NHS finances at the moment, it is still crucial that we agree our capital programme, in the main, for the coming financial year. That way we allow priority schemes to progress at a sensible pace against the known depreciation funded programme.

We will continue our work with the ICS Strategic Capital and Estates Group to understand the opportunity to supplement our capital programme through ICS funding. The ICS is expecting its capital allocation details imminently.

In terms of the available £5.057m of depreciation I would propose the Executive Committee recommends to the Board of Directors that we release £2m for digital improvements (against the requested £4.3m), we release £1m for backlog maintenance, we release £0.4m for the ward refurbishment programme and we retain £1.657m for further consideration during quarter 1 of the new financial year.

Clearly, during the quarter one review we will need to consider further releases against the digital infrastructure ask, and potential further backlog maintenance requirements, in the context of whether supplementary ICS funding has become available or not.

In preparation for the upcoming quarter one discussion in relation to the release of the remaining £1.657m of capital funding, Care Groups are asked to review their capital submissions to identify urgent investment need that must progress in 2021/22. The upcoming round of OPAMs can also be used to discuss and highlight issues that are not currently covered in this proposed programme.

In addition we continue to make strong representations to the ICS for backlog maintenance support (similar to in 2020/21) and we continue to pursue digital aspirant status to support the digital investment programme. Any funding secured through these routes can be used to supplement (or substitute if possible) our capital programme.

7. Recommendation

The Executive Committee at its meeting on 17 March 2021 approved the programme as described in this paper. The Executive Committee is recommending to the Board of Directors that this programme is approved. The Board of Directors is specifically asked to:

- Discuss and agree the capital programme at table 1.
- Discuss and agree the recommendation from the Executive Committee that in addition to the commitments in table 1 a further £2m is released for digital improvements (against the requested £4.3m), £1m is released for essential backlog maintenance, £0.4m is released for continuation of the ward refurbishment programme and that we retain £1.657m for further consideration during quarter 1 of the new financial year.
- Establish project teams to scope the work in relation to: air handling at York Theatres, York SCBU, Scarborough Radiology backlog maintenance, dialysis capacity and the development of the child development centre at York. In addition work continues to secure a development partner to provide HYMS teaching facilities.

York Teaching Hospital Facilities Management

Board of Directors – 31st March 2021
Draft LLP Operational Financial Plan 2021/22

Strategic Goals:
☒ **to deliver safe and high quality patient care as part of an integrated system**
☒ **to support an engaged, healthy and resilient workforce**
☒ **to ensure financial sustainability**

Recommendation

For information	☐	For approval	☒
For discussion	☒	A regulatory requirement	☐
For assurance	☐		

Purpose of the Report
To report on, and seek the Board of Director's approval on the YTHFM draft Income & Expenditure (I&E) plan 2021/22.

Executive Summary – Key Points
Following the emergency financial regime operating during 2020/21 as part of the NHS response to the Covid-19 pandemic, the publication of national planning guidance for 2021/22 is still awaited. Pending publication of the guidance, a draft I&E plan 2021/22 has been developed for YTHFM based on briefings received from NHSE&I.

This report presents the draft version of the I&E plan for 2021/22.

Further work in the interim is required to review the investment business cases and ensure all cost pressures are accounted for. Therefore, a full and final version of the Operational Financial Plan 2021/22 will be presented for approval to the Management Group at its April meeting.

Recommendation
The Board of Directors is asked to:

- Note and approve YTHFM's draft operational I&E plan for 2021/22.
- Note, that following receipt of the national planning guidance and allocations to be issued by NHSE&I, a final version of the full operational financial plan will be received for approval.

Author: Penny Gilyard, Director of Resources
Graham Lamb, Group Deputy Finance Director

Director Sponsor: Delroy Beverley, Managing Director

1. Introduction & Background

1.1 The LLP Management Group throughout the year has been advised of the emergency financial framework that was put in place by NHSE&I for 2020/21, as one measure to support the NHS in meeting the challenge presented by the Covid-19 pandemic.

1.2 At the time of writing this report, the Group is still awaiting the national planning guidance and notification of allocations for 2021/22. The draft plan 2021/22 is, therefore, constructed on the basis of a national briefing, detailed in the section below given by Julian Kelly (NHSE&I Chief Financial Officer) and his team. As part of this briefing the following broad timeframes were presented:

- Mid-March 2021: National planning guidance and notification of revenue / capital allocations issued.
- Mid-April 2021: system and organisational plans submitted to NHSE&I.

1.3 The Board of Directors is asked to consider and approve the draft version of the 2021/22 plan. Following receipt of the national planning guidance, notification of the allocations, and following the Group's discussion and agreement with system partners, a further report on the final version of the plan will be presented to the April Management Group meeting, before its expected submission to NHSE&I during April 2021.

2. Draft Planning Assumptions

2.1 The Draft planning assumptions are based on the National Briefing (25th February 2021).

2.2 The following are the key points presented at the briefing, together with some interpretation on areas not covered.

- It was confirmed that current emergency financial regime will continue into quarter 1 (Apr, May & June) 2021/22. There was a strong indication that it was almost certain this will continue into quarter 2 as well, and reference was made that the Central team are pushing the Treasury to ensure the emergency regime stays in place for the full 2021/22 financial year. This would mean the eventual post-covid financial reset would occur from 1 April 2022. However, other than the arrangements for quarter 1, the later quarter arrangements are still subject to confirmation.
- YTHFM's funding from the Trust will remain on the basis of fixed resource envelope going into 2021/22, with value being reset to reflect our actual spending in October, November and December 2020 (quarter 3 of the 2020/21 financial year). This will be adjusted for inflation and any anomalies in the new reference period, although this will not initially in quarter 1 cover cost of living pay inflation, as a decision on this is not expected until quarter 2 at the earliest. Once a cost of living award has been made, this will be backdated and funding made available to cover this in later quarters. The unitary payment will be increased accordingly to cover these adjustments.
- It is not clear from the briefing what will happen with covid funding going beyond quarter 1, but we should expect downward pressure as the Treasury seeks to

reduce the level of additional spending seen on Covid measures during 2020/21.

- The final position in relation to recovery activity funding has not been agreed with the Treasury but the ICS will get an additional allowance to support organisations that can go further. Further details are expected in the national planning guidance.
- It is expected that there will be no formal Cost Improvement Programme (CIP) requirement to be in place for quarter 1, although the DoH are going to be asking for productivity gains that improve and enhance elective activity recovery.
- There will be no growth funding for emergency levels, as the expectation from the Centre is that with the continuation of funding at recent 2020/21 quarter 3 levels, and including covid funding, this will cover any pressures.
- The absence of growth funding means that the Group's business planning process will remain suspended in the main part, certainly in the short term. Depending on the period on which the framework outlined for quarter 1 is extended over the rest of the financial year, it may be that the business planning process is suspended for the full year, especially if the regime continues and the financial reset button isn't pressed until April 2022. The management of the message throughout the Group is that we are unlikely to have any development funding during 2021/22 is going to be important.
- Any incremental investment that the Group chooses to make we will have to find equal and opposite expenditure to take out of the system. Rather than incremental investment we are going to need to manage a period of recycling existing spend to deal with the real priorities we feel we need to take forward.
- With regard to capital, we expect ICS allocations to be released shortly. It will then take a short time for these to filter out into the member organisations, but the Trust is well represented on the ICS groups that will be working with these allocations.

3. Income & Expenditure (I&E) Plans

3.1 YTHFM's draft I&E plans are based on the details from the national briefing described above. In summary, the draft I&E plan for 2021/22 is presented in **Appendix A**. An indicative full year is presented, although alongside it is the illustrative draft plan for quarter 1, on which the most certainty exists of the likely planning framework into 2021/22.

Income

3.2 Using the information from the draft briefing, income is based on an assessment of YTHFM's actual spend in quarter 3, 2020/21. All income figures have been inflated by 1% over the quarter 3 level, which have been kept deliberately low in recognition that any allocations received for quarter 1, 2021/22 will not cover pay awards.

Expenditure

3.3 Expenditure is based on the following:

- Base budget and reserves in 2020/21, to which are added cost pressures experienced during 2020/21 and those anticipated to arise during 2021/22.

- Inflation is included to meet primarily non-pay expenditure only. At this stage no provision is included for cost of living pay awards as per the briefing, however, once awarded it is expected that additional over that assumed will be made available to cover the additional cost.
- Additional provision is included to meet the unavoidable costs of pre-committed business cases.
- No efficiency target is included in the draft plan. The briefing received confirmed there would be no target for quarter 1 2021/22; with any ask for the remaining quarters being dependant on whether, and for how long the regime proposed for quarter 1 is extended throughout the rest of the year.
- At this stage no additional income or expenditure is assumed to meet activity beyond the underlying levels experienced during quarter 3 2020/21.

Balance Sheet & Cash Flow

3.4 The balance sheet and cash flow for (2021/22) is presented at **Appendices B and C**.

4. Investment

4.1 A number of investment business cases were prepared by YTHFM and submitted to the Trust for consideration. As new revenue investment funding is on hold, work needs to be undertaken to identify if some of the non-recurrent investment requirements could be funded via in year efficiency savings.

5. Cost Pressures

5.1 The Finance Manager over recent months has been provided with cost pressures for inclusion in the draft budget. However a final review needs to be undertaken to ensure all cost pressures have been captured. A meeting is scheduled with the Group's Deputy Director of Finance in March with the Directors.

6. Recommendations

6.1 The Board of Directors is asked to:

- Note and approve YTHFM's draft operational I&E plan for 2021/22.
- Note, that following receipt of the national planning guidance and allocations to be issued by NHSE&I, a final version of the full Operational Financial Plan will be received for approval.

Appendix A

York Teaching Hospital Facilities Management LLP
Summary Draft Income & Expenditure 2021/22

	2021/22	
	Full Year	Q1 Only
	£000	£000
Income		
York Teaching Hospital NHS Foundation Trust		
Unitary Payment		
Other income	-5,160	-991
Payroll expenditure	27,115	6,779
Non-pay direct expenditure	14,869	3,717
Non-pay indirect expenditure - pass through	6,603	1,651
Property rental charge	18,723	4,681
Lifecycle - backlog maintenance	1,900	475
Profit - lifecycle (3.5% on Direct pay and non-pay)	67	17
Profit - operations (3.5% on Direct pay and non-pay)	1,475	369
	65,591	**16,697**
Capital Revenue		
Capital Revenue	19,984	2,251
New Leases 2021/22	8,784	1,553
	28,768	**3,804**
	94,359	**20,501**
Other Income		
Catering - Scarborough	344	86
Catering - York	859	215
Energy & Sustainability	88	22
Estate Services - Scarborough	75	19
Estate Services - York	45	11
Health Safety & Security - Car Parking	1,741	136
Operational Facilities - Scarborough	193	48
Operational Facilities - York	153	38
Property Management	1,636	409
Trust Transport Department	27	7
	5,160	**991**
	99,519	**21,492**
Operating Expenditure		
Capital Expenditure		
Capital Expenditure	-19,885	-2,240
New Leases 2021/22	-8,740	-1,545
	-28,625	**-3,785**
Revenue Expenditure		
Payroll expenditure	-27,287	-6,759
Non-pay direct expenditure	-14,844	-3,669
Non-pay indirect expenditure - Utilities and Rates pass through	-6,456	-1,615
Annual lease rental	-18,723	-4,681
Lifecycle - backlog maintenance	-1,900	-475
Less: CIP	0	0
	-69,210	**-17,199**
	-97,835	**-20,985**
Operating Profit	**1,684**	**507**
Interest Receivable - Financial Debtor	1,211	283
Interest Receivable - Leases	461	93
Interest Payable - Loans	-1,406	-356
Interest Payable - leases	-459	-92
	-192	**-73**
Profit Before Tax	**1,492**	**435**
LLP Share of profit: allocated to YTHFT	-1,467	-429
LLP Share of profit: allocated to NHFML	-25	-6
Profit for the Year	**-0**	**0**
Retained Profit	**0**	**0**

York Teaching Hospital Facilities Management LLP
Balace Sheet
For the Year Ending 31 March 2022

	£000
ASSETS, NON CURRENT	
Finance Debtor - Built Assets	36,619
Finance Debtor - Leases	16,454
Other Debtors	0
Total Fixed Assets	53,073
ASSETS, CURRENT	
Inventories - Stock	598
Inventories - Work in Progress	16,236
Interest Receivable	0
Trade Receivables	15,342
Other receivables	2,216
Cash in Commercial Accounts/in Hand/Other	1,466
Total Current Assets	35,858
CURRENT LIABILITIES	
Trade and Other Payables: Capital	-1,461
Trade and Other Payables: Non-Capital	-6,083
Current Tax Payables	-1,262
Borrowings	-1,618
Leases	-2,877
Provisions	0
Total Current Liabilities	-13,301
TOTAL ASSETS LESS CURRENT LIABILITIES	**75,630**
NON CURRENT LIABILITIES	
Trade and Other Payables: Non-Capital	0
Borrowings	-60,466
Non current lease	-11,151
NON CURRENT LIABILITIES	**-71,617**
TOTAL ASSETS EMPLOYED	**4,013**
PARTNERSHIP FUNDS	
Partners Debt	25
Retained Profit	3,988
TOTAL TAXPAYERS' AND OTHERS' EQUITY	**4,013**

York Teaching Hospital Facilities Management LLP
Cash Flow
For the Year Ending 31 March 2022

	£000
CASH FLOW FROM OPERATING ACTIVITIES	
Surplus/(deficit) after tax	1,026
Non Cash Income and expense	
Movement in Inventories	-9,130
Movement in Financial Debtor	-25,748
(Increase)/decrease in Trade receivables	319
(Increase)/decrease in Other receivables	0
Increase/(decrease) in trade payables	0
Increase/(decrease) in other Capital Trade payables	0
Increase/(decrease) in other liabilities	0
Net cash generated from / (used in) operations	**-33,533**
CASH FLOW FROM FINANCING ACTIVITIES	
Loans from York Teaching -Capital funding received	29,015
Loans repaid	-1,042
Leases - New	8,740
Lease payments	-2,877
Interest received	1,672
Interest loans	-1,405
Interest leases	-459
Partners Equity	-25
Net cash generated from/(used in) financing activities	**33,619**
Increase/(decrease) in cash and cash equivalents	**86**

Cash and cash equivalents at start of period	1,380
Net increase/(decrease) in cash	86
Cash and cash equivalents at end of period	**1,466**

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NHS
York Teaching Hospital
NHS Foundation Trust

Audit Committee – March 2021

Key Issues Report

Report Date: 19.03.2021		Report of: Audit Committee Chaired by: Jenny McAleese
Date of last meeting: 09.03.2021		Membership Numbers: Quorate
1.	Agenda	The Committee considered an agenda which included the following: **YTHFM** • Internal Audit progress report and review of outstanding recommendations • Update on audit for 2019/20 • Internal Audit draft plan for 2021/22 • Scheme of Delegation, Standing Financial Instructions and Reservation of Powers **Trust** • Counter Fraud progress report and plan for 2021/22 • Draft Committee objectives for 2021/22 • Report from Quality Committee, Resources Committee and Data Quality Group • Update from External Audit and approval of Audit Strategy Memorandum • Internal Audit progress report and review of outstanding recommendations • Discussion of Head of Internal Audit Opinion • Internal Audit draft plan for 2021/22 • Plans for preparation of Annual Governance Statement • Progress on work to improve governance • Plans to develop a Risk Management Strategy, review the Risk Management Framework and re-model the BAF and CRR.

2.	**Alert**	The Committee wishes to alert the Board to the following: **For Approval** • Audit Committee recommends that the Board approve the Scheme of Delegation, Standing Financial Instructions and Reservation of Powers for YTHFM **For Decision** • The Committee is concerned that the escalation process from Committees does not always work as items are just noted rather than dealt with. **For Discussion** • Audit Committee is not assured that there is a robust system in place to manage proactively the Trust's relationship with the CQC and the whole Journey to Outstanding. This should be intrinsic to the work of both the Executive Committee and the Board and include work on the culture of the organisation. • In the Committee's discussions around Risk Management in the Trust, it noted the suggestion of a Risk Committee and very much supports and encourages this. It also noted the plans that responsibility for risk sits with the newly created post of Associate Director of Corporate Governance and very much supports the idea that the responsibility for all aspects of risk sits with one person. • In all its discussions around governance, learning and Quality Improvement, the Committee noted the cultural challenge in terms of getting staff engagement.
3	**Assurance**	The Committee received assurance that: • The Scheme of Delegation, Standing Financial Instructions and Reservation of Powers had undergone a thorough process, had been seen by both the YTHFM Management Group and Andy Bertram and Simon Morritt and were consistent with those of the rest of the Group. • The Internal Audit Plans for 2021/22 for both YTHFM and the Trust have been prepared on the basis of a risk approach and after consultation with the appropriate members of staff. • Action plans resulting from internal audits are monitored and the number of outstanding actions is small. • Where limited assurance is received, the audit sponsor is held to account by means of a meeting with Internal Audit and Andy Bertram as Deputy Chief Executive. • There has been a noticeable and welcome improvement in the engagement of YTHFM with internal audit and the whole governance agenda since the appointment of Delroy

		Beverley in 2020. • The external audit for the Trust is on track and the necessary handover has taken place between Grant Thornton and Mazars. • The fee for the audit is in line with the bid. • There are plans in place to address the weaknesses identified in governance systems and good progress is being made with these. • The licence restrictions had been lifted and the Trust has now been placed back in category 2. • There are plans in place to review the Risk Management Framework, the BAF and the CRR to remedy their deficiencies. We'll be receiving an update at our next meeting.		
4.	**Advise**	The Committee wishes to advise the Board of the following: • The Committee used the "Purple Box" for the first time and this worked really well, serving to reduce the length of the essential papers. We remain committed to reducing our agenda papers to a maximum of 150 sides. • The Committee was not able to review the Assurance Report in relation to the HPV event in YTHFM as insufficient progress had been made. Further work will be done off line and this will be picked up at our next meeting. • The Head of Internal Audit Opinion is likely to make reference to the Governance Framework, Risk Management, the BAF and CRR and Health and Safety.		
5.	**Risks Identified**	The Committee identified no new risks.		
6.	**Report compiled by**	Jenny McAleese		

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NHS
York Teaching Hospital
NHS Foundation Trust

Board of Directors – 31 March 2021
Group Audit Committee Minutes – 09 March 2021

Present:

Mrs J McAleese (JM), Non-executive Director (Chair)
Mr D Watson (DW), Non-executive Director
Mr S Holmberg (SH), Non-executive Director

In attendance:

Mr A Bertram (AB), Finance Director
Mr S Kitching (SK), Head of Corporate Finance & Resource Management
Mrs H Kemp-Taylor (HKT), Head of Internal Audit
Mr J Hodgson (JH), Internal Audit Manager
Ms E Shippey (ES), Assistant Audit Manager
Ms M Hall (MH), Counter Fraud Specialist
Mr D Beverley (DB), YTHFM Managing Director
Ms P Gilyard (PG), YTHFM Director of Resources
Mrs C Johnson (CJ), Deputy Director of Patient Care
Mr B Anwar (BA), Interim Risk Manager
Mr M Dalton (MD), Engagement Lead, Mazars
Mr M Outterside (MO), Senior Manager, Mazars
Ms J Hall (JHa), Interim Foundation Trust Secretary
Mrs T Astley (TAA), Assistant to FT Secretary, minute taker

Observers:

Mr M Reakes, Public Governor for City of York
Mrs M Jackson, Lead Governor
Mrs J Anness, Public Governor for Ryedale & East Yorkshire
Mrs R Abeysekera, Public Governor for City of York
Mr I Mackay Holland, Public Governor for Scarborough
Mr G Richardson, Stakeholder Governor for University of York

21/01 Apologies for Absence and quorum

JM welcomed everyone to the meeting and introduced JHa as the new Interim FT Secretary and BA as the new Interim Head of Risk. She also welcomed the governors as observers.

JM explained the new Purple Box which will be used for additional information to support the main agenda. The aim is to reduce the size of the agenda.
The main items that JM directed the Audit Committee to focus on were External Audit, Internal Audit, the Head of I.A. Opinion, and looking ahead to next year regarding the Internal Audit and Counter Fraud work.

No apologies were received. The meeting was declared as quorate.

21/02 Declarations of Interests

There were no new declarations of interests.

21/03 YTHFM Internal Audit Progress Report

JH reported that the report had been presented to the Management Group on 22 February for review. Changes to the audit plan, as stated in the report, required approval by the Committee.

DW referred to a discussion at Resources Committee around governance arrangements in the LLP and asked about the reasoning behind why the Committee was involved in the audit matters of the LLP when it had its own governing body and Board. In response it was noted that when the LLP was initially set up it had been agreed that rather than establish its own Audit Committee, audit matters would be dealt with via the newly named Group Audit Committee. It was further noted the governance arrangements for the LLP had been discussed at the Executive Performance Assurance Meeting. AB agreed to share the report.

HKT added that in her view as a wholly owned subsidiary, Internal Audit needed to report through to this Committee on the work they were doing regarding YTHFM. She confirmed that her Head of Internal Audit Opinion could have an impact on the Group. JM added that it had been agreed to hold one meeting with an allocated slot for LLP business.

JM asked for assurance around the Procurement and Residential Accommodation follow ups. It was noted a Procurement Task & Finish Group had been set up and identified those contracts that had been extended, any non-compliant contracts would now go through a full tender process. The team had received the necessary training and were working closely with the Procurement Team.

JM noted the 100% compliance rates, specifically on KPIs, noting it reflected the engagement from the LLP management team.

AB referred to the limited assurance meetings in which he attends as the Deputy Chief Executive and reported that under the current leadership there had been a marked improvement in engagement with the internal audit process adding that a different tone had been set at the top, and good progress was being made.

The Committee:

- **Received the Internal Audit Progress Report and noted its contents.**
- **Approved the changes to the 2020/21 Audit Plan.**

21/04 YTHFM Internal Audit Draft Operational Plan

JH referred to the Audit Plan Summary highlighting the detailed planning process involving the YTHFM Management Team focussing on risks and issues that were affecting the LLP. The Committee were reminded of issues raised by DB which Internal Audit had been working on throughout the year including 16 days allocated for additional management

requests as and when issues were identified. He stated that this year they have undertaken a joint audit on Health & Safety using the CIA process which was being finalised and will be presented to the Committee in due course.

A discussion took place on how the areas of work were selected for Internal Audit to undertake, the range and frequency of audits, and the deferral process. HKT added that the Internal Audit Programme was risk based and linked to the Trust's BAF, CRR and any changes to systems, etc. HKT explained the process in detail stating that the aim was to give the most meaningful assurances. Any deferrals would be reported in the Progress Report. Areas that had been deferred in previous years were included in the risk assessment process. DB added that over the next couple of years there would be changes to portfolios and the current operating model.

In response to a question on Internal Audits agility to respond, it was noted that the 16 days allocated allowed flexibility to respond and if additional days were needed this was agreed in consultation with the Trust's management.

JM was pleased to see the Management of Contractors was on the plan for next year and asked if staffing, recruitment, disciplinary procedures should be included. It was noted this will be covered in the Health & Safety report that was due to come to the Committee.

The Committee:

- **Approved the IA Operational Plan for the LLP for next year.**

21/05 YTHFM Outstanding Audit Recommendations Report

JH presented the report and updated on the outstanding actions noting that only 1 recommendation was outstanding. PG added that the Procurement follow up was currently taking place and will capture progress against outstanding recommendations.

JM stated that this was another example of where, under DB's leadership, the LLP had made tremendous strides forward in response to implementing action points resulting from audits.

The Committee:

- **Received the report and noted the continuing ability to address action points.**

21/06 YTHFM ISA 260 & Accounts Update

PG provided an update on the 2019/20 accounts which were due to be signed off at a the Management Groups meeting on the 22 March 2021 for submission to Companies House by 31 March 2021. She added that planning had already started for the 2020/21 accounts with Mazars.

DB referred to the handover process from Grant Thornton to Mazars noting that full access had been given to Grant Thornton's files and there was nothing of concern for the Committee.

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The Committee:

- **Received the update and noted that the accounts will be submitted to Companies House in line with statutory requirements.**

21/07 YTHFM Feedback from Management Group

DB provided feedback from the Management Group which included the internal audit reviews and HSE investigation. He added that the LLP Chair has been quite congratulatory on the progress made with Internal Audit. He added that the recent away day had looked at risk management as an effective part of the way business is carried out in the LLP. It was noted that BA will be coming to the April Management Group meeting to present a report on risk management.

21/08 YTHFM SFIs, SoDs & Reservation of Powers

The Audit Committee received the report which set out the process undertaken to review and update the LLP Scheme of Delegation and Reservations of Powers following the appointments of a number of positions within the LLP management structure.
AB explained and provided assurance to the Committee on the process to review the Scheme of Delegation.

AB reported that following a meeting with Chief Executive and DB there were further proposed changes that had been agreed:

- The Director Team, in their role of prime budget holders, limit to be set at £50k, in line with the Trust's CG Directors/Managers.
- The Managing Director's limit to be set at £100k.
- Anything above £100k will be subject to the Trust's processes.
- A review will take place in a year's time with AB/DB/Chief Executive.
- Only the Managing Director's terms of service were a matter for the Remuneration Committee The LLP director team. were on the A4C pay scale and therefore were subject to the national terms and conditions.
- The Scheme of Delegation referenced a Head of HR and a Company Secretary. DB advised these were functions carried out by the Director of Resources.

The Audit Committee were asked to agree the changes and recommend their approval to the Trust Board. It was noted that future reviews would be through EPAM.

DW referred to segregation of duties within the procurement system and asked for assurance that these proposals did not impact that. AB gave assurance that the segregation of duties was built in to the Trust's procurement system, Oracle, which the LLP used, with the same hierarchy.

The Committee:

- **Recommended to the Board for approval the SFIs, Reservation of Powers and the Scheme of Delegation subject to the changes outlined above.**
- **Was assured that a robust process had taken place in reviewing the documents.**

21/09 Discussion of any issues

DB wished to give his professional and personal thanks to HKT/JH and all of Audit Yorkshire that have supported him throughout the past 12 months.

21/10 Counter Fraud Progress Report

The Committee received the report of the LCFS noting there had been a drop in the number of referrals (that are taken to investigation level) compared to last year – four compared to ten in 2019/20. It was noted that this was in line with the national picture and could be a consequence of the pandemic and different ways of working. It was noted the National Fraud Agency (NFA) were reviewing the findings. Audit Yorkshire were doing a piece of work around sources of referrals to establish patterns. It was noted the biggest source of referrals in the Trust was HR.

JM referred to the informative monthly bulletins. MH added that during the pandemic they had replaced the quarterly newsletter. The Committee noted the value of the bulletins to get the message out about fraudsters.

The Committee discussed the report and noted that one of the common themes was working whilst off sick. There was also concern with people working whilst in isolation due to the pandemic and salary diversion scams. It was noted that a recommendation to the Trust to mitigate against salary diversion was to use ESR self-service which allowed staff members to change their own details, there had been some issues with engaging staff in this process.

The Committee:

- **Received the report and noted its contents.**

21/11 Annual Counter Fraud Plan 2021/22

The Committee received the report which set out the Annual Counter Fraud Plan 2021/22 which was based on the new standards. It was noted that the new standards had only recently been introduced and the Trust had to report its compliance as at 1st April. She added that nationally there was recognition that most Trusts would report non-compliant this year. It was suggested that the Standards should be discussed at the Committee's Away Day in July. It was noted the Trust would be non-compliant in 3 of the 13 standards:

- CFA strategy
- Risk Assessments
- Outcome based matrix

In response to a question on how Counter Fraud worked with internal audit to avoid duplication of work and if there were areas where the Trust was over or under controlled, it was noted that they worked closely together to avoid overlaps and information received from CFA or elsewhere was shared with Internal Audit. With reference to the controls element of the question, AB added that Internal Audit frequently identified management control weaknesses but could not recall any audit that had come to a conclusion around over control. HKT added that during the pandemic they did step some of the controls down, particularly in Procurement with regards to PPE as to whether certain steps could

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be stepped down safely. JH added that when auditing they looked at system efficiency and how controls were operating as opposed to over control.

AB referred to the CQC Use of Resources Assessment undertaken by NHSE/I last year that placed pressure on the Trust to reduce the number of audit days (including Counter Fraud) by a significant number. The benchmarking data showed that the Trust was an outlier in the number of audit days it was buying even though it showed that the Trust was securing excellent cost per day rates. In the Counter Fraud Plan there was no material changes proposed for 2021/22. AB recommended that, given the pandemic restrictions, which had resulted in a significant number of audits not taking place, it was not the time to review and step down further. AB, MH and the LCFM had met to discuss the plan and therefore AB recommended it be adopted.

The Committee:

- **Approved the 2021/22 Counter Fraud Plan.**

21/12 Patient Travel Expenses Policy

AB reported that the policy was an outstanding Audit recommendation. The Committee agreed to ratify the policy.

The Committee:

- **Ratified the Patient Travel Expenses Policy.**

21/13 Minutes of the last meeting

The minutes of the meeting held on 1 December 2020 were approved as a true record.

DW applauded TA for the huge amount of work that goes into the minutes and supported the direction of travel to reduce minutes across all meetings in the Trust.

21/14 Action Log

- Themes extracted from concerns - HKT/JH informed this was in progress.
- HPV Report – postponed until next meeting.
- Central Repository – HKT informed this was in progress.
- Job Planning and assurance required by Quality Assurance Committee – SH informed that he will continue to pursue this with the Medical Director.
- Committee objectives – on agenda.

The Committee noted that all other actions had been completed.

21/15 Feedback from the Board on Escalated Items

JM reported on a meeting she, DW and SH had with the Trust Chair where they discussed a number of matters in relation to governance including risk management, the admin of meetings, agenda papers, minutes, etc. The Committee further discussed the need to ensure that items escalated to Board from the Committees was given due time and consideration. It was noted that this was part of the work JHa would be undertaking. It

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was further noted that the advert for the Associate Director of Corporate Governance had been advertised.

The Committee:

- **Noted that it was work in progress on a number of issues JM/DW/SH raised with the Chair.**
- **Had a useful discussion about how the system could be improved so that escalated items to Board that need discussion/decision had the appropriate time allocated on the Board agenda.**

21/16 Draft Committee Objectives

The following suggestions were given:

- Improve Board engagement with sub committees
- Make the Committee more visible and accessible to teams, simplifying and demystifying risks, governance and assurance

Action: HKT/SK/AB to develop the Committee's visibility and accessibility to other teams within the organisation.

21/17 Quality Committee update

SH stated that future meeting consideration should be given to providing a summary of the escalated items from each of the sub-committees The Committee agreed.

JHa and CJ advised on work they had undertaken on a revised template for escalation reporting which was being trialled at QPAS.

21/18 Resources Committee update

DW provided an overview of the committee's key concerns:

- Culture within the Trust
- The need to upgrade the Trust's IT systems and funding availability
- Reduction of the maintenance backlog
- Priorities for Capital Expenditure
- Risk
- Governance and challenge

Action: JH/CJ to discuss with DW/SH how to present escalated items in a different way.

Action: DW/SH to provide a summary from meetings that have taken place in between the Group Audit Committee meetings.

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21/19 Data Quality Group update

AB advised that the dates for future meetings had now been agreed. DW requested and it was agreed that that future meetings would be held virtually.

21/20 Internal Audit Progress Report

AB provided assurance to the Committee that he, JH and ES met on a regular basis to review progress, adding his confidence for a meaningful Head of Internal Audit Opinion at the end of the year.

JM referred to the ceiling of care performance noting it had improved but had received a limited assurance audit. She added that the Medical Director believed the problem lay with the Ceiling of Care Policy that needed re-writing, coupled with the fact that decisions were not always recorded.

The Committee discussed the limited assurance meetings, chaired by the Director of Finance noting that the Chief Executive only attended those meetings where the Director of Finance was the audit sponsor, it was agreed that the report would be amended to reflect this.

DW referred to staff training issues in relation to Basic Life Support (BLS) where 563 clinical staff were recorded overdue with some dating back to 2010 and asked how overdue Stat Man training was reported and escalated. SH added that the level of compliance from medical and dental staff regarding Stat Man training was an issue frequently discussed at the Quality Committee. AB added that the Director of Workforce had recently presented a business case to the Executive Committee for additional investment in BLS/ALS trainers which had been agreed. It was agreed that the BLS issue should be escalated to Board.

The Committee discussed the Head of Internal Audit Opinion and HKT highlighted the support given to the organisation, including: Covid costs recovery, governance and assurance, finance governance around Covid arrangements, current risks and deployment of staff.

HKT highlighted the key risk areas that will feature in her Head of Internal Audit Opinion giving assurance that she would be able to provide a meaningful judgement at year end.

JH referred to a recent meeting with the Chief Nurse on Duty of Candour and was assured that 90% of the recommendations had been implemented. This would be validated and removed from the Head of Internal Audit Opinion. He added that the same process would be employed with regard to recommendations resulting from the Safeguarding audit recommendations.

The Committee:

- **Noted the report and useful update on the Head of Internal Audit Opinion.**
- **Acknowledged areas of weakness and that plans were place to address them.**
- **Acknowledged that HKT will be able to provide a meaningful Head of Internal Audit Opinion.**
- **Approved the proposed changes to the 2020/21 audit plan.**

21/21 Approve the Internal Audit Plan and fee for 2021/22

The Committee noted and approved the Internal Audit Plan and fees for 2021/22, in particular noting this had been developed in conjunction with the executive team. In particular he highlighted the discussion with the Freedom to Speak Up Guardian and that dates had been set for this piece of work.

DW suggested the development of an assurance map noting this would be part of the work JHa would be taking forward.

The Committee agreed that the number of Internal Audit days would not be reduced fro 2021/22.

The Committee:

- **Approved the 2021/22 Internal Audit Plan**
- **Agreed with the decision not to reduce the number of Internal Audit days for 2021/22**

21/22 Internal Audit Outstanding Recommendations Report

JH updated that the number of outstanding recommendations had reduced significantly since the last meeting. There were 4 partially outstanding and 2 that had not yet been implemented. He highlighted that there had been quite a few changes to the implementation dates due to Covid-19 and operational matters. Moving forward, the revised report would show any changes and where dates have been pushed back.

The Committee:

- **Received the report and noted with pleasure the improvements.**

21/23 Third Party Assurance

The Committee:

- **Received the report and noted its contents.**

21/24 BAF

JHa reported that she and BA were working together to develop a new BAF. Following her recent meeting with the Chief Executive, an update would be brought to the Board Away Day in April.

DW asked about the time frame for a Risk Committee to be put in place. In response JHa advised that it was in discussion at present. JM added that a Risk Committee should be executive led. SH asked for it not to be set up in isolation but had a very clear place within the wider assurance/risk/audit framework. BA added that it was a proposal he will put forward as part of the strategy.

The Committee:

- **Received the report and noted its contents.**

21/25 AGS

JH reported that the Annual Reporting Manual 2020/21 had been published in February. She was working with colleagues to collate the information required. She will also be speaking with HKT. A draft AGS will be presented at the May meeting. The Chief Executive will be present at the June Year End meeting to discuss the AGS.

The Committee:

- **Received the update and will received a draft AGS in May.**
- **Noted that the Chief Executive will attend the June Year End meeting.**

21/26 Governance Progress Report

CJ presented a report which provided an update on the revised governance structures. She described how the culture within the organisation in relation to governance was being embedded as well as peoples understanding of governance.

The Committee noted the work being done around the CQC recommendations, including the implementation of a Quality Regulations Group, lifting of the CQC conditions and being taken off Quality Board monitoring. It was noted she was working closely with JHa/BA to strengthen governance processes throughout the organisation.

In response to a question on what worried CJ most it was noted that she felt this was in relation to the CQC and that the Care Groups did not yet fully understand what was required of them in terms of putting the framework in place and be assured of an 'outstanding' outcome meant.

DW welcomed the work CJ was doing. He referred to the "Journey to Outstanding" phrase which echoed the summary of conversations that he, SH and JM had with the Chair over the Christmas period and believed this was something that should be echoed more throughout the Trust.

SH congratulated CJ and the wider team for the work being carried out around risk, the BAF, etc adding this should be a priority within the organisation.

The Committee:

- **Received an update and noted the progress being made.**
- **Noted the cultural challenge.**
- **Noted that CJ was most concerned about the CQC now that the organisation was not being so actively monitored.**

21/27 Risk Management Framework & System

The Committee received the report of the Head of Risk which described the work being undertaken to progress risk management throughout the organisation. The Committee noted that the over the next 3-6 months a revised risk management framework and strategy would be developed. An implementation plan would be developed to support the work and ensure risk was embedded across the organisation. The Committee supported the approach and the timeline described.

The Committee:

- **Received and Noted the report**

21/28 External Audit Strategy Memorandum (ASM)

MD explained the purpose of the ASM and the relationship between the External Auditors and the Trust.

In response to a question from DW on what "going concern" meant in the context of the NHS. MD explained the process and requirements to prepare accounts on a "going concern" basis. AB explained the national guidance that was required to be followed and ensure continuity of services should an event occur. He added that a report would be presented to Board confirming the Trust was a "going concern".

MD referred members to the following points in the report for noting: -

- Due to the pandemic NHSI did not require Trusts to commission external assurance on its Quality Report and therefore External Audit will not be undertaking any such work.
- The proposed audit fee was very much in line with the contract.
- No non-audit services were planned.
- Confirmed the independent and objectivity of the audit.

MO referred to the section on significant risks, key audit matters and other key judgement areas and highlighted some of the risks, including management overrides, revenue recognition, property valuations and the work planned to mitigate them. He referred to the information contained in the Materiality and other Misstatements section explaining the reporting threshold in thatit was set £245k which meant any errors found at and above that level would be reported. He referred to the Value for Money section noting the focus would be on the licence and the CQC.

AB advised that in respect of the CQC the Trust had applied for the notice to be lifted and were awaiting feedback. In respect of NHSI, all licence breaches have been lifted. He explained that NHSE/I used a single oversight framework, with a segmentation approach scoring of 1-4, in which they place Trusts. He explained that following the licence breach the Trust had been moved to segment 3. However he confirmed that now the breach had been lifted the Trust had been moved back into segment 2.

A discussion took place around the key changes to the Value for Money in accordance with the new Code of Audit Practice.

BA referred to the summary risk assessment and asked if there was any movement in those risks from 12 months ago. JM replied that these risks were stated on any audit plan at this stage.

AB referred to the fees and was happy to accept this.

The Committee:

- **Received the ASM and confirmed the audit fee.**
- **Welcomed the explanation of the new VFM arrangements.**

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- **Noted with pleasure that the licence restrictions have been removed and the Trust has now been placed back into segment 2.**

21/29 External Audit Progress Report

The Committee:
Received the report and noted is contents.

21/30 Any Other Business

There was no other business.

21/31 Items to be escalated to Board

The following items will be escalated to Board: -

- LLP, SFIs, Scheme of Delegation and the process these have been through;
- Concerns about the escalation process and how it worked across all the committees;
- CQC – making sure the process for managing the relationship proactively is as it should be and the issue around "journey to outstanding";
- Welcome the reintroduction of a Risk Committee and pleased to see that risk will sit together under the new FT secretary role;
- Raising the BLS training;
- Note the Head of Internal Audit Report and the Opinion;
- All on track with External Audit;
- Great progress in relation to the governance agenda, but raising particularly the cultural challenge and the need to ensure QI's were on everyone's radar, and the plans to update the BAF/CRR;

21/32 Review of the Work Programme

Following discussion it was noted that JM and JHa would review the work programme taking into consideration the points raised by DW.

21/33 Review of the Meeting

- It has been a great meeting, well chaired, huge contributions from everybody. Area for improvement would be more punchy papers/minutes;
- Interesting meeting. Really pleased with the positive feedback from DB/AB so will make sure that is disseminated throughout the I.A. team. Improvement would be to reduce the length of papers submitted.
- Enjoy hearing different opinions. Make meetings shorter.
- Good discussion, like the challenge coming from the NEDs. Negative would be meeting on webex at it lengthens out the meeting in the way people feel.
- Good challenges and good discussion. Should more executive members be invited to the meeting to be held accountable.

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- Really great discussions and feel that the members of the Committee were all of the same mind on issues. Negative would be the length of meeting and keeping engaged.
- Like the purple box but think that the agenda pick is still quite lengthy.
- Need to make more use of the purple box. Like the challenge about the Committee becoming more visible within the Trust.
- Purple box is a really good addition. Need clarity of what goes in there.
- Enjoys the diverse membership of the Committee. Reports need to be written to reflect the whole audience who will read them and they need to be clearer about what is expected.
- Enjoyed the counter fraud discussion. Miss the more detailed discussions around issues highlighted by I.A.
- Quite interesting to hear the topics of information. Negative would be the technology.
- Really well chaired, friendly atmosphere. Liked the explanation about "going concern".
- Really inciteful and see the challenges the Committee has. Challenge as a governor was the difficulty to review NEDs during a 4-hour meeting.
- Very good meeting. Agree with the length of the meeting being too long.
- It's nice to be able to participate. Would like to do this throughout the year.

21/34 Time and date of the next meeting

The next meeting will be held on 11 May 2021 at 9.00am via Webex.

Action Log

No	Meeting Date	Action	Owner	Due Date	Completed
1	01.12.20	Work with CJ and SH to look at themes coming out of speak ups.	HKT/ JH	Mar 21	In progress
2	01.12.20	Present an Assurance Report at the next meeting on the HPV incident that took place in September 2019.	HKT/ JH	~~Mar 21~~ May 21	
3	01.12.20	Discuss implementing a central repository (using datix) where recommendations could be tracked and followed up.	HKT/ JH/CJ/ PG	Mar 21	In progress
4	01.12.20	Contact the Medical Director to discuss job planning and assurance required by the Quality Committee.	SH/JH/ HKT	Mar 21	In progress
5	09.03.21	**Discuss with DW/SH how to present escalated items from the sub-Board committees in a different way.**	JH/CJ	May 2021	

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6	09.03.21	**Provide a summary from sub-Board meetings that have taken place in between the Group Audit Committee meetings.**	DW/SH	May 2021	
7	09.03.21	**Develop the Audit Committee's visibility and accessibility to other teams within the organisation.**	HKT/SK /AB	May 2021	

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York Teaching Hospital Facilities Management

Board of Directors – 31st March 2021
Standing Financial Instructions, Reservation of Powers and Scheme of Delegations

Strategic Goals:

☒ **to deliver safe and high quality patient care as part of an integrated system**
☒ **to support an engaged, healthy and resilient workforce**
☒ **to ensure financial sustainability**

Recommendation

For information	☒	For approval	☒
For discussion	☒	A regulatory requirement	☐
For assurance	☐		

Purpose of the Report

To provide the Board of Directors with the updated Standing Financial Instructions, Reservation of Powers and Scheme of Delegations for approval.

Executive Summary – Key Points

The Standing Financial Instructions, Reservation of Powers and Scheme of Delegations for YTHFM LLP have been reviewed and proposed changes made to reflect the new management structure, the levels of delegation and to ensure the reference material is up to date.

The documents were approved by the Audit Committee on the 9th March 2021.

Recommendation

The Board of Directors is asked to approve the revised Standing Financial Instructions, Reservation of Powers and Scheme of Delegations.

Author: Penny Gilyard, Company Secretary/Director of Resources
Director Sponsor: Delroy Beverley, Managing Director

1. Introduction and Background

1.1 The Standing Financial Instructions, Reservation of Powers and Scheme of Delegations have been reviewed jointly with the Trust's Deputy Finance Director to reflect the new management structure with YTHFM LLP.

1.2 The draft documents were presented and approved by the LLP Management Group on the 22nd December 2020 and the Audit Committee on the 9th March 2021.

2. Detail of Report

Standing Financial Instructions

2.1 The key changes proposed for the SFIs are:

- Updated to reflect the new management structure within the LLP
- LLP does not have Standing Orders but a Members Agreement
- Appendix 1 - EU Thresholds updated to match the Trust's procurement guidelines

Reservation of Powers and Scheme of Delegations

2.2 The key changes proposed are:

- Updated to reflect the new management structure within the LLP
- LLP Directors are Prime Budget Holders, Service Leads are Delegated Budget holders
- Level of authority for Business Case Revenue Investment included for LLP Delegated budget holders up to £50k, Directors to the maximum value of up to £50k and £100k for the Managing Director.
- Removal of the section relating to the Remuneration Committee for Directors (Directors on A4C T&Cs). The Remuneration Committee is only applicable for the Managing Director post.
- Standing Financial Instructions reference - updated
- LLP Finance Manual reference - updated

3. Next Steps

3.1 The Audit Committee approved the documents at its meeting in March. Once all approvals are obtained these documents will be communicated to LLP staff and provided to the LLP Finance Manager.

4. Detailed Recommendation

4.1 The Board of Directors is asked to approve the revised Standing Financial Instructions, Reservation of Powers and Scheme of Delegations.

York Teaching Hospital
Facilities Management

STANDING FINANCIAL INSTRUCTIONS

Author:	**Director of Resources**
Owner:	**Managing Director**
Publisher:	**Director of Resources**
Date of Issue:	**December 2020**
Version:	**2~~1~~**
Approved By:	**Management Group, Trust Audit Committee and Board of Directors**
Review date:	**December 2021 (annually, ~~along~~ with Reservation of Powers and Scheme of Delegation)**

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1. INTRODUCTION

1.1 General

1.1.1 York Teaching Hospital Facilities Management (hereafter referred to as the ‘LLP’) was incorporated in England and Wales as a limited liability partnership on 7 March 2018 under the Limited Liability Partnerships Act 2000; and is a wholly owned subsidiary of the York Teaching Hospital NHS Foundation Trust (hereafter referred to as the ‘Trust’).

1.1.2 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. As a wholly owned subsidiary of the Trust the code of accountability applies equally to the financial matters of the LLP. 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 LLP. They are designed to ensure that the LLPs 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 in relation to, and agreed by the LLP.

1.1.3 These Standing Financial Instructions identify the financial responsibilities that apply to everyone working for the LLP 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 Director of Resources ~~Deputy 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 ~~Trusts~~ Director of Resources ~~Deputy 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 LLPs Members Agreement.~~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 Trust’s Audit Committee for referring action or

ratification. All members of the Management Group and staff have a duty to disclose any non-compliance with these Standing ~~—~~Financial Instructions to the Director of Resources~~ or the Trusts Deputy Finance Director,~~ ~~or Group 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 LLP. He/she shall be responsible for ensuring the proper stewardship of public funds and assets. In accordance with the Act, this shall be the Managing Director.

"**Authorisation"** means the authorisation of the Trust by NHS Improvement, the Independent Regulator of NHS Provider Trusts

"**Board of Directors**" means the Chair, N~~n~~on-executive D~~d~~irectors and the E~~e~~xecutive D~~d~~irectors of the Trust, appointed in accordance with the Trust's Constitution.

"**Budget**" means a resource, expressed in financial terms, proposed by the Management Group, and agreed by the Trust's Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions of the LLP. This can be income, capital or revenue expenditure.

"**Budget Holder**" means the M~~m~~anaging D~~d~~irector or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the LLP.

"**Chair**" is the person appointed in accordance with the Constitution to lead the Trust's 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.

"**Commissioning**" means the process for determining the need for and for obtaining the supply of Facilities Management related services from the LLP.

"**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.

~~**"Deputy Finance Director"** means the lead finance officer for the LLP, under the reverse SLA agreed between the Trust and LLP.~~

"**Group Finance Director**" means the chief finance officer of the Trust.

"Director of Resources" (LLP) means the lead officer with responsibility for the Resources directorate which includes finance within YTHFM.

"**Legal Adviser**" means the properly qualified person appointed by the LLP to provide legal advice.

"**LLP**" means York Teaching Hospital Facilities Management, a Limited Liability Partnership incorporated in England and Wales on 7 March 2018 under the Limited Liability Partnerships Act 2000.

"**Management Group**" means the Management Group of the LLP constituted in accordance with clause 5.1 (Constitution of the Management Group) of the Members Agreement dated 7 March 2018 between York Teaching Hospital NHS Foundation Trust, Northumbria Healthcare Facilities Management Limited, and York Teaching Hospital Facilities Management. The Management Group comprises 3 representatives from York Teaching Hospital NHS Foundation Trust, an independent chair; and 1 representative from Northumbria Healthcare Facilities Management Limited.

"**Managing Director**" means the chief officer of the LLP.

"**Master Services Agreement**" means an agreement entered into between the Trust and the LLP to establish a long term partnering relationship for the delivery of services in connection with estates and facilities management, project feasibility, inception design and management.

"**Members**" means York Teaching Hospital NHS Foundation Trust and Northumbria Healthcare Facilities Management Limited, and any other person admitted from time to time as a member of the LLP, who wish to participate as members in the LLP for the purposes of carrying on the Business.

"**NHS England and Improvement**" means the ~~newly merged~~ Independent Regulator of NHS commissioning and provider organisations~~Provider Trusts~~.

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

"**Officer**" means employee of the LLP or any other person who exercises functions for the purposes of the LLP other than as a representative of the LLP.

"**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 Trust's Chief Executive and Trust's Finance Director are mandated to monitor and ensure compliance with these Directions

"**SFIs**" means Standing Financial Instructions.

"**MA's SOs**" means Members AgreementStanding Orders.

"**Representatives**" means:

(a) the Trust Representatives; and

(b) the NHFML Representative,

and Representative shall mean any of them as the context may require.

"**Trust**" means York Teaching Hospital NHS Foundation Trust.

1.2.2 Wherever the title Managing Director, Deputy Finance Director, Director of Resources or other nominated officer is used in these instructions, it shall be deemed to include such other 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 LLP when acting on behalf of the LLP.

1.3 Responsibilities and Delegation

1.3.1 The Management Group 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 Management Group 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 with regard to the LLP 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 With regard to the operation of the LLP, the Board of Directors and the Management Group 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, and agreed by the LLP.

1.3.4 Within the Standing Financial Instructions, it is acknowledged that the Managing Director is ultimately accountable to the Board of Directors and Members and as Accountable Officer for ensuring that the Management Group meets its obligation to perform its functions within the available financial resources. The Managing Director has overall executive responsibility for the LLPs activities; is responsible to the Chair and the Board of Directors, and the Members for ensuring that its financial obligations and targets are met and has overall responsibility for the LLPs system of internal control.

1.3.5 The Managing Director and Director of Resources 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 Managing Director to ensure that existing members of the Management Group and employees and all new appointees are notified of, and understand, their responsibilities within these Instructions.

1.3.7 The Director of Resources ~~Deputy Finance Director~~ is responsible for:

(a) implementing the LLPs 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 LLP at any time.

and, without prejudice to any other functions of the LLP, and employees of the LLP, the duties of the Director of Resources ~~Deputy Finance Director~~ include:

(d) the provision of financial advice to other members of the Management Group 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 LLP may require for the purpose of carrying out its statutory duties.

1.3.8 All members of the Management Group and employees, severally and collectively, are responsible for:

(a) the security of the property of the LLP;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources; and

(d) conforming to the requirements of Members Agreement ~~Standing Orders,~~ Standing Financial Instructions, Financial Procedures, Reservation of Powers and the Scheme of Delegation.

1.3.9 Any contractor or employee of a contractor who is empowered by the LLP to commit the LLP to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Managing Director to ensure that such persons are made aware of this.

1.3.10 For any and all members of the Management Group and employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Management Group and employees discharge their duties must be to the satisfaction of the Director of Resources ~~and Deputy Finance Director~~.

2 AUDIT

2.1 Audit Committee

2.1.1 In accordance with the Members Agreement ~~Standing Orders t~~he 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 of the LLP by:

(a) overseeing Internal and External Audit services;

(b) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;

(c) review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the LLPs activities, that supports the achievement of the LLPs objectives

(d) monitoring compliance with Members Agreement~~Standing Orders~~ and Standing Financial Instructions;

(e) reviewing schedules of losses and compensations and making recommendations to the Management Group;

(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 Chair of the Audit Committee should raise the matter at a full meeting of the Management Group. Exceptionally, the matter may need to be referred to NHS England and Improvement.

2.1.3 It is the responsibility of the Group 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 Director of Resources ~~Deputy Finance Director~~

2.2.1 The Director of Resources ~~Deputy 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, the Management Group, 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 Director of Resources ~~Deputy 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 Management Group or employees of the LLP;

(c) the production of any cash, stores or other property of the LLP under a member of the Management Group 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 LLPs 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 Director of Resources ~~Deputy 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 Managing Director, Chair and Chief Executive of the Trust.

2.3.4 The Head of Internal Audit shall be accountable to the Group Finance Director. The reporting system for internal audit shall be agreed between the Group 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 Managers of LLP Functional Departments at the conclusion of each piece of audit work, within an appropriate timescale. Outstanding audit reports will be reviewed by the Director of Resources~~eputy 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 Resources~~eputy Finance Director~~ 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 Managing Director 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 Managing Director and Director of Resources ~~Deputy 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 Group 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 Trust's Council of Governors from an approved list recommended by the Audit Committee and paid for by the LLP. 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 Trust's Council of Governors. If the issue cannot be resolved by the Trust's Council of Governors it should be reported to NHS England and Improvement.

3 BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

3.1 Preparation and Approval of Business Plans and Budgets

3.1.1 The Managing Director will compile and submit to the Members an annual business plan which takes into account LLP 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 Director of Resources ~~Deputy Finance Director~~ will, on behalf of the Managing Director, ensure annual budgets are prepared. Such budgets will:

(a) be in accordance with the aims and objectives set out in the annual business plan;

(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 Director of Resources~~Deputy Finance Director~~ shall monitor financial performance against budget and business plan, periodically review them, and report to the Management Group.

3.1.4 All budget holders must provide information as required by the Director of Resources ~~Deputy Finance Director~~ to enable budgets to be compiled and monitoring reports to be prepared.

3.1.5 The Director of Resources ~~Deputy 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 LLP Finance Manual.

3.2 Budgetary Delegation

3.2.1 The Managing Director 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 Managing Director, prime budget holders and delegated budget holders must not exceed the budgetary total set by the Management Group.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Managing Director, 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 Managing Director.

3.3 Budgetary Control and Reporting

3.3.1 The Director of Resources ~~Deputy Finance Director~~ will devise and maintain systems of budgetary control. These will include:

(a) regular financial reports to the Management Board in a form approved by the Management Board 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 Managing Director and/or Director of Resources ~~Deputy 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 Management Group;

(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 Managing Director via the Trust's Vacancy Control process.

3.3.3 The Managing Director 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 Managing Director is responsible for ensuring that appropriate support is leant to the LLP in completing monitoring forms for submission to the requisite – monitoring organisation – e.g. NHS England and Improvement.

4 ANNUAL ACCOUNTS AND REPORTS

4.1 The Director of Resources Deputy Finance Director, on behalf of the LLP, 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 England and Improvement with the approval of HM Treasury.

4.2 The LLPs annual accounts must be audited by the external auditor appointed by the Trust's Council of Governors. The LLPs audited annual accounts must be approved by the Members and presented at the Annual General Meeting.

4.3 The LLP will publish an annual report, in accordance with guidelines on local accountability, and present it at the Annual General Meeting. The document will comply with NHS England and Improvement FT Annual Reporting Manual (FT ARM) as relevant, and the companies act as appropriate.

5 BANK ACCOUNTS, INVESTMENT AND EXTERNAL BORROWING

5.1 General

5.1.1 The Director of Resources ~~Deputy Finance Director~~ is responsible for managing the LLPs banking arrangements and for advising the LLP on the provision of banking services and operation of accounts. This advice will take into account NHS England and Improvement guidance/directions.

5.1.2 The Management Group shall approve the banking arrangements.

5.2 Bank Accounts

5.2.1 The Director of Resources ~~Deputy Finance Director~~ is responsible for:

(a) the operation of bank accounts;

(b) establishing separate bank accounts for the LLPs non-exchequer 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 Management Board 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 Director of Resources ~~Deputy 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 LLPs accounts.

5.3.2 The Director of Resources ~~Deputy Finance Director~~ must advise the LLPs bankers in writing of the conditions under which each account will be operated.

5.4 Investments

5.4.1 The Group 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 Group 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 Group 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 Director of Resources ~~Deputy Finance Director~~ will review the commercial bank arrangements of the LLP 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 Director of Resources ~~Deputy 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 Director of Resources ~~Deputy Finance Director~~ is also responsible for the prompt invoicing and banking of all monies received.

6.2 Fees and Charges

6.2.2 The Director of Resources ~~Deputy 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 Director of Resources ~~Deputy 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 Director of Resources ~~Deputy Finance Director~~ promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements 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 Director of Resources ~~Deputy 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 Director of Resources ~~Deputy 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 LLP.

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 Director of ResourcesDeputy 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 LLP is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the LLP 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 Deputy Director of Resources 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 LLPs Losses and Special Payments procedures.

7 NHS SERVICE CONTRACTS FOR PROVISION OF SERVICES

7.1 The Managing Director, as the Accountable Officer, is responsible for ensuring the LLP enters into suitable legally binding service contracts with service commissioners for the provision of NHS services.

7.2 The form of contract between the LLP and the Trust shall be through the Master Services Agreement

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 Managing Director to ensure that the LLP 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 LLP can jointly manage risk with all interested parties.

7.4 The Managing Director, as the Accountable Officer, will need to ensure that regular reports are provided to the Management Group detailing actual and forecast income from the service contract. This will include information on costing arrangements.

8 TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF LLP REPRESENTATIVES 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 Managing Director employed by the LLP 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 Managing Director to ensure they are fairly rewarded for their individual contribution to the LLP – having proper regard to the LLPs 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 Managing Director for setting of remuneration and conditions of service for those employees not covered by the Committee.

8.2 Funded Establishment

8.2.1 The workforce plans of the LLP 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 Managing Director, on the advice of the Director of Resources in consultation with the Trust's Director of Workforce & OD.

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 Managing Director; 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 Management Group will approve procedures presented by the Managing Director for the determination of commencing pay rates, condition of service, etc., for employees.

8.4 Processing Payroll

8.4.1 The Director of Resources ~~Deputy 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 Trust's Director of Workforce & OD);

(c) making payment on agreed dates; and

(d) agreeing method of payment.

8.4.2 The Director of Resources ~~Deputy 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 Director of Resources ~~Deputy Finance Director's~~ instructions and in the form prescribed by the Director of Resources~~Deputy Finance Director~~; and

(d) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee'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 Director of Resources ~~Deputy Finance Director~~ must be informed immediately.

(e) taking responsibility for managing staff costs within the available resources and engaging staff in accordance with LLP policies and procedures.

8.4.4 Regardless of the arrangements for providing the payroll service, the Director of Resources ~~Deputy 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 Management Group shall delegate responsibility to managers

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Trust's Director of Workforce & OD 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 Members and the Management Group will approve the level of non-pay expenditure and the Managing Director will determine the level of delegation to budget managers as part of the Reservation of Powers and Scheme of Delegation.

9.1.2 The Managing Director, as the Accountable Officer, will determine:

(a) prime and delegated 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 Managing Director shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

9.1.4 The Managing Director 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 LLP. In so doing, the advice of the Property & Asset ManagementEstates or Purchasing department shall be sought. Where this advice is not acceptable to the requisitioner, the Director of ResourcesDeputy Finance Director (and/or the Managing Director) shall be consulted.

9.2.2 The Director of Resources Deputy 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 Director of ResourcesDeputy Finance Director will:

(a) advise the Management Group 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 LLP 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 Director of Resources ~~Deputy 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 Trust's 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 LLP Manager 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 LLP if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) the Director of Resources ~~and Deputy 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 Managing Director if problems are encountered.

9.2.5 Official orders must:

(a) be consecutively numbered;
(b) be in a form approved by the Director of Resources ~~and Deputy Finance Director~~;
(c) state the LLPs terms and conditions of trade; and
(d) only be issued to, and used by, those duly authorised by the Managing Director.

9.2.6 Managers and officers must ensure that they comply fully with the guidance and limits specified by the LLP Director and that:

(a) all contracts, leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Resources ~~and Deputy 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 NHSE/I 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 Director of ResourcesDeputy Finance Director on behalf of the Managing Director;

(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 Director of ResourcesDeputy 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 Director of ResourcesDeputy 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 Director of Resources Deputy Finance Director.

9.4 Building and Engineering Transactions

9.4.1 The Director of Resources ~~Deputy 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 Managing Director.

9.5 Tendering Quotation and Contract Procedure

9.5.1 The LLP 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 ~~Manging~~Managing Director or Director of Resources through the Scheme of Delegation where one or more of the following applies:

(a) The estimated expenditure or income does not, or is not reasonably expected to, exceed £25,000 (this figure is reviewed annually). It is a breach of the Regulations to spilt contracts to avoid the thresholds. The value used should be the overall contract value for the life of the equipment or service not annual costs;

(b) This is an extension to an existing (or very recently expired) contract which was sourced by competitive selection or via a framework either by the LLP, 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 LLP, 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 LLP 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 Managing Director 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 Managing Director 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 LLP shall procure goods and services in accordance with procurement procedures approved by the Management Group.

9.5.10 The Managing Director shall be responsible for ensuring the best value for money can be demonstrated for all services provided under contract

or in-house. The Management Group 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 LLP;

10 CAPITAL PROJECTS, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

10.1 Capital Projects delivered by the LLP for the Trust

10.1.1 The Managing Director:

a) shall ensure that there is an adequate process in place that enables the LLP to support the Trust with running project initiation and initial project appraisal, and in doing so help the Trust arrive at a prioritised schedule of project requests and backlog maintenance proposals;

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 LLP present to the Trust appropriate information including capital cost schedules at key stages of the capital project process for the Trust to approve. The LLP will not proceed past defined points in the capital projects process until it has received a formal approval from the Trust to do so..

10.1.2 For every capital expenditure proposal the Managing Director shall ensure:

(a) that the LLP in delivering a capital project for the Trust:

(i) undertakes a capital option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs, as the first stage of project development work; and

(ii) sets out appropriate project management and control arrangements;

(iii) involves appropriate Trust personnel and external agencies; and

(b) that the Director of Resources ~~Deputy Finance Director~~ has certified professionally to the capital costs detailed in the option appraisal.

10.1.3 For capital schemes where the contracts stipulate stage payments, the Managing Director will issue procedures for their management in accordance to the form of contract that is being utilised and incorporating the recommendations of "CONCODE".

The Director of Resources ~~Deputy 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 Director of Resources ~~Deputy 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 by the Trust shall not constitute approval for the initiation of expenditure on any project by the LLP. The LLP will only proceed with a project once it has received formal approval from the Trust.

10.1.5 The Director of Resources ~~Deputy 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.

(d) Authority to enter into framework contracts using *DHSC P21+/P22 frameworks or other design and minor works frameworks.*

10.1.6 The Director of Resources ~~Deputy 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.

10.3 Asset Registers

10.3.1 Where the LLP has its own assets, the Managing Director is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Resources ~~Deputy 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 LLP 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 NHSE/I.

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 Director of Resources ~~Deputy 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 Where the LLP has its own assets, the overall control of fixed assets is the responsibility of the Managing Director.

10.4.2 Asset control procedures, (including both purchased and donated assets) must be approved by the Director of Resources~~Deputy 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 Director of ResourcesDeputy Finance Director.

10.4.4 Whilst each employee and officer has a responsibility for the security of property of the LLP, it is the responsibility of Management Board 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 Management Board. Any breach of agreed security practices must be reported in accordance with instructions.

10.4.5 Any damage to the LLP premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by management and employees in accordance with the procedure for reporting losses.

10.4.6 Where practical, assets should be marked as LLP property.

10.4.7 Equipment and other assets may be loaned to or from the LLP. Employees and managers must ensure that the LLPs management procedure is followed, in particular conditions attaching to the loan are documented and the assets identified. Assets loaned to the LLP must not be entered in the LLPs 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 Director of resources ~~Deputy 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 fuel oil and coal of the 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 Director of Resources ~~Deputy 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 LLP property, must be commensurate with the value and attractiveness of the stock;

(e) stocktaking arrangements are agreed with the Director of Resources ~~Deputy 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 Director of Resources~~Deputy Finance Director~~;

(g) there is a system, approved by the Director of Resources~~Deputy 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 Director of ResourcesDeputy Finance Director;

(h) losses and the disposal of obsolete stock are reported to the Director of ResourcesDeputy Finance Director.

11.4 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of ResourcesDeputy 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 Managing Director 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 Director of Resources ~~Deputy 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 LLP asset, the head of department or authorised deputy will determine and advise the Director of Resources ~~Deputy Finance Director~~ of the estimated market value of the item, taking account of professional advice where appropriate. The Director of Resources ~~Deputy Finance Director~~ shall ensure that the arrangements for the sale of disposable assets maximise the income to the LLP.

~~12.1.2~~12.1.3 The disposal of Trust assets will be the subject of the Trust's approval hierarchy.

~~12.1.3~~12.1.4 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Resources ~~Deputy Finance Director~~;

(b) recorded by the Condemning Officer in a form approved by the Director of Resources ~~Deputy 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 Director of Resources~~Deputy Finance Director~~.

~~12.1.4~~12.1.5 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 Director of Resources ~~Deputy Finance Director~~ who will take the appropriate action.

12.2 Losses and Special Payments

12.2.1 The Director of Resources ~~Deputy Finance Director~~ must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The Director of resources ~~Deputy 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 Managing Director and the Director of Resources ~~Deputy Finance Director~~ or inform an officer charged with responsibility for responding to concerns involving loss confidentially. This officer will

then appropriately inform the Director of Resources ~~Deputy Finance Director~~ and/or Managing Director. 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 Director of Resources ~~LLP 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 Director of Resources ~~Deputy 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 Director of Resources~~Deputy 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 Director of Resources~~Deputy Finance Director~~ must immediately notify:

(a) the Management Group

(b) 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 Director of Resources ~~in consultation with the Deputy Finance Director~~ should consider whether any insurance claim could be made.

12.2.8 The Director of Resources ~~Deputy 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 Director of Resources ~~Deputy Finance Director~~ shall be authorised to take any necessary steps to safeguard the LLPs 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 LLP.

13 COMPUTERISED FINANCIAL SYSTEMS

13.1 The Director of Resources~~Deputy Finance Director~~, who is responsible for the accuracy and security of the computerised financial data of the LLP, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the LLPs 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 Director of Resources ~~Deputy Finance Director~~ shall satisfy themselves ~~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 Director of Resources~~Deputy 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 Director of Resources ~~Deputy 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 Director of Resources ~~Deputy 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 Director of Resources ~~Deputy Finance Director~~ shall satisfy themselves ~~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) Director of Resources ~~Deputy Finance Director~~ staff have access to such data; and

(d) such computer audit reviews are being carried out as are considered necessary.

14 ACCEPTANCE OF GIFTS BY STAFF

14.1 The Director of Resourceseputy Finance Director shall ensure that all staff are made aware of the LLP 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.

15 RETENTION OF DOCUMENTS

15.1 The Managing Director 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”.

15.2 The documents held in archives shall be capable of retrieval by authorised persons.

15.3 Documents held in accordance with Department of Health guidelines shall only be destroyed at the express instigation of the Managing Director 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 LLPs policy for document management and retention.

16 RISK MANAGEMENT

16.1 The Managing Director shall ensure that the LLP has a programme of risk management, in accordance with the terms of the licence issued to the Trust by NHS England and Improvement. This programme will be approved and monitored by the Management Group.

16.2 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 LLP 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 the Management Group.

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 by NHS England and Improvement.

16.3 The Management Group shall review insurance arrangements for the LLP.

APPENDIX 1 **EU Thresholds**

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 2020 are given below. Thresholds are net of VAT.

	Supply, Services[1] and Design Contracts	Works Contracts[2]	Social and other specific services[3]
~~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~~
Central Government[4]	£122,976 €139,000	£4,733,252 €5,350,000	£663,540 €750,000
Other contracting authorities	£189,330 €214,000	£4,733,252 €5,350,000	£663,540 €750,000
Small Lots	£70,778 €80,000	£884,720 €1,000,000	n/a

[1]With 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).

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

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

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

	Supply, Services and Design Contracts	Works Contracts	Social and other specific services
~~Utility authorities~~	~~£363,424 €443,000~~	~~£4,551,413 €5,548,000~~	~~£820,370 €1,000,000~~
Utility authorities	£378,660 €428,000	£4,733,252 €5,350,000	£884,720 €1,000,000

Time Limits (Minimum Timescales)

MINIMUM TIME	IF ELECTRONIC TENDER PERMITTED	IF URGENT	WHERE PIN PUBLISHED*
Open Procedure (1 stage progress) Minimum time limit for receipt of tenders: 35 days	Minimum time limit for receipt of tenders: 30 days	Minimum time limit for receipt of tenders: 15 days	Minimum time limit for receipt of tenders: 15 days
Restricted Procedure (2 stage process) Minimum time limit for requests to participate: 30 days	-	Minimum time limit for requests to participate 15 days	Minimum time limit for requests to participate 30 days
Minimum time limit for tenders: 30 days	Minimum time limit for receipt of tenders: 25 days	Minimum time limit for tenders: 10 days	Minimum time limit for tenders: 10 days
Competitive Negotiated Procedure/ Innovation Partnerships Minimum time limit for requests to participate: 30 days		Minimum time limit for requests to participate: 15 days	Minimum time limit for requests to participate: 30 days
Minimum time limit for initial tenders: 30 days	Minimum time limit for receipt of initial tenders: 25 days	Minimum time limit for tenders: 10 days	Minimum time limit for tenders: 10 days
Competitive Dialogue Minimum time limit for requests to participate: 30 days No explicit time limits for submission of initial/subsequent tenders			

Help choosing the right procedure

The choice of procedure requires a careful balancing act. Often, you may be able to use an existing framework agreement but, if not, then the open procedure or the restricted procedure is often the most appropriate. The table on the next page indicates some of the key considerations.
For any uncertainty, or for further guidance on which procedure is likely to be appropriate for your needs please ask any questions via purchasingenquiries@york.nhs.uk and we'll do our best to help.

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

York Teaching Hospital
Facilities Management

York Teaching Hospital Facilities Management LLP

RESERVATION OF POWERS

AND

SCHEME OF DELEGATION

Author: Foundation Trust Secretary
Owner: YTHFM Managing Director
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YTHFM LLP Reservation of Powers and Delegation of Powers

Introduction

This document sets out the powers reserved to the YTHFM Management Group and the York Teaching Hospital NHS Foundation Trust's (YTHFT) Board of Directors together with the Scheme of Delegation including financial limits and approval thresholds. Notwithstanding any specific delegation, the YTHFT Board of Directors remains accountable for all of its functions, including those which have been delegated. Therefore the YTHFT Board of Directors ~~expect~~expects to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

All powers of the YTHFM LLP which have not been retained as reserved by the YTHFM Management Group or YTHFT Board of Directors or delegated to a YTHFM Committee or YTHFT Board Committee shall be exercised on behalf of the YTHFT Board of Directors by the Managing Director or other Directors. The Scheme of Delegation identifies any functions which the Managing Director shall perform personally ~~or in conjunction with the Deputy Finance Director on behalf of the LLP~~ and those delegated to other directors or officers. All powers delegated by the Managing Director can be re-assumed by them ~~him/her~~ should the need arise or by any other individual duly authorised to represent them.

Purpose

1.1 The purpose of this document is to define the control framework set by the YTHFM LLP and YTHFT Board of Directors for committing LLP resources. The YTHFT Board of Directors 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 Managing Director shall perform personally ~~or in conjunction with the Deputy Finance Director on behalf of the LLP~~ and those which he has delegated to other Officers.

1.2 All powers delegated by the Managing Director can be re-assumed by him/her should the need arise. In the absence of the Managing Director the powers of the Managing Director are delegated to the Director of Resources ~~Deputy Finance Director on behalf of the LLP or Deputy Managing Director~~.

1.3 The Scheme of Delegation shows only the top level of delegation within the LLP. The Scheme is to be used in conjunction with the LLPs Members Agreement, Schedule of Matters Reserved to the Board, Standing Financial Instructions including the system of budgetary control and other established policies and procedures.

~~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 YTHFM Management Group or the YTHFT Board of Directors. If the Managing Director is absent, powers delegated to them ~~him~~ may be exercised by the Director of Resources. ~~or the Trusts Deputy Finance Director~~ acting ~~on~~ on behalf of the LLP ~~under the reverse service level agreement. or Deputy Managing Director~~.

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 (this is seen as good practice and applies to subsidiary company 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 their normal remit, it should be referred to their manager. Failure to do so may result in disciplinary action.

2.4 The document forms part of the LLP's corporate governance framework, which is the regulatory framework for the business conduct of the LLP within which all LLP officers are expected to comply. The aim is not to create bureaucracy but to protect the LLP'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 and Delegation of Powers:

- Members Agreement;
- Standing Financial Instructions.

2.5 Wherever the title Managing Director, Members Representatives, Director of Resources, ~~Deputy Finance Director on behalf of the LLP,~~ or other nominated officer is used in these instructions, it shall be deemed to include such other employees who have been duly authorised to represent them. This aligns with section 1.2.2 of the Standing Financial Instructions.

Principles of the Scheme of Delegation

3.1 Principles that are followed by the Scheme of Delegation

- There is no expenditure beyond authorised limits except with the express written approval of the Managing Director and the Director of ResourcesDeputy Finance Director on behalf of the LLP.
- The business case process is mandatory.

Scheme of matters reserved for the Trust's Board of Directors

The Trust's Board of Directors 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.

- 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)
- Specify Partnership Organisations
- Approval, suspension, variation or amendment of the Members Agreement, Reservation of Powers and Delegation of Powers and Standing Financial Instructions for the regulation of its proceedings and business in conjunction with the Management Group
- Prescribe the Financial and Performance reporting arrangement required by the Board of Directors
- 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
- Acquisition, disposal of land/ or buildings above a value of £1m.
- Change of use of land
- All investment regardless of size of new activity or any disinvestment
- Approve final business cases for the use of private finance for capital schemes including those involving NHFML Finance.
- Continuous appraisal of the affairs of the LLP by means of the receipt of reports as it sees fit from Directors, Committees and Officers of the LLP

Scheme of matters reserved for the Members
(Reserved matters cannot be undertaken without a member's resolution – Membership Agreement)

1. Amendments to the Agreement
2. The commencement of any winding-up or dissolution or of the appointment of any liquidator, administrator or administrative receiver of the LLP or any of its assets unless it shall have become insolvent.
3. Any decision for the LLP to make a proposal for a voluntary arrangement, scheme of compromise or arrangement with its creditors under the Insolvency Act.
4. A change of name of the LLP.
5. Any change in status of the LLP as a limited liability partnership.
6. The allocation of any further profit share in the LLP other than in accordance with the Business Plan.
7. Assignment of rights under the Agreement
8. Approval of the annual Business Plan.
9. Any change to the approved Business Plan.
10. The increase in any indebtedness of the LLP other than in accordance with the Business Plan (including any refinancing of the LLP).
11. The agreement of and any change to the distribution of profits save where such distribution is made in accordance with the approved Business Plan.
12. The devolution or transfer of management control to persons outside the Management Group or in the Business Plan, and if approved, the terms of such devolution.
13. The commencement by the LLP of any new business not being ancillary to or in connection with the Business or making any material change to the nature of the Business.
14. Approval of annual accounts.
15. Change in accounting policies
16. Change to the Accounting Date
17. Change in registered address of LLP
18. The making of loans or advances, or the grant of any credit, in excess of {£5,000} by the LLP (other than in the ordinary course of business) or giving any guarantee or indemnity
19. Entering into or terminating any contract or arrangement of a material nature outside the normal course of business
20. The LLP acquiring or disposing of any asset or real estate other than in accordance with the Business Plan
21. A variation of any rights attaching to any profit share in the LLP other than in accordance with this Agreement and the approved Business Plan
22. The appointment or dismissal of a Representative otherwise than in accordance with this Agreement, or the amendment of any rights for Members to appoint certain numbers of Representatives
23. Participating in any activity which is detrimental to and/or incompatible with the life sciences/ healthcare sector or the reputation of the National Health Service
24. Any decision which would result in a change to the 95/5% Capital Contribution split of the LLP

25. Sale or transfer of a member's share in the LLP outside of the original Members
26. The acquisition or disposal by the LLP of any partnership interest, share capital or other securities in a body corporate or any merger or consolidation of the LLP or its assets, property and business
27. The formation by the LLP of any subsidiary undertaking, acquisition of any business, acquisition of any share, interest or loan capital of any body corporate or decision to enter into a partnership or joint venture or other income or profit sharing arrangement with any person.
28. The commencement, continuation, settlement or compromise of any material litigation or legal proceedings instituted or threatened against the LLP other than in pursuit of debts or damages to which the LLP is entitled to recovery under the terms of agreements or arrangements put in place in the ordinary course of business to carry out the Business as set out in the Business Plan, or submitting to arbitration or alternative dispute resolution any dispute involving the LLP.
29. Any material departure from the principle that staff transferring to the LLP from the Trust under any Partnership Agreement shall do so under the same terms and conditions of employment as applied immediately prior to that member of staff's transfer to the LLP (or as near to the same terms and conditions as the LLP has the capacity to provide).
30. The engagement of any consultant by the LLP at a cost for any such person exceeding £50,000 on any project or any variation of any consultancy agreement.
31. Any decision to enter into any guarantee, bond or become bailee or surety for any person.
32. The creation or grant by the LLP of any encumbrance over the whole or any part of the Business, undertaking or assets of the LLP or agreement to do so other than liens arising in the ordinary course of business or any charge arising by the operation or purported operation of title retention clauses and in the ordinary course of business.
33. The incurrence by the LLP of any item or items of capital expenditure of the limits set by the Standing Financial Instructions.

Scheme of matters reserved for the Management Group – subject to those matters reserved to the Trust Board of Directors and Members

- Make available for inspection by members of the public the following: Register of Members; Register of Directors; Register of Debenture Holders; Register of Interest of Directors; and Register of People with Significant Control.
- Prepare Annual Accounts, any reports of the Auditor on them.
- Prepare the Annual Report in conjunction with the Group Annual Report.
- Prepare the Business Plan
- Approval, suspension, variation or amendment of Reservation of Powers and Delegation of Powers and Standing Financial Instructions for the regulation of its proceedings and business in conjunction with the Audit Committee and Trust Board of Directors
- Approval of the Reservation of Powers and Delegation of Powers from the Management Group to officers
- Requiring and receiving the Declaration of Interests from Directors or officers which may conflict with those of the Management Group and determining the extent to which that Director may remain involved with the matter under consideration

- Adoption of the organisational structure processes and procedures to facilitate the discharge of business by the LLP and to agree any modification there to subject to any business cases required.
- To establish terms of reference and reporting arrangements of all committees established by the Management Group
- Ratification of any urgent decisions taken by the Managing Director in accordance with the Members Agreement
- Approval of the Management Group banking arrangements (SFI 5.12)
- Ratify or otherwise instances of failure to comply with Members Agreement
- Discipline members of the Management Group or Officers who are in breach of statutory requirements or the Members Agreement
- Call meetings of the Management Group
- Approve minutes of the proceedings of the meetings of the Management Group
- Resolve to adjourn any meeting of the Management Group
- The appointment and dismissal of Management Group Committees save those joint Committees with the Trust (Audit Committee, Remuneration Committee)
- Through the Remuneration Committee the appointment, remuneration and appraisal of the Managing Director and the disciplinary procedures of the Trust
- The appointment of any representative body outside the organisationDefine and approve the strategic aims and objectives of the LLP
- Approve strategic business plans incorporating a programme of investment in respect of the application of available financial resources in conjunction with the Trust
- Approve annually LLP budgets
- Approve proposals for action on litigation against or on behalf of the LLP
- Purchase and maintain insurance against liability.
- Approve opening and closing of any bank account
- Consideration and approval of the Annual Accounts
- 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 LLP Managing Director and Trust's 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 Managing Director 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 the Members Agreement. All reference material is available from staffroom.

General Area	Delegated matter	Authority delegated to	Scope of Delegation	Details/ Reference
Accountability	Accountable to the YTHFT for the stewardship of LLP Resources	Managing Director and Members Representatives	Full	Membership Agreement
	Ensure the expenditure by the LLP complies with the Trust's requirements	Managing Director and Members Representatives	Full	Membership Agreement
	Ensure appropriate advice is given to the YTHFM Management Group and YTHFT Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness	Managing Director, Members Representatives, LLP Company Secretary and Company Secretary YTHFTFoundation Trust Secretary on behalf of LLP		
Declaration of Interests	The keeping of a declaration of LLP Senior Officers and Members Representatives interests	LLP Company Secretary Foundation Trust Secretary on behalf of LLP		
Receipt of Gifts and Hospitality	Receipt or provision of hospitality and gifts	All LLP employees have a duty to declare		Standards of business conduct policy
	Approve procedures for declaration of hospitality and sponsorship	Management Group		
	Maintenance of gifts and hospitality register	LLP Company Secretary Foundation Trust Secretary on behalf of LLP		

	Approval of receipt of both individual and collective hospitality	Prime budget holder		
Financial Procedures and LLP accounting policies	Approve and communicate all financial procedures and LLP accounting policies	LLP Director of ResourcesDeputy Finance Director on behalf of the LLP	All	FReM and NHSI guidance SFI 1.1.3

Asset Register	Maintenance of the A~~a~~sset Register	Managing Director	All	SFI 10.3
Investment of funds	Investments – agreed by the Board of Directors	Board of Directors	All	Treasury Manageme~~-~~nt Policy
Capital Investment and Business Cases	Backlog Maintenance element of the Capital Programme	Capital Programme Executive Group	Up to £100k	SFI 10
		Chief Executive or Group Finance Director through Capital Programme 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, where these do not seek further investment by the Trust. All business cases seeking further investment by the Trust will be subject to the Trust business case process and scheme of delegation. (Any expenditure over £25k must be advertised under procurement rules. Further advice should be sought from procurement)	Delegated ~~Prime~~ budget holder	Up to £50k	
		Prime budget holder (Directors)	Up to £50k	
		Managing Director	Up to £100k~~Over £50k - £250k~~	
		Management Group	Over £250k- £1m	
		Board of Directors	Over £1m All PFI proposals	
Planning & Budgetary Control	Prepare and submit a B~~b~~usiness P~~p~~lan including any in year adjustment to the B~~b~~usiness P~~p~~lan	Managing Director		SFI 3
	Management of budgets for the totality of services	Managing Director ~~Deputy Finance Director on behalf of the LLP~~		SFI 3.1.2

	At Department level Prime budget holders are those staff who hold all operating budgets for the Departments they manage including, where appropriate, income, activity and expenditure.	Prime budget holder		LLP ~~Trust~~ Finance Manual Section 8
	At individual budget unit level (pay and non-pay). Prime Budgets Holders can delegate budgetary authority to delegated budget holders. These are typically senior and other operational managers who control budgets on a day to day basis.	Delegated budget holder		LLP ~~Trust~~ Finance Manual Section 8
	Virement (planned transfer) of resources between department budgets (per annum):	Director of Resources ~~Deputy Finance Director on behalf of the LLP~~		SFI 3.2.3 LLP ~~Trust~~ Finance Manual Section 8.2.3
	Non pay requisitions – Decisions to rent or lease in preference to outright purchase	Head of Corporate Finance on behalf of the LLP		SFI Sections 9 and 10
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 Director of Resources~~Deputy Finance Director on behalf of the LLP~~)	Prime budget holders are expected to set delegated limits for delegated budget holders and advise the Assistant Director of Finance – Financial Management for inclusion in the authorised signature list	SFI Section 9 LLP ~~Trust~~ Finance Manual Section 5.2 ~~Section 9~~

	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).	Director of Resources ~~Deputy Finance Director on behalf of the LLP~~		SFI 9.2.6(e)
	Purchasing Cards: Authority to issue purchasing cards and setting of limits	Director of Resources ~~Deputy Finance Director on behalf of the LLP~~		
Non clinical income credit notes		Managing Director ~~Prime budget holder~~	Up to £50k	
		Assistant Director of Finance – Financial Management on behalf of LLP	£50k to £500k	
		Deputy Finance Director on behalf of the LLP	Over £500k	
Credit notes to correct posting errors		Accounts Receivable Team Leader on behalf of LLP	Up to £1k	
		Financial Accountant on behalf of LLP	£1k to £10k	
		Deputy Head of Corporate Finance on behalf of LLP	£10k to £500k	
		Head of Corporate Finance on behalf of LLP	£500k to £1m	
		Deputy Finance Director on behalf of the LLP	Over £1m	

Write offs		Managing Director or Director of Resources ~~Deputy Finance Director on behalf of the LLP~~	Up to £10,000	

		Management Group	Over £10,000	
Bidding for Work	Decision to bid or not, under a re-procurement exercise, for an existing contract	Management Group	Up to 1% of LLP turnover	
		Board of Directors	More than 1% of LLP turnover or If it is anticipated that not re-bidding for a contract of up to 1% of turnover is likely to involve significant reputational and political concern then this matter reverts to the Board of Directors for approval	
Quotations, Tendering and Contracts	Obtaining a minimum of 3 written competitive tenders for goods/services over £25K	Head of Procurement on behalf of the LLP	Over £25k	
	Waiving of quotations and tenders subject to SFIs and SOs (including approval of single tenders)	Head of Procurement on behalf of LLP ~~Deputy Finance Director onn behalf of the LLPand~~ Managing Director and Director of Resources	Under £50k Over £50k	SFI 9.5.2
	Opening tenders – manual	Managing Director LLP Company Secretary ~~Foundation Trust Secretary on~~		SFI 9.5

		behalf of LLP		

	Opening tenders – electronically the system prevents quotes/tenders from being opened before the deadline	Head of Procurement on behalf of LLP		
	Acceptance of quotations/ permission to consider late quotations	Head of Procurement on behalf of LLP	Under £50k	
	Acceptance of tenders/permission to consider late tenders	Managing Director	Over £50k	SFI 9.5
	Accepting contracts and signing relevant documentation	Head of Procurement on behalf of LLP Director of Resources ~~Deputy Finance Director on behalf of the LLP~~ and Managing Director	Under £50k Over £50k	
Authority to sign Documents (Deeds)		Any two Member's representatives can sign.		SO10
Insurance policies	Insurance	Managing Director		
	Review of all statutory compliance legislation and Health and Safety requirements including Control of Substances Hazardous to Health Regulations	Health and Safety Manager in conjunction with Trust Health & Safety Manager		
Loans	Loan arrangements	Group Finance Director		SFI 5.5
Bank Accounts		Director of Resources ~~Deputy Finance Director on behalf of the LLP~~		

Petty cash disbursements	Expenditure	Petty cash holder	Up to £50 per item	

		Director of Resources Deputy Finance Director on behalf of the LLP	Over £50 per item	
Property transactions	Disposal and acquisition of Trust land and buildings	Chief Executive, Group Finance Director Capital Programme Executive Group	Up to £500k	SFI 10,12
		Executive Board	£500k - £1m	
		Board of Directors	Above £1m	
	Lets and Leases			
	Preparation and signature of all TtenancyAagreements/ licenses for all staff subject to Trust Policy on accommodation for staff	Managing Director		
	Extensions to existing leases	Managing Director		
	Letting of premises to outside organisations, subject to business case limits	Managing Director		
	Approval of rent based on professional assessment	Managing 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		
	Maintain a losses and special payments register	Director of Resources Deputy Finance Director on behalf of		

		the LLP		

	Non-clinical cases	Group Finance Director & Managing Director	Up to £500k	
		Executive Board	£500k-£1m	
		Board of Directors	Over £1m	
	Review schedules of losses and compensations and make recommendations to the Management Group	Audit Committee		
	Special payments – outside the terms of any contract obligation	Treasury approval		
Condemning and disposal –LLP 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)	Director of Resources ~~Deputy Finance Director on behalf of the LLP~~		SFI 12.1 Disposal and Transfer policy
Provision of services to other organisations	Legal and financial arrangements for the provision of services to other organisations and individuals	Managing Director		SFI 6.2.3
	Signing agreement with other organisations and individuals	Director of Resources~~Deputy Finance Director on behalf of the LLP~~		SFI 7
Audit and Accounts	Approve the appointment and where necessary dismissal of the External Auditors	Council of Governors		SFI 4
	Receive the annual management letter from the External Auditor.	Management Group		
	Receive the annual management letter from the external auditor and agree proposed action, taking account of the advice, where appropriate, of the Audit Committee	Management Group		
	Receive an annual report from the Internal Auditors and agree action	Audit Committee		
Annual Report and Accounts	Receive and approve the Accounts	Management Group		

	Sign the annual statements including the annual	Chair of the		

	accounts on behalf of the Management Group	Management Group		
	Implementation of internal and external audit recommendations	Director of Resources ~~Managing Director~~		SFI 2.~~2~~
	Receive and approve the LLP sections of the Group Annual Report	Management Group		
Retention of Records	Maintaining archives of records to be retained	Managing Director		SFI 15~~7~~
Personnel and Pay	Approve management policies including personnel policies incorporating arrangements for the appointment, removal and remuneration of staff	Managing Director		
	Authorisation of timesheets (including agency timesheets)	Delegated budget holder~~Line Manager~~		
	Authority to fill funded post on the establishment with permanent staff	Managing Director/ Vacancy Control		
	Authority to appoint staff to post not on the formal establishment	Managing Director		
	Granting of additional increments to staff within the context of policy (HR process up to 2 incremental points	Workforce Lead on behalf of LLP in conjunction with Director of Resources ~~the delegated budget holder~~	All subject to compliance with A4C regulations	
	Above policy level	Managing Director		
	Managing Director	Remuneration Committee		
	Non-executive Directors and Chair	Nominations and Remuneration Committee		
	Upgrading and re-grading Subject to compliance with regulations	Director of Workforce on behalf of LLP		SFI 8.3
	Authorising overtime	Delegated budget holder		SFI 8.4.3
	Authorising travel and subsistence	Line Manager and Delegated budget		

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		holder		
	Approval of annual leave	Delegated budget holderLine Manager		Annual Leave and Bank Holiday Policy and Procedure
	Annual leave – approval of carry forward	Delegated budget holderLine Manager	Up to a maximum of 5 days in exceptional circumstances only:	
		Over 5 days in exceptional circumstances only	Prime budget holder	
	Approval of compassionate leave	Delegated budget holder Line Manager	Up to 5 days	Special Leave Guidance
		Prime budget holder in consultation with HR	Up to 10 days	
	Special leave	Delegated budget holder Line Manager	Paternity	Special Leave Guidance
		Delegated budget holderLine Manager	Other	

		Delegated budget holder ~~Line Manager~~	Maternity leave	
		Delegated budget holder ~~Line Manager~~	Leave without pay	
		Delegated Budget Holder ~~Line Manager~~	Time off in lieu	
		Delegated budget holder ~~Line Manager~~	Flexible working arrangements	Flexible Working Policy
		Director of Workforce & OD	Extension of sick leave on half pay up to 3 months Return to work part time on full pay to assist recovery	Sickness Absence Policy
	Study Leave	Managing Director	Study leave outside the UK – other	
		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)	Prime b~~B~~udget h~~H~~older Director of Resources ~~Deputy Finance Director on behalf of the LLP~~	Up to £6,000	Relocation Expenses Policy
		Managing Director, Director of Resources ~~Deputy Finance Director on behalf of the LLP~~, Director of Workforce & OD	£6,000 - £8,000	

	Requests for new posts to be authorised as car users or mobile phone users	~~Prime budget holder~~ Director of Resources, Director of Facilities, Director of Property & Asset Management		Lease Car and Mobile Communica-tion

				Equipment Policies
	Renewal of fixed term contracts – must be linked to business needs and available funding	Director of ResourcesDeputy Finance Director on behalf of the LLP/ Vacancy Control		
	Authorisation of retirement on the grounds of ill health	Director of Workforce & OD (the decision can only be made by the NHS Pensions Agency – when involving NHS Pension)		
	Authority of staff redundancy	Managing Director, Director of ResourcesDeputy Finance Director on behalf of the LLP, Director of Workforce & OD		Redundanc-y Policy
		Group Finance Director on behalf of LLP (with HM Treasury approval where required)	Any termination settlement	
	Authority to suspend staff	Prime budget holder, Director of Workforce		Disciplinary Policy and Procedure
	Authorisation of staff dismissal	Managing Director, Director of Resources, Director of Facilities, Director of Property & Asset		

		Management Anyone reporting directly to the Managing Director eg Head of service (or designated deputy)		

	Booking of all bank and agency staff	Delegated Prime budget holder		
Security and risk management	Corporate responsibility for implementation of the Security Policy	Managing Director		Security Policy
	Overall statutory responsibility for security management within the Trust	Chief Executive		
	Where an offence is suspected	Head of Security and Car parking	Criminal offence of a violent or clinical nature	
	Authority for the issue of ID and security badges and car park passes	Head of Security and Car Parking (theft)/ Trust Local Counter-Fraud Specialist (fraud)	Where fraud or theft is involved	
Complaints	Overall responsibility for ensuring that all complaints are dealt with effectively	Managing Director, Patient Experience Team Lead		Concerns and Complaints Policy and Procedure
	Agreement of financial compensation	Deputy Finance Director on behalf of the LLP		Losses procedure
Engagement of Solicitors		Managing Director Director, Director of Resources/ LLP Company Secretary, Director of FacilitiesDeputy Finance Director on behalf of the LLP, Director of Property & Asset ManagementDeputy Directors,		

		~~Foundation Trust Secretary on behalf of LLP~~		

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York Teaching Hospital
Facilities Management

Board of Directors – 31st March 2021
Health & Safety Policy

Strategic Goals:

☒ **to deliver safe and high quality patient care as part of an integrated system**
☒ **to support an engaged, healthy and resilient workforce**
☐ **to ensure financial sustainability**

Recommendation

For information	☐	For approval	☒
For discussion	☒	A regulatory requirement	☐
For assurance	☐		

Purpose of the Report

For the Board of Directors to receive the YTHFM Health & Safety Policy for approval.

Executive Summary – Key Points

The existing YTHFM Health & Safety Policy has been updated to include the following revisions:

- Updated policy statement to include product demonstrations and trials
- Extended the scope the policy applies to
- Included the role of the Trust's Head of Safety & Security
- Updated the section relating to specialist competent advisors
- Inclusion of LLP Chair's signature

The Trust's Health & Safety Committee, YTHFM Management Group and EPAM have approved the proposed amendments.

Recommendation

The Board of Directors is asked to approve the updated policy.

Author: Penny Gilyard, Director of Resources
Director Sponsor: Delroy Beverley, Managing Director

NHS
York Teaching Hospital
Facilities Management

Health and Safety Policy

Document Purpose:	This policy sets out Health and Safety Policy for York Teaching Hospital Facilities Management LLP
Document Author:	Penny Gilyard, Director of Resources
Endorsed by YTHFT Health & Safety Lead	Colin Weatherill, Head of Safety & Security
Owner	Delroy Beverley, Managing Director
Publisher	Resources
Date of first Issue	22-08-2019
Target Audience	All LLP Staff, Contractors, sub-contractors, visitors, volunteers and others employed in delivering a service to YTHFM. (this includes contracts/suppliers providing demonstrations and trials)
Approving body / route.	H&S Committee York Teaching Hospital Facilities Management Board, Executive Performance Assurance Meeting (EPAM), Trust Board of Directors/NHFML
Approval Date:	
Publication Date:	January 2021
Version:	1.3 - Draft
Next Review:	February 2022

Version History Log

This area should detail the version history for this document. It should detail the key elements of the changes to the versions.

Version	Date Approved	Version Author	Status & location	Details of significant changes
1.0		Brian Golding	DRAFT NHS PAM Folders	Development and update of policy
1.1	22-08-2019	Brian Golding	Held locally on (YTHFM)	Policy reviewed
1.2	17-11-2020	John Dickinson	Held locally on (YTHFM) and added to intranet	Policy reviewed
1.3		Penny Gilyard	Director of Resources	Policy reviewed

1. Policy Statement

1.1 York Teaching Hospital Facilities Management LLP (YTHFM) recognises the health, safety and the well-being of our employees, customers[1], contractors, volunteers, visitors and is committed to ensuring the highest standards of health, safety and welfare. YTHFM accepts responsibility as an employer, for the duties placed upon it by the Health and Safety at Work etc. Act 1974 and related legislation. YTHFM recognises doing so provides not just legal and financial assurance, but is morally the right thing to do and is critical to our continued success of the business.

1.2 YTHFM operates a systematic approach to the identification of hazards and the management of risk within its operations, in line with York Teaching Hospital NHS Foundation Trust Policy[2], in supporting wider Trust and NHS overall strategy.

1.3 YTHFM will ensure statutory compliance is maintained as a minimum standard and strive for continual improvement by:

- Meeting all relevant legal requirements relevant to safety by ensuring health and safety management is integral to YTHFM activities;
- As reasonably practicable adoption of best practice in all aspects of safety at work;
- Adequately control health and safety risk arising from work activities;
- Consult with employees and their representatives on health and safety matters;
- Provide and safely maintain plant and equipment;
- Ensure the safe use, handling and storage of identified hazardous substances;
- Provide as appropriate suitable, information, instruction, training and supervision of employees, contractors, sub-contractors, (including those who carry out product/service/equipment demonstrations and trials on site) and others who may be affected by work activities;
- Seek to prevent occurrences of work related accidents or ill-health; Maintenance of safe and healthy working conditions;
- Cooperate with others involved in work activities to help ensure the health, safety and welfare of all concerned; implement a 'No Blame Culture' to move forward positively
- Appropriate procurement policies to ensure that only competent contractors and suppliers are engaged by YTHFM;
- To strive to continually improve health, safety and welfare performance, taking a proactive approach to health & safety and the provision of adequate resources to achieve this;
- To monitor, audit and review YTHFM safety policy and procedures at regular and prescribed intervals.

1.4 This policy statement will be reviewed annually as part of the management review process and communicated to all employees.

Delroy Beverley

Managing Director
York Teaching Hospital Facilities Management LLP
Date :

Michael Keaney

Chair – Management Group
York Teaching Hospital Facilities Management LLP
Date :

[1] *Customers include patients and service users in healthcare settings.*
[2] *A Limited Liability Partnership and wholly owned subsidiary of York Teaching Hospital NHS Foundation Trust.*

2. Introduction

2.1 YTHFM provides high quality estates and facilities management (including but not limited to maintenance, engineering, security, cleaning, grounds, catering and energy) services, primarily to York Teaching Hospital NHS Foundation Trust and our clients in the UK. Our aim is to deliver a proactive, positive and inclusive working environment to meet our vision of excellence in health, safety and welfare to our employees and others who may be affected by our work activities. We will ensure our responsibilities for health and safety are clearly understood and communicated, to provide for an environment that values and encourages the highest standards of safety performance and service.

3. Scope

3.1 This health and safety policy applies to all employees of YTHFM, contractors, sub-contractors, visitors, volunteers and others employed in delivering a service to YTHFM.

4. Accountabilities and Responsibilities

The Management Board (YTHFM)

4.1 The Management Board are responsible for setting the strategic direction, policies, and objectives. The Management Board will ensure this is discharged through a delegated structure, ensuring the necessary support and resources are made available to allow for effective implementation of this policy.

Managing Director YTHFM

4.2 The Managing Director holds ultimately responsibility for the adherence to health and safety legislation within YTHFM and is accountable for the establishment and achievement of health and safety policies and procedures within the organisation. In the event of the Managing Director's absence, a Board nominated Director will take up these responsibilities.

Directors and Heads of Service YTHFM

4.3 Directors and Heads of Service are to have active involvement in the management of health and safety in their areas of control and collective responsibility for health, safety and welfare in the organisation. They are responsible for the safety of their staff and the activities in their charge and provide leadership by example by proactively promoting a positive attitude and safety culture.

Managers and Supervisors YTHFM

4.4 Managers and Supervisors are responsible for the impact of the overall health safety and risk on their departments as it may relate to staff, patients, contractors or visitors and have the responsibility to ensure this is effectively managed. They are expected to promote a high degree of health and safety awareness amongst all their teams and ensure the adherence to and work with Heads of Service and Directors in the development of health & safety policies and procedures.

Head of Safety & Security (YTHFT)

4.5 The Trust's **Head of Safety and Security** provides competent advice as required to assist in developing, implementing and maintaining measures to comply with relevant statute, YTHFM Company and as appropriate applicable wider York Teaching Hospital NHS Foundation Trust and NHS policy and strategy.

YTHFM Health and Safety Manager

4.6 The health and safety manager is appointed to provide competent advice and to, as required assist in developing, implementing and maintaining measures to comply with relevant statute, YTHFM company and as appropriate applicable wider York Teaching Hospital NHS Foundation Trust and NHS policy and strategy.

Specialist / Competent Advisors YTHFM

4.7 YTHFM has in place appointed / responsible specific topic experts. This culture will be assisted by a Competency Training Matrix, which will assist those individuals with carrying out their fiduciary duty of YTHFM Health and Safety obligations in the roles. This will be continuously reviewed to take into account legislation and Industry best practice. These Specialist / Competent advisors will provide YTHFM with unbiased and balanced advice in their field of specialism, supported by the training they have undertaken.

Employee Safety Representatives

4.8 YTHFM promotes active involvement and encourages that employee safety representatives are appointed by trades unions to represent their members on health and safety issues. Employee safety representatives are to be involved in discussions regarding employee health safety and welfare issues.

All YTHFM Employees[3]

4.9 All employees, including work experience, agency, and temporary staff within the YTHFM are required to accept responsibility for carrying out and adhering to the health and safety polices of the organisation. All employees are to comply with their duties set out in UK health and safety legislation by taking reasonable care for themselves and others who may be affected by their acts or omissions. Employees are accountable to their line managers and assist towards making YTHFM a safe and healthy place in which to work. In all cases, failure to comply with health and safety responsibilities could result in disciplinary action being taken as set out in the Disciplinary Policy and Procedure.

4.10 Employees are to inform YTHFM management of any potential shortcomings in employer's protection arrangements at the earliest opportunity using the appropriate medium to engage with YTHFM.

Contractors, Consultants and Visitors Responsibilities

4.11 Any person who is not directly employed by YTHFM but is undertaking work on its behalf, must not act in a manner that is prejudicial to the safety of others, whilst conducting their work and observe YTHFM health and safety policy and procedures. No contractor (this includes product demonstrations and trials) is to work on the client's premises unless they follow the Control of Contractor's Policy and Procedure the correct type of method statement and/or risk assessment has been completed and agreed by the relative manager. If work to be undertaken is particularly hazardous this must not commence until the appropriate permit to work is obtained from the appropriate relative source/manager.

5. Policy Arrangements

This policy will be delivered by:

1. Ensuring as a minimum the requirements defined in this policy are met, and as a wholly owned subsidiary of York Teaching Hospital NHS Foundation Trust (Trust) will follow and comply with wider corporate Trust policy, procedures and arrangements in place to ensure work activities are carried out safely.
2. Ensuring compliance with all service level agreements with the Trust and meet agreed key performance indicators.
3. YTHFM has in place robust governance arrangements and structures to effectively manage business process including safety.
4. Ensuring competent advice on related estates and facilities topics, ensuring appropriate arrangements[4] are developed as required and in place to fulfil YTHFM and Trust statutory duties and associated NHS guidance.

[3] *As defined in the Health and Safety at Work etc. Act 74, section 7 and Management of Health and Safety at Work Regulations 99, regulation 14*

5. Where YTHFM is required to carry out work activity, for other customers than the Trust, YTHFM shall in consultation and conjunction with the Trust develop our own specific or additional policy, procedure or arrangements that will ensure customers are provided with assurance of YTHFM safety credentials and that these arrangements are not in conflict with Trust policy.

6. Policy Distribution

6.1 This policy will be implemented throughout YTHFM and will be available via:

- The organisation's intranet
- Toolbox talks
- Forms part of the agreed YTHFM induction training programme.

7. Main Policy References

- Health and Safety at Work etc. Act 1974
- The Management of Health and Safety at Work Regulations 1999
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) (as amended).

8. Training

8.1 The contents of this policy forms part of the mandatory health & safety training delivered at induction and refresher courses.

9. Equality Impact Assessment

9.1 A copy of the Equality Impact Assessment for this policy is at Appendix A.

10 Accountability & Responsibilities

10.1 YTHFM corporate accountabilities and operational implementation, delivery and monitoring of this policy are defined in sections 4 and 5.

11. Consultation and Approval Process

11.1 The list below details the consultation, and approval process

- YTHFT Board of Directors/NHFML (for approval – reserved matter)
- YTHFM Management Board (for approval)
- YTHFM Senior Leadership Team;
- YTHFM Operational Management Group
- YTHFM Staffside Safety representatives (consultation)
- Group Health and Safety Committee (for information)
- Group JNCC (for information)

12. Document Control including Archiving

12.1 The register and archiving arrangements for policies will be managed by YTHFM.

13. Monitoring Compliance and Effectiveness

13.1 This policy will be monitored by YTHFM Management Board and in line with the Master Service Agreement (MSA) the Executive Performance & Assurance Meeting (EPAM) via reporting on compliance, safety performance, complaints and concerns.

14 Review and Revision Arrangements

14.1 The date of review is given on the front coversheet of this policy and noted in the footer of each page (this document is not controlled once printed; please ensure any printed copy is checked against YTHFM website).

14.2 The policy will be reviewed on an annual basis or earlier if subject to legislative changes.

Equality Impact Assessment Tool **Appendix A**

Name of Policy:	**YTHFM Health and Safety Policy**

1.	**What are the intended outcomes of this work?** The policy sets out the process for the YTHFM for effective health and safety management across all sites.	
2	**Who will be affected?** All YTHFM staff, temporary staff, contractors, including subcontractors and those carrying out demonstrations, visitors, patients and public etc. to the Trust and other customers.	
3	**What evidence have you considered?** Legislative compliance and OH&S guidance.	
a	**Disability -** The policy is inclusive	
b	**Sex -** The policy is inclusive	
c	**Race** - The policy is inclusive	
d	**Age** .- The policy is inclusive	
e	**Gender Reassignment** - The policy is inclusive	
f	**Sexual Orientation -** The policy is inclusive	
g	**Religion or Belief** - The policy is inclusive	
h	**Pregnancy and Maternity -** The policy is inclusive	
i	**Carers** - The policy is inclusive	
j	**Other Identified Groups** -The policy is inclusive	
4.	**Engagement and Involvement** The policy is inclusive	
a.	Was this work subject to consultation?	See below
b.	How have you engaged stakeholders in constructing the policy	See below
c.	If so, how have you engaged stakeholders in constructing the policy	See below
d.	For each engagement activity, please state who was involved, how they were engaged and key outputs. Engagement and involvement of the development of the policy has included relevant YTHFM staff and relevant Trust Lead for health and safety.	
5.	**Consultation Outcome** The policy references and meets the requirements of the Policy for the Development and Management of Policies and relevant legislation. *Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups*	
a	Eliminate discrimination, harassment and victimisation	The policy is inclusive
b	Advance Equality of Opportunity	The policy is inclusive
c	Promote Good Relations Between Groups	The policy is inclusive
d	What is the overall impact?	The policy is inclusive
	Name of the Person who carried out this assessment: Imran Khan, H&S Consultant	
	Date Assessment Completed 29 January 2021	
	Name of responsible Director (YTHFM) Delroy Beverley	

If you have identified a potential discriminatory impact of this procedural document, please advise the Director of Resources together with any suggestions as to the action required to avoid/reduce this impact.

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York Teaching Hospital
NHS Foundation Trust

Board of Directors – 31 March 2021
Policies, Trust-Wide Documents, and Service Level Documents – Development and Management Policy

Trust Strategic Goals:

☒ **to deliver safe and high quality patient care as part of an integrated system**
☐ **to support an engaged, healthy and resilient workforce**
☐ **to ensure financial sustainability**

Recommendation

For information	☐	For approval	☒
For discussion	☐	A regulatory requirement	☐
For assurance	☐		

Purpose of the Report

The purpose of the policy is to create a standardised approach to document management across the organisation. This policy has had approval from Quality & Patient Safety Group in January 2021. Following feedback from the Executive Committee in February 2021 some slight amendments were made and are highlighted in yellow. The Executive Committee is happy following these changes to recommend the Board of Directors receive this for final approval and sign off.

Executive Summary – Key Points

1. Standardised policy and procedure template across the organisation including prompts for information that is required.
2. Policy will allow for appropriate governance around the management of policies and documents.
3. Reduce the number of extended policy/documents by doing this on an exception basis only with approval from the relevant group/committee.
4. Streamline policies and documents to enable a Trust approach rather than site specific documents (where achievable)
5. Advocate the use of national guidance and legislation when creating and updating documents/policies within the Trust.

Recommendation

1. Approve this policy for use across the Trust.

Author: Shaun McKenna, Head of Compliance & Effectiveness

Director Sponsor: Heather McNair, Chief Nurse

Date: March 2021

Reference:

Policies, Trust-Wide Documents, and Service Level Documents - Development and Management Policy

Summary	This is the policy for the development and management of policies, procedures, and Trust documents within York and Scarborough Teaching Hospital NHS Foundation Trust ("The Trust")	
Keywords	Policy, policies, procedure, procedures, documents, policy management, policy development.	
Target audience	All staff employed by the Trust including bank and agency staff. All volunteers and students within the Trust.	
Date issued	TBC	
Approved & Ratified by	Patient Safety & Quality Group Trust Board	Date of meeting:
Next review date		
Author	Mike Boulton, Policy Manager Shaun McKenna, Head of Compliance	
Executive Director		

The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust Intranet is the most up-to-date version. **If, for exceptional reasons, you need to print a policy off, it is the responsibility of the department / care group to ensure the most up to date version is used.**

Version Control

Change Record

Date	Author	Version	Page	Reason for Change
05/01/2021	Mike Boulton Shaun McKenna	1		Draft Document

Reviewers/contributors

Name	Position	Version Reviewed & Date
Mike Boulton	Policy Manager	Version 1: 05/01/2021
Shaun McKenna	Head of Compliance	Version 1: 05/01/2021
Liam Wilson	Lead AHP for Patient Safety & Governance	Version 1: 05/01/2021

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1. Introduction

Organisations have a duty to have appropriate procedural documents in place that comply with legislation and/or reflect best practice to enable staff to fulfil the requirements of their roles safely and appropriately.

This policy sets out the requirements for the production, review, approval, and dissemination of all York Teaching Hospital NHS Foundation Trust (YTHNHSFT) documents. The policy will guide staff through the process, standards and format that authors must follow in the development and management of a document.

The management and control of procedural documents is essential, not only to comply with corporate and clinical governance requirements, but as a key means of ensuring standardisation in the provision of safe care and a safe working environment across the organisation.

All documents will be held electronically on the Trust's document management system (Q-Pulse) and will be published on the Trust's intranet (Staff Room). Staff must access the documents via the staff intranet to ensure the most up to date versions are accessed. The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust Intranet is the most up-to-date version.

The Trust is aware that there will be instances where hard copies are required. In this case it will be the responsibility of the department / care group to ensure processes are in place to ensure printed documents are controlled and the most up to date version is used.

2. Scope

This policy applies to all employees of the Trust including volunteers, students and bank/agency staff working within the Trust. All staff must adhere to the standards laid out in this guideline to ensure quality and consistency of all documents.

3. Duties and responsibilities

All employees are responsible for:

- Reading, complying with and maintaining up-to-date awareness of policies and procedures relevant to their role
- Accessing training and developing competencies to enable them to comply with policies and procedures relevant to their role and identified training needs

Managers/Leaders are responsible for:

- Enabling staff to access the most up-to-date local and Trust policies and procedures and monitoring adherence to them
- Ensuring staff can be released to attend/access training as required enabling the successful implementation of policies and procedures

Document Authors are responsible for:

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- Ensuring the requirements set out within this policy is upheld.
- Ensuring that the appropriate version control is included at the time of review and revision.
- Ensuring an Equality Impact Assessment is carried out for all Policies and Procedures. An Equality Impact Assessment should be considered for other Clinical Documents but will not be relevant to all.

Clinical Governance Facilitators are responsible for:

- Maintaining a database of current and archived Care Group Specific procedures / documents (Q-Pulse).
- Carrying out the quality control checks on all documents to ensure they meet the quality standards
- Uploading documents onto both the staff intranet (Staff Room) once approved and archiving previous versions ensuring that only the most up to date policies and procedures are available.

Policy Management Team is responsible for:

- Maintaining a database of current and archived Policies and Trust-Wide procedures/documents (Q-Pulse)
- Carrying out the quality control checks on all documents to ensure they meet the quality standards
- Uploading documents onto both the staff intranet (Staff Room) once approved and archiving previous versions ensuring that only the most up to date policies and procedures are available.

Working / Expert Groups are responsible for:

- Ensuring the requirements set out within this policy is upheld.
- Identifying requirements for Trust documents relevant to their area.
- Identify appropriate author(s) to produce the required Trust documents.
- Reviewing new and revised documents prior to approval.
- Approve documents relevant to their area.

Care Group Quadrumvirate is responsible for:

- Ensuring the requirements set out within this policy is upheld.
- Identifying requirements for Trust documents relevant to their area.
- Identify appropriate author(s) to produce the required Trust documents.
- Reviewing new and revised documents prior to approval.
- Approve Care Group specific procedures / documents.

Committees are responsible for:

- Ensuring the requirements set out within this policy is upheld.
- Approving Trust policies where appropriate, as and when delegated from the

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Trust Board.

Executive Directors are responsible for:

- Ensuring the requirements set out within this policy is upheld.
- Identifying requirements for Trust documents relevant to their area.
- Identify appropriate author(s) to produce the required Trust documents.
- Approving Trust policies where appropriate.

The Trust Board is responsible for:

- Ratification of all Trust policies (This may be delegated to an appropriate committee)
- Ensuring appropriate delegation of policies to Committee's for ratification.

The Chief Executive Officer is responsible for:

- The overall content of all Trust policies and their subsequent implementation.

4. Main Content

4.1. Document Standards & Templates

Authors must adhere to the following standards for all Trust documents:

- All Documents must be written in plain English, with clear and concise sentences.
- The trust logo must be visible on the top of all Trust documents.
- Version control must be clearly identified on all Trust documents.
- Abbreviations must only be used after being written in full for the first time, but should be avoided where possible.
- Use font "Arial" at size 12 for all text within the body of the document.
- Use font "Arial" in bold size 12 for all subheadings in the document; do not use the underline function.
- Use line spacing 1.15 for all text within the document.
- All documents must be watermarked as "Draft" until they have received approval.
- Trust Policy Template – Appendix 1 – Prompts are included within the template and must be followed.
- Trust Standard Operating Procedure – Appendix 2 – Prompts are included within the template and must be followed

Although the above standards must be used for all documents within the Trust, there is no standard template for service level documents; there are numerous different options available and a standard approach to this could impact on the quality of the document. It is essential that Expert / Working Groups and Care Groups have a standardised approach to service-level documents where possible.

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4.2. Creating and Approving a Policy / Trust-Wide Document

Rationale

An Executive Director, Expert/Working Group or Care Group Quadrumvirate can identify the need for a new Policy / Trust-Wide Document. This may be because there is no existing policy covering an identified subject, or due to national directives indicating the need for Trust action. Any requests for a policy or Trust-Wide Document should be made to the relevant Executive Director, Expert/Working Group or Care Group Quadrumvirate.

Author(s) Identification

An Executive Director, Expert / Working Group or Care Group Quadrumvirate identifies the most appropriate author(s), confirming the rationale for requiring the document.

Review of Existing Documents

The author(s) must review the existing policies/documents within the Trust to ascertain whether a new policy/document is required or if a current policy/document can be updated / amended. All relevant documents already in use within the Trust must be captured within the overall policy / Trust document.

Literature Review

The author(s) must carry out a literature review to ensure the Policy / Trust-wide document includes the latest legislation, evidence base, and national guidance. *Useful resources include: Department of Health, Care Quality Commission, National Institute for Health and Clinical Excellence, Royal Colleges and Professional bodies, Cochrane library, and NHS Employers (The Trust Library services are happy to assist with literature searches if required).*

Draft Document

The author(s) must compile the draft Policy / Trust-wide document following the guidance set out in this policy.

Consultation

The author(s) must circulate the draft document to a diverse sample of the target audience and relevant services for feedback. The consultation period should be at least two weeks to allow for an adequate response.

The author(s) should also consider whether it is appropriate to circulate the draft document to service user and patient groups for feedback. It may also be appropriate to circulate to external stakeholders for comment.

The author(s) must liaise with the authors of any associated documents to ensure they are appropriately cross referenced / linked and are consistent with each other.

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Final Draft Document
The author(s) must amend the document, as appropriate, following any feedback from the consultation. The document must then be submitted to the requesting Executive Director, Expert / Working Group, or Care Group Quadrumvirate for approval.

Final Draft Document Review
The document must be reviewed by the requesting Executive Director, Expert / Working Group, or Care Group Quadrumvirate. The review must ensure that the standards set out in this policy have been adhered to. Please note that some documents may require final approval from the Trust Board or a delegated committee. (Please contact PolicyManagement@york.nhs.uk if this is not made clear by the requestor)

Document Approval
The requesting Executive Director, Expert / Working Group, or Care Group Quadrumvirate must ensure there is evidence of minutes from the meeting where the document has been approved. The document, along with the meeting minutes must be sent to PolicyManagement@york.nhs.uk to enable the upload to the central database (Q-Pulse) and the staff Intranet (Staff Room). Please note that some documents may require final approval from the Trust Board or a delegated committee. (Please contact PolicyManagement@york.nhs.uk if this is not made clear by the requestor)

HR Documents
Documents are updated in line with changes in legislation; updated terms and conditions or in response to evolving local strategies. The draft is shared with trade union colleagues and discussed / negotiated through the Employment Policy Group (EPG). Once agreed the final draft is submitted to either the Joint Local Negotiating Committee (JLNC) for medical staff or the Joint Negotiating Committee (JNCC) for non-medical staff to be ratified.

System Upload
The policy management team will allocate a reference number to the document and will publish the document on the central database (Q-Pulse) and the staff Intranet (Staff Room) once final approval has been given.

Information about new and reviewed Trust documents will be cascaded on the Trust intranet (Staff Room) and via the monthly staff newsletter. All staff are expected to follow the document once it is published on the intranet. The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust Intranet is the most up-to-date version.

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Ongoing management
Existing Policies and Trust-Wide Documents must be reviewed when a review date is reached – usually 3 year intervals (suggested) or when guidance / practice has changed, whichever occurs first. Extensions will not be routinely allowed; in exceptional circumstances requests for extensions must be made to the relevant committee with associated discussions evidenced in the minutes of the meeting.

4.3. Creating and Approving a Service Level Document

Rationale
An Expert/Working Group, Care Group Quadrumvirate, or specialty level triumvirate can identify the need for a Service Level Document. This may be because there is no existing service level document covering an identified subject, or based on learning from events. Any requests for a service level document should be made to the relevant Expert / Working Group, Care Group Quadrumvirate, or Specialty Level Triumvirate

Author(s) Identification
The Expert / Working Group, Care Group Quadrumvirate or Speciality Level Triumvirate must identify the most appropriate author(s), confirming the rationale for requiring the document.

Review of Existing Documents
The author(s) must review the existing policies/documents within the Trust to ascertain whether a new document is required or if a current document can be updated / amended. All relevant documents already in use within the Trust must be considered for use before creating a new document.

Literature Review
The author(s) must carry out a literature review to ensure the document is based upon the latest legislation, evidence base, and national guidance. *Useful resources include: Department of Health, Care Quality Commission, National Institute for Health and Clinical Excellence, Royal Colleges and Professional bodies, Cochrane library, and NHS Employers (The Trust Library services are happy to assist with literature searches if required).*

Draft Document
The author(s) must compile the document following the guidance set out in this policy.

Consultation
The author(s) must circulate the draft document to a diverse sample of the target audience and relevant services for feedback. The consultation period should be at

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least two weeks to allow for an adequate response.

The author(s) should also consider whether it is appropriate to circulate the draft document to service user and patient groups for feedback. It may also be appropriate to circulate to external stakeholders for comment.

The author(s) must liaise with the authors of any associated documents to ensure they are appropriately cross referenced / linked and are consistent with each other.

Final Draft Document

The author(s) must amend the document, as appropriate, following any feedback from the consultation. The document must then be submitted to the requesting Expert / Working Group, Care Group Quadrumvirate or Speciality Level Triumvirate for approval.

Final Draft Document Review

The document must be reviewed by the requesting Expert / Working Group, Care Group Quadrumvirate or Speciality Level Triumvirate. The review must ensure that the standards set out in this policy have been adhered to.

Document Approval

The requesting Expert / Working Group, Care Group Quadrumvirate or Speciality Level Triumvirate must ensure there is evidence of minutes from the meeting where the document has been approved. The document, along with the meeting minutes must be sent to the Care Group Governance Facilitator to enable the upload to the central database (Q-Pulse) and the staff Intranet (Staff Room).

System Upload

The Clinical Governance Facilitator or nominated person within a service will allocate a reference number to the document and will publish the document on the central database (Q-Pulse) and the staff Intranet (Staff Room) once final approval has been given.

Information about new and reviewed Trust documents will be cascaded on the Trust intranet (Staff Room) and via the monthly staff newsletter. All staff are expected to follow the document once it is published on the intranet. The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust Intranet is the most up-to-date version.

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Ongoing management
Existing Service Level Documents must be reviewed when a review date is reached – usually 3 year intervals (suggested) or when guidance / practice has changed, whichever occurs first. Extensions will not be routinely allowed; in exceptional circumstances requests for extensions must be made to the relevant committee with associated discussions evidenced in the minutes of the meeting.

5. Training Requirements

Clinical Governance Facilitators / Nominated persons within a service will receive training on Q-Pulse to enable them to effectively manage Service Level Documents.
Q-Pulse training can be provided to any staff member if the decision is reached for them to update Q-Pulse; this will be facilitated by the Policy Management Team. Please contact PolicyManagement@york.nhs.uk if this is required)

6. Monitoring Compliance

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements
Policies and Trust-Wide Documents to be within their review date.	Policy Manager	Monthly report generated from Q-Pulse to Head of Compliance.	Monthly	Quality & Patient Safety Group Medical Director Report
Service Level Documents to be within their review date.	Clinical Governance Facilitator	Monthly report generated from Q-Pulse	Monthly	Care Group Governance.

7. Document Review

This document will be reviewed every 3 year, or sooner if changes to practice / legislation occur.

8. Associated Trust Documents

Nil

9. References

Nil

10. Definitions

Term	Definition
Policy	A set of statements documenting the standards, intentions and/or expectations of how a practice or course of action will be implemented and adopted. It is considered binding and a breach

	of policy may have contractual consequences for the employee. Staff must follow policies.
Standard Operating Procedure (SOP)	A step by step guide about how a particular task or procedure should be carried out.
Trust-wide Document	A Trust-wide Document is considered a document which spans more than one Care Group. This includes SOP's, guidelines, flowcharts, pathways etc.
Service Level Document	A Service-Level Document is considered a document which spans an individual service or is retained within a Care Group. This includes SOP's, guidelines, flowcharts, pathways etc.

11. Equality Impact Assessment

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service population and workforce, ensuring that none are placed at a disadvantage over others. The Equality Impact Assessment has been completed in Appendix 3.

Appendices

Appendix 1: Trust Policy Template - **Embed link**

Policy Template.docx

Appendix 2: Trust Standard Operating Procedure **Embed link**

SOP Template.docx

Appendix 3: Equality Impact Assessment **Embed link**

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York Teaching Hospital
NHS Foundation Trust

Board of Directors – 31 March 2021
Group Modern Slavery and Human Trafficking Act 2015

Trust Strategic Goals:

☒ **to deliver safe and high quality patient care as part of an integrated system**
☒ **to support an engaged, healthy and resilient workforce**
☒ **to ensure financial sustainability**

Recommendation

For information	☐	For approval	☒
For discussion	☒	A regulatory requirement	☐
For assurance	☐		

Purpose of the 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.

Executive Summary – Key Points

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 and LLP Management Group.

The aim of the statement is to encourage transparency within organisations. There are potential consequences for organisations who fail to produce a slavery and human trafficking statement for a particular year.

The statement has been prepared on a Group basis.

Recommendation

The Board is invited to approve the Modern Slavery Act Statement for publication on the Trust's website and members should support the Trust to foster a culture in which modern slavery is not tolerated in any form.

Author: Jill Hall, Foundation Trust Secretary

Director Sponsor: Simon Morritt, Chief Executive

Date: March 2021

Modern Slavery and Human Trafficking Act 2015
Annual Statement 2021

York Teaching Hospital NHS Foundation Trust and York Teaching Hospital Facilities Management LLP 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 and York Teaching Hospital Facilities Management LLP provide 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 approximately £0.5bn. We manage 8 hospital sites, 1,127 beds (including day-case beds) and have a workforce of over 9,000 staff working across our hospitals and in the community.

The Group have internal policies and procedures in place that assess supplier risk in relation to the potential for modern slavery or human trafficking. There are robust recruitment policies and processes in place, including conducting eligibility to work in the UK checks for all directly employed staff and agencies on approved frameworks.

There are a range of equal opportunities controls in place to protect staff such as a Freedom to Speak Up Guardian, Fairness Champions and a Raising Concerns and Whistleblowing Policy.

The Group has in place a Standards of Business Conduct Policy which covers the way in which the organisation and staff behave.

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 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.

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 Group has written to its top supplier requesting them to affirm their compliance with the legislation.

Modern Slavery is referenced in the 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. In addition the safeguarding adults team has a delegated Modern Slavery Lead to ensure that all relevant national, regional and local context is embedded in

processes in a timely manner. In the last year the Safeguarding Adults team have developed networking relationships with Trading Standards where concerns cans be raised with them without breaching patient confidentiality.

The Group 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 Group's position around anti-slavery and human trafficking.

Aim

The aim of this statement is to demonstrate the Group 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

…………………………………
Simon Morritt
Chief Executive

25 March 2021

……………………………
Mike Keaney
Chair (YTHFM LLP)

…………………………………..
Delroy Beverley
Managing Director (YTHFM LLP)

NHS
York Teaching Hospital
NHS Foundation Trust

Board of Directors – 31 March 2021
Standards of Business Conduct Policy

Trust Strategic Goals:

☒ **to deliver safe and high quality patient care as part of an integrated system**
☒ **to support an engaged, healthy and resilient workforce**
☒ **to ensure financial sustainability**

Recommendation

For information	☐	For approval	☒
For discussion	☐	A regulatory requirement	☐
For assurance	☐		

Purpose of the Report

To seek approval to the small revision to the Standards of Business Conduct Policy.

Executive Summary – Key Points

A control improvement audit has been carried out on the Standards of Business Conduct Policy and it was noted that the policy requires all registers to be published on the website. However, the minimum standard is the publication of the Gifts and Hospitality register. It has therefore been decided to remove the gold standard of publishing all registers until the Trust has done further work to raise awareness of the policy's requirements to all staff.

The revision is on page 11 of the policy, section *5.2 Publication:*

The Trust will:

- Publish the interests declared by decision making staff in
  - Register of Secondary Employment;
  - Register of Pecuniary (Financial) Interests;
  - Register of Hospitality, Gifts or Sponsorship.

- Refresh this information annually;
- Make the Register of Hospitality, Gifts or Sponsorship available on the Trust's website.

Recommendation

The Board of Directors is asked to approve the revised policy.

Author: Jill Hall, Interim Foundation Trust Secretary

Director Sponsor: Simon Morritt, Chief Executive

Date: March 2021

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NHS
York Teaching Hospital
NHS Foundation Trust

Board Assurance Framework

Board Assurance Framework – At a glance

Strategic Goals

- **To deliver safe and high quality patient care as part of an integrated system**
- **To support an engaged, healthy and resilient workforce**
- **To ensure financial stability**

Goal	Strategic Risks	Exec Lead	Quality of Resources	Original Risk Score	Residual Risk Score	Target Risk Score
Patient Care	1. Failure to maintain and improve patient safety and quality of care	CN	Quality	25	25 ↔	6
Patient Care	2. Failure to maintain and transform services to ensure sustainability	COO	Quality	20	20 ↔	6
Patient Care	3. Failure to meet national standards	COO	Quality	25	20 ↔	1
Patient Care	4. Failure to maintain and develop the Trust's estate	FD	Resources	25	16 ↔	9
Digital & Information	5. Failure to develop, maintain/replace and secure IT systems impacting on security, functionality and clinical care	CDIO	Resources	20	16 ↔	12
Workforce	6. Failure to ensure the Trust has the required number of staff with the right skills in the right location	W& OD	Resources	25	20 ↔	9
Workforce	7. Failure to ensure a healthy, engaged and resilient workforce	W& OD	Resources	20	16 ↔	6
Workforce	8. Failure to ensure there is engaged leadership and strong, effective succession planning systems in place	W& OD	Resources	16	12 ↔	1
Finance	9. Failure to achieve the Trust's financial plan	FD	Resources	25	9 ↔	6
Finance	10. Failure to develop and maintain engagement with partners	COO	Quality	16	9 ↔	4
Finance	11. Failure to develop a trust wide environmental sustainability agenda	CN	Quality	20	12 ↔	1
Finance	12. Failure to achieve the System's financial plan	FD	Resources	25	9 ↔	6

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Principal Risk: (1) Failure to maintain and improve patient safety and quality of care <u>Causes</u> – staffing vacancies, infection rates including Covid, limited capital available for remedial and development work <u>Effects</u> – staffing issues, ward closures, issues with old estate and equipment **Lead Committee:** Board (last formal review – Jan 21) **Director Lead:** Chief Nurse	Risk Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 5 Score: 25	Likelihood = 5 Severity= 5 Score: 25	Likelihood = 2 Severity= 3 Score: 6

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)

Trust Committee/Governance Structure including
Strategies, Policies & Procedures
Systems &Monitoring
- Incident Reporting, SIs/Never Event Reports, Claims, Quality Priorities
- CQUINs & contract monitoring
- Recording of escalation systems NEWS etc
- Medicines Management/EPMA implementation
- National Surveys, NICE, NSF & Clinical Audit
- Capital Programme
- Maternity CNST
- Performance & accountability (reviews/ dashboards)
Statutory and mandatory training
7 day working local adaptations
Lead medical examiner role introduced
Covid 19 intn/extn command structure together with specific SOPS, IPC BAF and risk assessed measures for management of beds and waiting lists
	- External inspections incl CQC Reports
	- Internal Audit Programme
	- CQC and Choices website feedback
	- SHMI
	- New Clinical Environment Risk Group implemented to oversee backlog maintenance spend risk management
	- National Survey Action Plans, Friends & Family Test
	- Reports incl Premises Assurance Model, PLACE/TAPE, Patient Experience, Pressure Ulcer & Falls, Mortality/Learning from Deaths, IPC, IBR, maternity, staffing, Health & Safety, Safeguarding Childrens & Adults
	- Quality Report
	- Patient Safety Walk Rounds
	- NICE, NSF and Clinical Audits/Effectiveness Reports
	- Learning Hub Data
	- 7 day audit – 7 day task & finish group & plan
	- Integrated Board Report
	- COO led monthly operational performance meetings with each Care Group
	- CEO led efficiency meetings with each Care Group
	- QIA of each efficiency scheme signed off by MD and Chief Nurse.
		- CQC Unannounced visit & Well Led responses and action plans (monthly monitoring at Board & Quality Committee) - the transitional regulatory self-assessment due to Quality Committee January 2021 will indicate further actions required to achieve compliance **(Jan 21).**
		- Implementation of 7 day working systems and controls
		  - Jnr Drs Contract (National)
		  - 2003 Consultants Contract does not facilitate 7 day working(National) **(current position review quarterly)**
		- Risk registers are not fully aligned - Full review of risk registers to ensure risks appropriately rated and managed **(April 2021)**
		- Governance structures have some gaps affecting the effectiveness of ward to Board communication - New Corporate Clinical Governance Structure implemented November 2020, however, further improvement work required at Care group level to improve processes. To support this a Governance Facilitator development programme is to be delivered to enhance care group knowledge of clinical governance **(Review June 2021)**
		- Quality of SI investigations identified as variable and learning not sufficiently embedded - Quality improvement project underway to redesign the incident management processes (including serious incidents and learning) **(July 2021)**
		- Staffing Vacancies PEM consultant Scarborough, medical staffing at Scarborough and nursing – East Coast Review looking at sustainability – **(quarterly review)**
		- C Diff rates at Scarborough due to estate issues/limited capital funds - Infection Control - NHSE/I Lead Review & Report – Capital prioritisation due to take place in Feb 21 at Exec Committee **(Apr 21)**
		- Under performance against key national targets and standards - Care Group improvement programmes & performance recovery plans

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	- Medical Examiner appointed - Local ownership of MCA/DoLS – matrons audit carried out - MCA/DoLS action plans/reaudit- took place in Nov 19 with action plans now in place & no significant concern raised. - Performance recovery plans - Performance framework (OPAMs) - Daily and weekly Covid 19 actions logs - Review at weekly gold CEO led group - Covid 19 dashboard - Submission of required Covid 19 returns for assurance	developed by each Care Group **(reviewed & updated monthly)** - Surge plan if social distancing ineffective – Surge plans in place **(Apr 21)** - Critical care capacity – establishment of Nightingale Y&H facility – transfer of care – internal surge plan and use of HCV ICS option **(quarterly review)** - Access & maintenance of adequate oxygen supply – oxygen guidance documents in place for each site – 2 flow monitors purchased **(review quarterly)** - Access to appropriate supply & distribution of PPE – compliant with national push stock system, daily national reporting, dedicated stores (Y&S), mutual aid in place, part of ICS emergency stock holding centre **(quarterly review)** - Increased risk of secondary deaths due to services not being accessed and impact of long waits for elective surgery. Clinical harm SOP in development to ensure capture and investigation of clinical harms. **(February 2021)** - Possible increased risk to children & adults in community due to social distancing - Safeguarding Team aware of risk to vulnerable adults & children – access to team for advice & support established during this period (**review Mar 21)** - Possible increased risk that some routine elements may be negatively impacted due to reduced reporting or staff absence

Principal Risk: (2) Failure to maintain and transform services to ensure sustainability <u>Causes</u> – Covid 19, Staffing levels, Capacity & Demand, Capital <u>Effects</u> – Sustainability, Service Constraints **Lead Committee:** Board (last formal review – Jan 21) **Director Lead:** Chief Operating Officer	Risk Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 4 Score: 20	Likelihood = 5 Severity= 4 Score: 20	Likelihood = 2 Severity= 3 Score: 6

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)
- Trust Committee & Governance Structure • Executive Directors Portfolios – Chief Operating Officer is the Trust Transformation Lead • Operational Performance & Assurance Meeting (OPAM) – escalation of key services issues that affect sustainability & service eg: performance, quality, workforce, finance & identification of improvement/ transformation opportunities • Care Group Boards (x6) - responsibility for the effective delivery of sustainable services • Business case management system for significant service change • Performance Management Framework - The Trust works in partnership to identify & deliver service transformation & sustainability; including: • HCV ICS, including Clinical Leads Network and Acute Care Collaborative. • Operational Delivery Networks eg: Stroke/ Critical Care • North Yorkshire and York System Leaders Executive • Joint Planned Care Board • HCV Cancer Alliance & Trust Cancer Strategic Board • Health and Care Resilience Board • SGH Services Review • Facilitated External review, eg: ECIST, Elective IST, GIRFT & Model Hospital • Health & Well-Being Boards • Local Resilience Forums • Contract Management Arrangements	A range of regular reports are provided to monitor delivery of our work. These include: - Integrated Board Report - Executive Committee Forward Plan and reports, e.g. SGH Services Review, Winter Resilience, Business Cases and Care Group Escalations Reports are shared with system partners as required. Minutes and action logs from partnership meetings are shared across the Operational leadership to ensure Trust actions are implemented. Humber Coast and Vale and Regulatory action plans, including: - Operational Plans - COVID operational plans, Phase2, Phase 3 - Scenario testing of surge plans - CQC action plans - Winter planning and Resilience plans: system escalation structures.	- Sustainable workforce in particular at the East Coast <u>Actions:</u> SGH Services Review and appointment of Programme Director to drive change and delivery. Post commenced in 23rd November 2020 **(Quarterly Review)** - Establishment of East Coast Leadership Team, Deputy Chief Operating Officer, Deputy Chief Nurse and Deputy Medical Director from 4th January 2021 (**Quarterly Review)** - Capacity across Hospital Estate and wider partnerships to deliver transformational pathways (financial constraints, capital constraints) <u>Action</u>: Engagement in system partnerships to explore options for capital monies to support estate reconfiguration, equipment opportunities and collaborative pathways, e.g. Emergency Department Capital Schemes **March 2021** - Trust wide clinical strategy (in development) Action: Clinical Strategy Programme Director commenced in post September 2020. **(Quarterly Review)**

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Principal Risk: (3) Failure to meet national standards Causes – Covid 19 pressures, increased demand, recruitment issues, capacity issues Effects – targets not met, increased risk of harm to patients, regulatory intervention, patient dissatisfaction **Lead Committee:** Board (last formal review – Jan 21) **Director Lead:** Chief Operating Officer,	Risk Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 5 Score: 25	Likelihood = 5 Severity= 4 Score: 20	Likelihood = 1 Severity= 1 Score: 1

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)
- Trust/Committee Governance Structure - Corporate Performance Team - Performance Management Framework – including Business Managers across the Care Group Structure and processes for escalation and resolution through Operational Performance Assurance Meetings and Executive Committee. - Commissioner and provider forums - Trust Operational Planning – Annual cycle supported by weekly and monthly monitoring - Winter Resilience & Emergency Planning Functions - Strategies, Policies & Procedures including operational plans - Training & Development incl. Capacity/demand Elements of assurance framework deferred ie: work plans, engagement with Internal Audit and 'routine' operational planning. In line with national guidance, usual reporting arrangements have been suspended. Current reports as per national requirements but minimal.	The Trust receives assurance through - Reports and the Integrated Board Report - Live, daily and weekly management information through corporate dashboards - Externally commissioned reports, e.g. EY - CQC action plans - Performance Recovery Plans - Winter Resilience Plan - Emergency Planning - including scenario testing. - E & Y Reports - External Benchmarking of systems and pathways - Internal Audit Programme - Operational Performance Recovery Plan - Winter Plan/System Resilience Plan - SAFER Local Delivery Plan - Planned Care Transformation Plan - Validation - Operational Plan - Learning Hub Data	- Sustainable delivery of access targets at the East Coast: Actions: - Programme Director appointed for Scarborough Services Review commenced 23rd November. **(Quarterly Review)** - Establishment of East Coast Leadership Team, Deputy Chief Operating Officer, Deputy Chief Nurse and Deputy Medical Director from 4th Jan 2021**(Quarterly Review)** - HCV HCP capital bid for SGH – business case approved & machines on site – Trust working to national timetable for submissions **(review quarterly)** - Continued challenges around achieving the ECS on a sustainable basis Action: - ECS Daily Monitoring (Ongoing daily Review) - Breach Review **(weekly)** - Ambulance handover action plan developed – improvement trajectory agreed with NHSI **(reviewed monthly)** - Delivery of long wait routine care as a result of the national pandemic: Actions: - Surge Plan actions (elective stand down SOP) to minimise and mitigate patient impact during wave 3. - Phase 3 recovery plan for elective care, supported by weekly monitoring **(monthly review to Quality Committee)**

Principal Risk: (4) Failure to maintain and develop the Trust's estate <u>Causes</u> - due to lack of resources including capital and staffing, volume of work required <u>Effects</u> – worsening of backlog maintenance issues, substandard estate, regulatory intervention **Lead Committee:** Board (last formal review – Jan 21) **Director Lead:** Finance Director	Risk Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 5 Score: 25	Likelihood = 4 Severity= 4 Score: 16	Likelihood = 3 Severity= 3 Score: 9

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)
- Trust Committee/Governance Structures o SLAs between Trust and LLP – contract management structure o LLP Committees/Governance Structure - Strategies, Policies & Procedures o Capital Programme o Estates Strategy o PLACE/TAPE Programme o Compliance Report Schedule o HCV Estates Strategy	- Compliance with P21+ and DH approved process for specific capital schemes - Condition Surveys - HCV HCP Capital Group Reports & Minutes - Internal Audit Programme - NHS Premises Assurance Model - Board/Committee Reports incl: Compliance, Capital, Sustainable Development, Health Safety & Fire - Full site backlog maintenance survey - Prioritised backlog maintenance register - Enhanced transparency of capital programme management via Executive Committee & Board.	1. Lack of capital to maintain/develop Trust estate – Pursuing discussions with ICS over access to supplementary PDC **(Quarterly Review) –** Commissioned RIBA 0, 1 and 2 reviews of key development issues in order to support business case development **(Quarterly Review) –** Seeking to place the Trust in the best possible position to bid for nationally released PDC funding **(Quarterly Review) -** Targeted and proactive use of Trust depreciation funding to remedy critical infrastructure issues **(Quarterly Review) -** Business planning process 21-22 has included a full Care Group and supporting Directorates assess of capital investment needs. This will be prioritised at Exec Comm on the 3.2.21 **(Feb 21)** 2. Work associated with realigning wards for Covid has meant some minor works have been deferred (although some work has taken place) 3. Some key projects aligned to the CQC plan have been put on hold ie childrens area in York ED - CQC Plan areas ie: childrens area in York ED will be delivered from emergency Covid 19 **(Mar 21)** 4. Capacity of the LLP to support the Covid 19 expanding work programme – Procurement of temporary capacity **(Jan 21)** 5. LLP ability to monitor full set of KPIs and provide assurance – procuring LLP KPI automated monitoring system (CAFM)**(Apr 21)** 6. Cultural acceptance of poor quality environment – Cultural work underway in LLP **(July 21)**

Principal Risk: (5) Risk of a failure to develop, maintain, replace and secure information and technology systems in a timely manner. Causes - increased demand , increased complexity, limited capacity (technical, workforce and financial funds) and capability (technical, workforce) Effects - data breaches, regulatory fines, loss of reputation, inefficient ways of working **Lead Committee:** Board Quarterly (last forma review – Jan 21) **Director Lead:** CDIO	Risk Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 4 Score: 20	Likelihood = 4 Severity= 4 Score: 16	Likelihood = 3 Severity= 4 Score: 12

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	**Assurance** (Where our controls/ systems on which we are placing reliance, are effective)	**Gaps in Control/ Assurance** (Where we are failing to put control/ systems in place)

- CDIO appointment August 2020
- Statutory, contractual and quality reporting
- Care Group support being provided
- Dashboards and reports being produced
- Collaborative working with partners
- Inpatient clinical coding function being delivered
- Business continuity and disaster recovery plans being reviewed
- Information Asset Owners and System Owners being identified and appointed
- Reporting structure into Exec Committee, Resources and Board
- To continue to support
    - On-call Service
    - Internal monitoring/alerting systems
    - Third Party Monitoring
    - Ongoing User Awareness Programme
	- External & Internal Audit Reports
	- External review and Health Check
	- Information Governance Exec Group Reports
	- Board NHSI Declaration – Data Security & Protection Requirements
	- Learning Hub Data
	- DSP Toolkit Compliance
	- Information Asset Owner Register
	- Cyber Security Assessment & Action Plan
	- SUS Data Quality
	- Incident Management reporting and learning
	- CDIO immediate observations and recommendations – September 2020 to committees and board.
	- Coding audits
		Lack of capacity and capabilities in the team - Case for staffing increase to be discussed as part of the business planning process **(Apr 2021)**, Develop proposals for shared services and partnering across the region/ICS **(Apr 2021)**
		
		Lack of operational funds - Develop the case for staffing increase across critical roles (Jan 2021), Develop the case for external funds through close working across the ICS, with NHSX **(Apr 2021)**
		
		Lack of capital funds - Develop the case to secure funding for essential services program capital scheme (Feb 2021), Develop the case for external funding sources through close working across the ICS, with NHSX **(Apr 2021)**
		
		Lack of prioritisation or strategic alignment of work coming into DIS - Deliver new Project and Portfolio Management approach to bring rigour to project delivery, set priorities and manage the pipeline of work into DIS **(May 2021)**
		
		Lack of CCIO, Digital Nurses and AHPs available capacity to work with DIS on delivery - Develop Digital Ready Workforce and Leadership Plan **(Apr 2021)** - Develop proposals for modern change methodology to be introduced to the Trust to all change projects going forwards to ensure outcomes are achieved/benefits realised in the most effective way**. (Apr 2021)**

	-	Lack of Digital Leads or "Business Partners" embedded into care groups - Develop Digital Ready Workforce and Leadership Plan **(Apr 2021)** – Subject to funding develop proposals for modern change methodology to be introduced to the Trust to all change projects going forwards to ensure outcomes are achieved/benefits realised in the most effective way. **(Apr 2021)** Lack of effective and standard change methodology or approach – Subject to funding develop proposals for modern change methodology to be introduced to the Trust to all change projects going forwards to ensure outcomes are achieved/benefits realised in the most effective way. **(Apr 2021)**

Principal Risk: (6) Risk of failure to ensure the Trust has the required number of staff with the right skills in the right location <u>Causes</u> – inability to recruit the levels of nursing/medical staff required especially on the East Coast, limited applicants available in some specialties, national policy on training numbers <u>Effects</u> – Compromised service delivery, limited capacity to open surge/esc areas, regulatory scrutiny **Lead Committee:** Board Quarterly (last formal review – Jan 21) **Director Lead:** Dir. of Workforce and OD	Risk Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 5 Score: 25	Likelihood = 5 Severity= 4 Score: 20	Likelihood = 3 Severity= 3 Score: 9

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	**Assurance** (Where our controls/ systems on which we are placing reliance, are effective)	**Gaps in Control/ Assurance** (Where we are failing to put control/ systems in place)
- Workforce & OD Strategy & workforce redesign - People Plan - HCV HCP Workforce Strategy - Bank Management and Governance - Appraisal processes – Job Plans - Apprenticeship & Volunteering Programmes - Overseas Recruitment - Statutory and Mandatory Training - East Coast Medical Recruitment Programme - SLAM course - CleverTogether staff engagement forums and outcomes Covid19 specifically - Skills questionnaire to enable safe deployment of staff Homeworking enabled where possible 7-day swabbing service for staff and household members NHS Covid 19 App Health and Wellbeing measures to support resilience Race Equality Network	- Staff Survey/Staff FFT - National standards & visits - Trust Committee/Governance Structure - - ROA reporting to HEE - Internal audit programme - Programmes designed and evaluated by HEI and NHS Elect - SSW/FTSUG Monitoring Reports - Board & Committee reports - Data from E-rostering Data/CHPPD, Learning Hub, Exit Questionnaires - NHSI maintaining workforce safeguards - QIA for new nurse roles Covid 19 update Real time sickness data being captured through central 'hub' Staff requiring isolation to be signed off via OH and placed on medical suspension	- Work/life balance expectations of the future workforce - Objective Structural Clinical Exam (OSCE) - International Nurse recruitment **(Mar 21)** - Age Profile – Workforce Plan **(Oct 21) -** Health & Wellbeing Initiatives being implemented **(Jan 22)** - Workforce planning - Apprenticeship Steering Group Outputs **(Jul 21) -** Continue to develop Bank **(Dec 21)** - Effective utilisation of E Rostering Tool – Electronic E Rostering roll out **(Jan 23) -** Medical rostering system (not yet procured. BC **approved Sept 20**) - Implementation of electronic job planning - e-Job Planning **(Oct 21)** - HEE Policy – jr dr allocations - HCV HCP Workforce Action Plan **(Oct 21)** - Organisational Culture - Clever Together actions **(Mar 21) -** Revised Agile Working Policy approved, but needs embedding **(Oct 21)** - Medical Staffing gaps - East Coast medical recruitment project **(on-going)**

Principal Risk: (7) Risk of failure to ensure a healthy engaged and resilient workforce Causes – high levels of Covid related absence, constant pressure in the system ie: Covid, winter, flu Effects – Compromised service delivery, organisation culture, regulatory scrutiny, lowering of morale and wellbeing, limited capacity, vacancy rate across nursing/medical, increased staff attrition **Lead Committee:** Board Quarterly(last formal review – Jan 21) **Director Lead:** Director of Workforce & OD	Risk Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 4 Score: 20	Likelihood = 4 Severity= 4 Score: 16	Likelihood = 3 Severity= 2 Score: 6

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	**Assurance** (Where our controls/ systems on which we are placing reliance, are effective)	**Gaps in Control/ Assurance** (Where we are failing to put control/ systems in place)
- Occupational Health Service/EAP - Junior Doctor Forum & LNC/JNCC - Workforce & OD Strategy - Star Awards/Celebration of Achievement & Benefits programme - Recruitment and Retention Processes - Workforce redesign - Appraisal processes – Job Plans - Schwartz Rounds & RAFT - Emergency planning - Statutory and Mandatory Training - FTSU/SWG & Fairness Champions Covid 19 update: Psychological support increased – drop in sessions (now virtual) for staff working in cohorted areas. Tailored Schwartz rounds Headspace app being pursued Clear daily communication updating staff Staff testing for Covid 19 – Test & Trace Helpline and support sessions staffed by Clinical Psychologists RAFT/TiPi Apps to support mental wellbeing (Headspace, unmind and Sleepio). 7-day swabbing service for staff and household members Resilience Training	- Staff Friends and Family Test - Sickness absence/turnover analysis - Board & Committee reports - Trust Committee/Governance Structure - Data - E-rostering Data/Flexible working, health & Wellbeing, Learning Hub, Health Assured & FTSU/SWG monitoring - Staff Survey - RAFT evaluation Covid 19 update: Real-time sickness data collated via central ‘hub’. Support for Managers for virtual working	Work/life balance expectations of the future workforce Shift patterns and impact on Health & Wellbeing Actions to address the gap: Clever Together actions **(Mar 21)** Values and Behaviours implementation **(Sept 21)** Implementation of Agile Working policy **(Mar 21)** Continued Implementation of RAFT **(Nov21)** Implementation of Health & Well-being Strategy **(Dec 21)** Workforce Plan implementation **(Oct 21)** Safe Working Group Feedback initiatives **(continuous)** Line Manager Competency Training **(continuous)** Clever Together Programme **(Mar 21)** Impact of Lateral Flow Testing Programme/Test and Trace – Covid vaccine – (**Review Quarterly)**

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Principal Risk: (8) Failure to ensure there is engaged leadership and strong, effective succession planning Causes – FT Catchment area; new (and unfamiliar) application of talent management framework and workforce planning. Effects – Lack of appropriate strategy; poor culture; increased staff attrition; compromised quality of patient experience. **Lead Committee:** Board (last formal review – Jan 21) **Director Lead:** Director of Workforce and OD	Risk Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 3 Severity= 4 Score: 12	Likelihood = 2 Severity= 3 Score: 6	Likelihood = 1 Severity= 1 Score: 1

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)
- Trust Committee/Governance Structure - Workforce & OD Strategy - Gender Pay Analysis - WRES/WDES - HCV HCP workforce plan - Appraisal / Revalidation Processes - Board Development - Talent Management Framework - Progression and evaluation of internal leadership courses Covid Guidance for Managers for remote working	- Succession Planning Papers - Directors Portfolios - Team Structures - Learning Hub Data - Board/Committee HR Reports - Internal Leadership/Managerial Programmes - Revalidation data - WDES/ WRES action plan - NED development programme	Board Development Programme needs revising due to Covid - Board development **(Quarterly Review)** Shadow Board - this will recommence following Covid **(Quarterly Review)** Up to date Succession Plan - Succession Plan being developed **(Sept 21)** BAME representation at Board and in senior management – to be addressed when the next NED position becomes available **(2024) -** NED Development – (ICS) Programme starts **(Jan 21)** Previous values & behaviours not aligned/embedded – Embedding values and behaviours **(Sept 21)**

Principal Risk: (9) Failure to achieve the Trust's financial plan <u>Causes</u> – pressure from agency spend, system finance pressures, <u>Effects</u> – regulatory scrutiny **Lead Committee:** Board Quarterly (last formal review – Jan 21) **Director Lead:** Finance Director	Risk Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 5 Score: 25	Likelihood = 3 Severity= 3 Score: 9	Likelihood = 2 Severity= 3 Score: 6

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	**Assurance** (Where our controls/ systems on which we are placing reliance, are effective)	**Gaps in Control/ Assurance** (Where we are failing to put control/ systems in place)
- Governance Structure incl: OPAMs, CPEG, EDG - Annual Planning & Business Planning Processes - SFIs, Scheme of Delegation, Policies and Procedures - Collective Board Ownership - Legally binding contracts - Partnership Working (stakeholders, LA's, Trusts (Harrogate, Hull, Leeds) (HCV Contractual MOU) - Shared Risk Contract - Engagement through System Delivery Board - System Medium Term Financial Plan - Care Group CIP Delivery Plans - Financial systems, cost controls and monitoring - Control Total Agreement (multi-year) - North Yorkshire & York Leadership System - Primary Care Networks through CCGs <u>COVID-19 Exceptional Measures:</u> - Temporary suspension of PbR with nationally set block contracts recognising cost of services. - Commissioner allocations adjusted to reflect increased provider funding. - Claims process for exceptional covid related revenue for Apr to Sep. Additional allocation for Oct onwards - Capital bidding opportunities. - National cash process paying 1 month early to ensure strong cash position for all providers. - Temporary suspension of efficiency requirements.	- External and Internal Audit Programmes - NHSE/I Reporting - External Audit - Value for money review - NHSE/I Use of Resources Review - Monthly Accounts & Reports - Operational Plan - Business Cases and benefits monitoring - Committee Papers - Capital Programme Reports and monitoring - Medium Term Financial Planning - East Coast Review	1. Continued recruitment difficulties placing financial pressure from agency and locum replacement staff resulting in pressure against the Trust's agency cap. 2. Additional staffing requirement from covid segregated areas and duplication of functions. **To address gaps 1 and 2:** Multiple Recruitment initiatives listed on strategic risk 6 – MD, CN & DoWF scrutiny & challenge of agency rates, structured review of long term commitments each week **(ongoing review quarterly).** - Premium implemented for bank staff 3. Failure to deliver system wide QIPP with financial pressure on the system partners and the Trust through the shared risk contract (temporarily suspended) 4. System affordability issues in relation to delivery of constitutional standards **To address gaps 3 and 4:** Development and refinement of a system wide financial recovery plan for Oct to Mar. Awaiting planning guidance & financial operating framework for Apr 21 onwards **(Due Dec 20) – delayed (quarterly review)**. Work underway with ICS on understanding current financial positions and resource requirements going forwards. Details of Restoration and Recovery Plan submission awaited but delayed **(quarterly review)**

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Principal Risk: (10) Failure to develop and maintain engagement with partners <u>Causes</u> – lack of governance/structures, lack of system maturity <u>Effects</u> – lack of cohesion, lack of plans, NHSE/I intervention **Lead Committee:** Board (last formal review – Jan 21) **Director Lead:** Chief Operating Officer	Risk Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Scor RAG Rating – 5x5
	Likelihood = 4 Severity= 4 Score: 16	Likelihood = 3 Severity= 3 Score: 9	Likelihood = 2 Severity= 2 Score: 4

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)
The Trust works through the Humber Coast and Vale Integrated Care System and associated governance structures. Support Corporate Operations this includes (not exhaustive): • HCV - Clinical Leads, Executive Group, Planned Care Board, Cancer Alliance and associated sub-structures, Acute Care Collaborative • North Yorkshire and York Systems Leaders Executive • Urgent Care Network • North Yorkshire and York Health and Care Resilience Board (Urgent Care) • North Yorkshire and York Joint Planned Care Board National pandemic response - engaged in the North East and Yorkshire Regional Cell and associated sub-structures, including Local Resilience Forums. Through Business as Usual arrangements, the Trust has regular communication and meeting arrangements with commissioners and regulators to negotiate and manage contractual issues to reduce the risk of financial penalties. This includes: - Contract management arrangements - Monthly performance meetings with commissioners - CQUIN quarterly reviews NHSE/I Quarterly reviews and deep dive assurance meetings through HCV.	The Trust receives assurance through - Appropriate level attendance at partnership meetings to act on behalf of the Trust - Minutes and action logs of the partnership meetings - CQC System Reports - NHSE/I action plans - Contractual reports to Resources Committee and Board - Integrated Board Report.	- Place Based Strategic Plans. <u>Action:</u> ICS Place governance structures and population health plans (April 2021) - System governance arrangements: <u>Action:</u> - Phase 3 recovery plans developed at place and Humber Coast and Vale level. Programme for recovery at place in development **(February 2021)** - North Yorkshire and York Finance and Performance Meeting established to lead on planning and delivery **(November 2021)** - Provider analytical networks established to support and inform the Acute Care Collaborative **(October 2021)**

Principal Risk: (11) Failure to develop a trust wide environmental sustainability agenda Cause – lack of awareness/engagement/commitment Effect – Inability to achieve national targets, waste, inefficiencies **Lead Committee:** Board (last formal review – Jan 21) **Director Lead:** Chief Nurse	Risk Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 4 Score: 20	Likelihood = 4 Severity= 3 Score: 12	Likelihood = 1 Severity= 1 Score: 1

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)
- Trust/LLP Committee/Governance Structure ○ Board Commitment ○ Travel and Transport Group ○ Head of Sustainability ○ Sustainable Development Group - Processes & Systems ○ Sustainability Development Assessment Tool ○ Sustainability Reporting Portal (measures Carbon footprint) ○ Sustainability Champions ○ Consultancy Contract Phase 1 and 12 month sustainable awareness development programme - Partnership Working ○ City of York Council ○ NYCC ○ York and North Yorkshire LEP ○ Humber Coast & Vale Sustainability Network Group	- Sustainable Development Management Plan/Green paper under development to comply with Standard Contract 2020/21 - Sustainable Development (SD) Reports/Papers - Transport Group Reports/papers - Compliance with NICE - Sustainability Annual Report - Trust Annual Report Sustainability Section - Carbon Savings figures - Savings Cost Benefit Analysis - Travel Plan - Benchmarking using SD Assessment Tool - Travel Survey - York Hospital selected as one of 12 in UK for Modern Energy Partners Programme to provide free sub-metering and pathway programme for buildings with aim of achieving 50% carbon reduction by 2032 - Funding secured for electric vehicle charging at York Hospital	- Engagement of staff incl Snr Management – develop engagement plan **(Dec 2020)** Sustainable Development Assessment Tool Action Plan **(Mar 20 62% - improve by Mar 21)** - Covid 19 impact on waste – Review waste monitoring data to determine impact of Covid 19 **(Dec 20) –** improve waste recycling for domestic black bag/catering waste (new tenders delayed due to Covid 19 work) **(anticipated post Jan 21**) - National Clinical Waste Provision Issue - NHSI monitoring nationally agreed (Mar 21) contract - awaiting further developments, National Waste Strategy to be published in Summer of 2020 (delayed)(**Review Jan 21)** - Travel Survey Analysis – Travel Plan being updated **(finalised Dec 20)** - Long Term Climate Change Act target 0 carbon by 2050 Delivering a Net Zero NHS document requires 80% carbon reduction on carbon emissions by 2028/32 - Green Plan with projects to achieve Climate Change Act Targets and Delivering a Net Zero NHS targets – reviewed annually **(Review Jan 21)** - NHS operational planning guidance 2020/21 requires all new builds to be net zero carbon standard (currently suspended due to Covid-19) - Proposed new SGH ED to be built to BREEAM excellent and new guidance awaited on building to net zero carbon standards (**Review Apr 21)** - NHS Long Term Plan targets 2019 & Standard Contract 2020-21- contract requires a plan by Mar 21 - Review of SD/Green plan **(Mar 21)** - Capital budgets not allocated for delivering a Net Zero NHS - Business cases: electric vehicle charging infrastructure, reducing estate carbon emissions; reducing waste/water, vehicle use & procurement impact & achieving Climate Change Act Targets **(Review Jan 21)**

Principal Risk: (12) Failure to achieve the system's financial plan <u>Causes</u> – financial pressures on organisations within the system, lack of capital/revenue, unforeseen expenditure requirements such as equipment failure <u>Effects</u> – ICS and regulatory scrutiny, loss of reputation **Lead Committee:** Board Quarterly (last formal review – Jan 21) **Director Lead:** Finance Director	Risk Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 5 Score: 25	Likelihood = 3 Severity= 3 Score: 9	Likelihood = 2 Severity= 3 Score: 6

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	**Assurance** (Where our controls/ systems on which we are placing reliance, are effective)	**Gaps in Control/ Assurance** (Where we are failing to put control/ systems in place)
- Governance Structure incl: OPAMs, CPEG, EDG - Annual Planning & Business Planning Processes - SFIs, Scheme of Delegation, Policies and Procedures - Collective Board Ownership - Legally binding contracts - Partnership Working - Shared Risk Contract - HCV & Partnership working ie: Contractual MOU - Engagement through System Delivery Board - System Medium Term Financial Plan - Care Group CIP Delivery Plans - Financial systems, cost controls and monitoring - Control Total Agreement (multi-year) <u>COVID-19 Exceptional Measures</u> - Temporary suspension of PbR with nationally set block contracts recognising cost of services. - Commissioner allocations adjusted to reflect increased provider funding. - Claims process for exceptional covid related revenue for Apr to Sep. Additional allocation for Oct onwards. - Capital bidding opportunities. - National cash process paying 1 month early to ensure strong cash position for all providers. - Temporary suspension of QIPP and efficiency requirements	- NHSE/I Reporting - Quarterly System Finance Meetings - Internal & External Audit - Monthly Accounts & Reports - Operational Plan - Medium Term Financial Planning - East Coast Review	1.Failure to deliver system wide QIPP with financial pressure on system partners and the Trust through the shared risk contract (temporarily suspended) 2.System affordability issues in relation to delivery of constitutional standards. 3.Pressure on non-York FT CCG contract expenditure. 4.Operational pressures for the Trust **To address gaps 1 to 4** - Development and refinement of a system wide financial recovery plan for Oct to Mar. Awaiting planning guidance & financial operating framework for Apr 21 onwards **(Due Dec 20) – delayed (quarterly review)** - Work underway with ICS on understanding current financial positions and resource requirements for Oct to Mar. Details of Restoration and Recovery Plan submission awaited but delayed. - Full engagement with the ICS to develop and agree longer term recovery plans **(expect to submit April 21)**

Board Assurance Framework

BAF definition adopted by the Governance, Assurance & Risk Network (GARNet): 'the key source of information that links the strategic objectives to risk and assurance'.

All Trusts are required to prepare public statements to confirm that they have done their reasonable best to maintain a sound system of internal control to manage the risks to achieving their objectives. This is achieved by the Chief Executive providing a signed Annual Governance Statement, which covers the risk management and review processes within the Trust. The evidence to back up this Statement is supported by the Board Assurance Framework.

The Trust's Board Assurance Framework is based upon the identification of the Trust's strategic goals, the principal risks to delivering them, the key controls to minimise these risks, with the key assurances of these controls identified. These are monitored by the Board of Directors to resolve issues or concerns and to improve control mechanisms.

The risk scoring matrix (appendix 1) is part of the Trust's Risk Management Framework and will be used to score risks.
Risk Appetite (appendix 2) is part of the Trust's Risk Management Framework

Strategic Goals	**The planned objectives which an organisation strives to achieve**
Principal Risks	**The key risks the organisation perceives to achieving its strategic goals**
Key Controls	**The controls or systems in place to assist in addressing the risk**
Assurances on Controls	**Sources of information (usually documented) which service to assure the Board that the controls are having an impact, are effective and comprehensive**
Gaps in Controls	**Where we are failing to put control/systems in place**
Gaps in Assurance	**Where we are failing to gain evidence that our control systems, on which we place reliance are effective**
Risk Appetite	**The amount and type of risk that an organisation is willing to take in order to meet their strategic objectives – appendix 2: Trust Risk Appetite.**

Revised BAF approved in Aug 18 – current version 0.30 (Jan 21)

Temporary governance arrangements in relation to the Covid 19 pandemic which follow national guidance

- The Trust has introduced a bronze, silver and gold command structure to co-ordinate efforts for the pandemic – all decisions are logged
- Bronze, silver and gold meetings are held every day with a weekly gold group which has replaced the Executive Committee during this period – Executive Committee planned to restart in June
- The Board and sub-committees are following the 'reducing the burden' national guidance and meetings have been limited to a one hour meeting which discusses Covid issues and then there is a section for papers which are for information.
- Any documents still requiring approval of the Committees/Board are covered under any matters of urgency – due to large number of items for approval in March, this was done by email (all emails retained) a paper detailing the approvals was taken to the April Board.
- The Board is introducing a bi-monthly workshop which is longer in order to discuss Covid issues in more detail – this is initially planned until September 2020
- Board and Committee Action Logs dates continue to be scrutinised to ensure that elements are covered or reviewed periodically
- Audit Committee in May streamlined to focus on year-end only – the July time out meeting will now be a normal agenda incorporating the time out elements
- The Council of Governors has been stood down, but communications are still being sent from the Chair and FT Secretary – in May 2020 a plan was agreed to look at how technology could be used to get the governors around a virtual table.
- Covid capital and revenue spend processes have been put in place

Appendix 1: Calculating Risk

This section describes how to score risks by estimating severity of impact and likelihood of occurrence using a standard 5x5 matrix. Each risk can be measured by multiplying the severity of harm and the likelihood of that harm occurring.

SEVERITY INDEX		LIKELIHOOD INDEX*		
5	Multiple deaths caused by an event; ≥£5m loss; May result in Special Administration or Suspension of CQC Registration; Hospital closure; Total loss of public confidence	5	Very Likely	No effective control; or ≥1 in 5 chance within 12 months
4	Severe permanent harm or death caused by an event; £1m - £5m loss; Prolonged adverse publicity; Prolonged disruption to one or more Directorates; Extended service closure	4	Somewhat Likely	Weak control; or ≥1 in 10 chance within 12 months
3	Moderate harm – medical treatment required up to 1 year; £100k – £1m loss; Temporary disruption to one or more Directorates; Service closure	3	Possible	Limited effective control; or ≥1 in 100 chance within 12 months
2	Minor harm – first aid treatment required up to 1 month; £50k - £100K loss; or Temporary service restriction	2	Unlikely	Good control; or ≥1 in 1000 chance within 12 months
1	No harm; 0 - £50K loss; or No disruption – service continues without impact	1	Extremely Unlikely	Very good control; or < 1 in 1000 chance (or less) within 12 months

*Use of relative frequency can be helpful in quantifying risk, but a judgment may be needed in circumstances where relative frequency measurement is not appropriate or limited by data.

Severity - Severity is graded using a 5-point scale in which 1 represents the least amount of harm, whilst 5 represents catastrophic harm/loss. Each level of severity looks at either the extent of personal injury, total financial loss, damage to reputation or service provision that could result. Consistent assessment requires assessors to be objective and realistic and to use their experience in setting these levels. Select whichever description best fits.

Likelihood - Likelihood is graded using a 5-point scale in which 1 represents an extremely unlikely probability of occurrence, whilst 5 represents a very likely occurrence. **In most cases likelihood should be determined by reflecting on the extent and effectiveness of control in place at the time of assessment, and using relative frequency where this is appropriate.**

Differing Risk Scenarios - In most cases the highest degree of severity (i.e. the worst case scenario) will be used in the calculation to determine the residual risk. However, this can be misleading when the probability of the worst case is extremely rare and where a lower degree of harm is more likely to occur. For example, multiple deaths from medication error are an extremely rare occurrence, but minor or moderate harm is more frequently reported and may therefore have a higher residual risk. **Whichever way the risk score is determined it is the highest l risk score that must be referred to on the risk register**.

Appendix 2 - Risk Appetite Statement (Risk Management Framework - Appendix 4)

1. Quality & Safety - Delivering high quality services is at the heart of the Trust's way of working. The Trust is committed to the provision of consistent, personalised, high quality and safe services, a journey of continuous quality improvement and has an on-going commitment to being a learning organisation. The trust has a risk adverse (Low) appetite to risk which compromises the delivery of high quality and safe services which jeopardise compliance with its statutory duties for quality and safety.

2. Patient Centred Care - This Trust has made a commitment to enable people to be at the centre of their care and treatment, and to empower and enable people and communities to be at the centre of the design and delivery of our services. The trust is risk adverse (Low) to enabling care without validating and verifying what outcomes are possible and desirable with all stakeholders.

3. Partnerships - This trust is committed to developing partnerships with statutory, voluntary and private organisations that will bring value and opportunity to the trust's current and future services. The trust has a risk seeking (High) appetite for developing these partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with its statutory duties.

4. Financial Stability - The Trust is committed to fulfilling its mandated responsibilities in terms of managing public funds for the purpose for which they were intended. This places tight controls around income and expenditure whilst at the same time ensuring public funds are used for evidence based purpose. The Trust is averse (Low risk appetite) to committing non evidence based expenditure without its agreed control limits.

5. Recovery - As a Trust we look beyond clinical recovery through facilitating recovery and promoting social inclusion by measuring the effectiveness of treatments and interventions in terms of the impact of these on the goals and outcomes that matter to the person and their family. The trust is risk adverse (Low) to recovery that does not provide high levels of compliance with service user outcome measures.

6. Improvement and Innovation - Innovation is at the heart of developing successful organisations that are capable of delivering improvements in quality, efficiency and value. The trust has a risk tolerant (Moderate) appetite to risk where benefits, improvement and value for money are demonstrated.

7. Leadership & Talent - The trust is committed to developing its leadership and talent through its Organisational Development and Workforce strategy. The trust is committed to investment in developing leaders and nurturing talent through programmes of change and transformation. The trust has a tolerant (Moderate) appetite to risk where learning and development opportunities contribute to improvements in quality, efficiency and effectiveness.

8. Operational Delivery of Services -The Trust is committed through its embedded strategy, governance and performance management frameworks to deliver the activity for which it has been commissioned. The Trust has an adverse (Low) appetite for failing to deliver the requirements outlined and agreed in commissioner contracts.

Q

NHS

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 31 March 2021
Medical Director's Report

Trust Strategic Goals:

☒ **to deliver safe and high quality patient care as part of an integrated system**
☒ **to support an engaged, healthy and resilient workforce**
☒ **to ensure financial sustainability**

Recommendation

For information	☒	For approval	☐
For discussion	☒	A regulatory requirement	☐
For assurance	☐		

Purpose of the Report

This report provides an update from the Medical Director in quality, safety and effectiveness.

Executive Summary - Key Points

- The ceiling of care internal audit returned a limited assurance opinion – an action plan is in place to address the issues identified in the report.
- The follow-up audit of the mortality processes returned a significant assurance opinion
- The Serious incidents declared in February are reported.

Recommendation

The Board of Directors are asked to note the Medical Directors Report for March 2021.

Author: Caroline Johnson, Deputy Director of Governance & Patient Safety

Director Sponsor: James Taylor, Medical Director

Date: March 2021

1. Introduction and Background

The Medical Director's report provides an update in relation to clinical effectiveness, audit, and patient safety.

2. Clinical Effectiveness and Audit

Quality Accounts

There are currently 19 outstanding Trust reports for Quality Account Audits. These reports were predominantly released in the last three months. During the first two weeks in March, the Clinical Effectiveness Team will create WebEx meetings with audit leads and governance facilitators to discuss the reports and the subsequent required actions. It is anticipated that the current 19 Trust reports will be completed by the end of July 2021 and involves a supportive approach utilising national resources where available. Where a subsequent annual report has been released, the previous year report is no longer included in the number of outstanding reports. One Quality Account report has been reported as an outlier and a response is awaited from the Care Group, this is due in Apr-21.

NCEPOD

2 NCEPOD benchmarking assessments remain outstanding, both of which are overdue and have been for a considerable period of time. A plan is in place for each of the outstanding assessments, with an anticipated completion scheduled for April 2021. A further NCEPOD self-assessment checklist has been released by the National Provider in February 2021 and this has been shared with the relevant Trust leads for self-assessment.

NICE Guidance

Progress in completing NICE baseline assessments has continued; however the number of overdue baseline assessments continues to remain high across the Trust. It is anticipated that this will improve in the next 4-8 weeks as COVID activity has continued to decrease. The Patient Safety Improvement Lead post has successfully been recruited into; a core aspect of this role will be to facilitate the completion of NICE baseline assessments including any subsequent patient pathways which may be required. The role will bring all of the relevant professions from the relevant specialties together to determine compliance and subsequent actions. It is anticipated that the successful candidate will be in post within the next 8 weeks.

Outstanding Actions

A total of 214 overdue clinical effectiveness actions are outstanding across the Trust. The clinical effectiveness team will review the actions, cross referencing with other results to ascertain if any evidence is available to close some actions, in conjunction with the clinical governance facilitators. Duplicate actions are evident where reports have found repeat recommendations; these will be condensed into a single SMART action where appropriate.

3. Internal Audits

Ceiling of Care

The Trust has received limited assurance in relation to the Ceiling of Care Audit. The report concluded that there is an effective system in place to facilitate the documentation of a patient's Ceiling of Care (CoC) decision on the Core Patient Database (CPD) which can be viewed by all staff providing care to that patient. Access to document a CoC decision on CPD has been restricted to ensure that decisions are being recorded by suitably senior and qualified staff.

The review identified that a CoC had been recorded on CPD for 45% of all inpatients in September 2020 indicating that CoC decisions are not always being recorded in accordance with Trust policy. It was also found that changes to a CoC status, following a review during admission, is only documented in the paper records and therefore the primary care record, CPD, is not always complete.

In addition, weaknesses were identified in relation to the recording and monitoring of incidents, complaints and legal claims relating to CoC.

An action plan is in place to address all the issues identified in the audit. This includes a review of the policy to ensure that the appropriate patients are included for consideration of their ceiling of care.

Mortality Review Follow up Audit

A follow up internal audit of the recommendations made in the previous mortality internal audit has returned an overall opinion of significant assurance.

4. CQC National review of DNACPR decisions

The CQC has undertaken a national review of the use of DNACPR decisions during the pandemic. This review was undertaken in response to widely reported concerns that elderly and vulnerable people may be being subjected to DNACPR decisions without their consent or with little information to allow them to make an informed decision.

A report published by the national LeDeR programme highlights that several reviewers noted that frailty or 'learning disabilities' were given as rationales for a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision for people who had died from COVID-19, yet this was not the case for people who had died from other causes.

All patients with a learning disability who die within the hospital are referred to LeDeR and an SJCR is undertaken. As chair of the DNACPR group Donald Richardson (Deputy Medical Director), completes the majority of the reviews and no DNACPR issues have been identified through the SJCR process.

5. Quality Improvement Strategy

The QI strategy group has met on 2 occasions and engagement is good. The group have agreed that the starting point for the development of the strategy is to undertake an organisational readiness assessment developed by the Health Foundation.
https://www.health.org.uk/sites/default/files/Organisational%20checklist.pdf

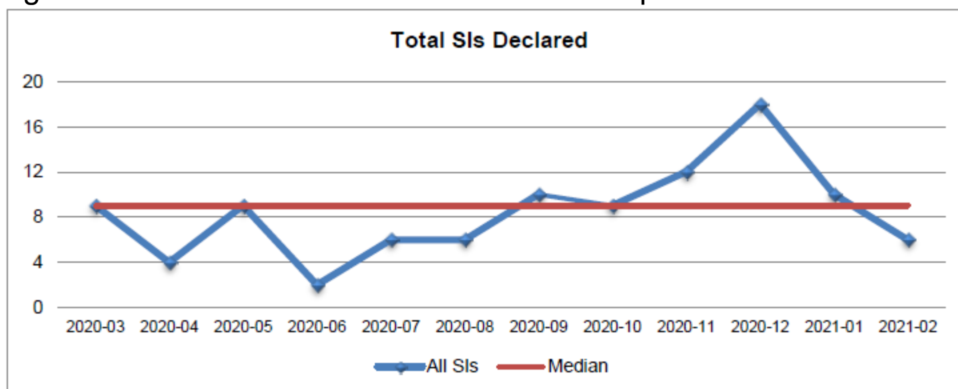
The readiness tool will assist in ensuring that the appropriate actions are taken to ensure the findings of the readiness tool will be shared with the Quality Committee in May 2021.

In addition to the readiness tool completion a stakeholder engagement strategy is being developed to ensure that the strategy is co-produced with staff, patients and carers to ensure it is owned organisation wide.

6. Serious Incident investigations

There have been 6 serious incidents (SI) declared in February (figure 1).

Figure 1: Total number of serious incidents reported



The redesign of the incident management processes is moving into the next phase with the SI investigation process being reviewed to enable a move towards the new national framework which is due for implementation in spring 2022.

7. Recommendations

The Board of Directors are asked to note the updates within this report.

Q1

NHS
York Teaching Hospital
NHS Foundation Trust

Board of Directors – 31 March 2021
Implementing Continuity of Carer in Midwifery Services

Trust Strategic Goals:

☒ **to deliver safe and high quality patient care as part of an integrated system**
☒ **to support an engaged, healthy and resilient workforce**
☒ **to ensure financial sustainability**

Recommendation

For information	☒	For approval	☒
For discussion	☒	A regulatory requirement	☐
For assurance	☒		

Purpose of the Report

To update against the action plan to deliver 35% of continuity of midwifery carer to York Teaching Hospitals NHS Foundation Trust by March 2021

Executive Summary – Key Points

There is strong evidence along with many national drivers to support the use of Continuity of Carer in maternity services as an operating service model and choice for women. Bookings onto a Continuity pathway for January 2021 are 50.2%; National trajectory is achieved and has been consistently over the last twelve months.

Please note planned actions to focus further expansion of Continuity programme to include BAME and social deprivation groups specifically.

Recommendation

This report is provided for information and to note progress. No action required.

Author: Lynda Fairclough, Named Midwife for Safeguarding Children

Director Sponsor: Heather McNair, Chief Nurse

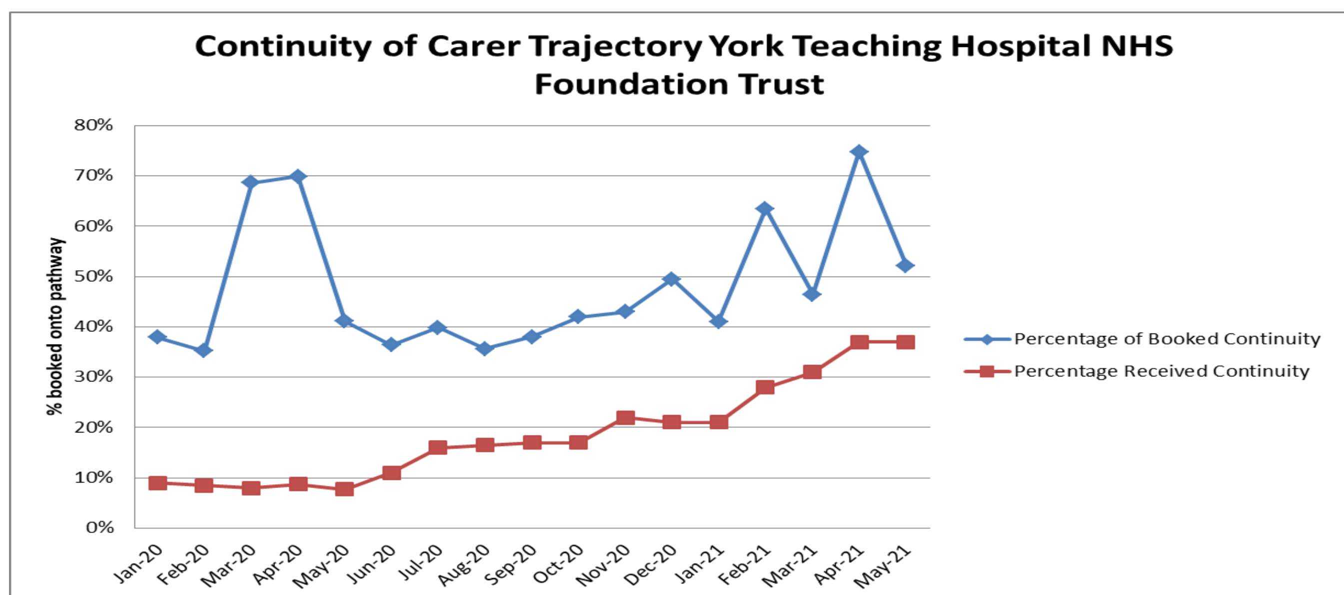
Date: 15/02/2021

1. Introduction and Background

Maternity Services in England have remained in the spotlight since the publication of Better Births in April 2016, the report of the National Maternity Review. The national Maternity Transformation Programme is the vehicle used to facilitate the implementation of the Better Births recommendations.

2. Detail of Report and Assurance

2020	SGH bookings onto CoC pathway	York bookings onto CoC pathway	Total bookings onto a continuity pathway(A)	SGH transfers onto pathway <29w	York transfers onto pathway <29w	Total transfers (B)	A + B	Total Trust wide bookings (C)	B + C	Percentage of women booked onto pathway	Total Trust Births	Percentage of Women receiving Continuity of Carer	Comments
January	185		185			0	185	488	488	37.9%	364	9%	
February	154	3	157			0	157	446	446	35.2%	329	9%	Sapphire team launched - not on call
March	166	29	195	100	36	136	331	482	618	68.7%	370	8%	
April	188	27	215	136		136	351	502	638	69.9%	326	9%	
May	139	18	157			0	157	382	382	41.1%	360	8%	
June	128	17	145			0	145	398	398	36.4%	338	11%	Sapphire team relaunch
July	168	19	187			0	187	469	469	39.9%	367	16%	Jasmine Team launch
August	137	14	151			0	151	424	424	35.6%	341	17%	
Septembe	121	18	139			0	139	366	366	38.0%	375	17%	
October	168	8	176			0	176	421	421	41.8%	381	17%	
Novembe	164	25	189			0	189	436	436	43.3%	264	22%	Malton Team Launch as on call
December	156	25	181			0	181	366	366	49.5%	333	21%	1.0 WTE to aSapphire team with caseload
2021													
January	160	21	181			0	181	441	441	41.0%	349	21%	
February	160	45	205		75	75	280	441	516	63.5%	349	28%	2nd on call team - York site (Jorvik)
March	160	45	205			0	205	441	441	46.5%	349	31%	3rd on call team - Scarborough
April	160	70	205		75	75	330	441	541	74.8%	349	37%	3rd on call team - York Site
May	160	70	230			0	230	441	441	52.2%	349	37%	



Current Trust Position

Booked onto a continuity of carer Pathway Statistics – January 2021

Total Trust bookings for January = 378
Scarborough bookings = 169
Sapphire team bookings = 21

Percentage booked onto a CofC pathway for January= 50.2%.
BAME booked = 47.8%
Postcode for top decile for deprivation booked CofC = 96.7%

Received Continuity of Carer Statistics – January 2020

Intrapartum care received = 22%
Intrapartum CofC received in Scarborough = 63.5%
BAME received = 11%
Postcode for top decile for deprivation received CofC = 54.5%

**Projected plans for 2021 are currently unapproved and will rely on a finance to create further teams in improve CoC care on York site. We will update with any progress.

3. Next Steps

1 year Celebration Event of Continuity of Carer has been arranged and will take place on the 26th February 2021.

Lead Midwife for Continuity of Carer - Lynda Fairclough sharing project lead with Claire Welford. They are sharing 1.0 WTE. Commenced 1st February 2021.

Immediate planned actions include;

- Continue to strengthen teams and work with service users and Midwives to outline the direction of the existing teams.
- Identify projects within existing York teams that will help embed Continuity of Carer, creating working groups and actively increasing motivation and appetite for change.
- The action plan for expansion of Continuity of Carer will focus on actively building teams to refer women identifying as BAME into as it is acknowledged that the increased risk to this group can be mitigated by continuity.
- A specific focus will also exist around building a team in the Selby area as this will encompass some of the more deprived areas.
- Await Birthrate plus review before updating the action plan and building a business case to facilitate plans for 2021.

4. Detailed Recommendation

This report is provided for information and to note progress. No action required

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 31 March 2021
Head of Midwifery Annual Report 2020

Trust Strategic Goals:

☒ **To deliver safe and high quality patient care as part of an integrated system**
☒ **To support an engaged, healthy and resilient workforce**
☒ **To ensure financial sustainability**

Recommendation

For information	☒	for approval	☒
For discussion	☒	A regulatory requirement	☐
For assurance	☒		

Purpose of the Report

To inform the Board of Directors of annual activity and achievements from January to December 2020 including risks, priorities and future development for maternity services in 2021.

Executive Summary – Key Points

The Covid 19 pandemic has provided significant challenge to maternity service delivery in 2020 and continues to do so. Although all services continued to be provided throughout, alterations to methods of delivery and restriction to partner access have been extremely challenging, the staff absence created through the pandemic have also had a significant effect on service delivery. Maternity transformation based on Better births 2016 continues to be a central part of maternity services. Humber, Coast and Vale Local Maternity System (LMS) continued to develop in structure and reach in 2020. Major focus remained on building the delivery of continuity of carer, the target of 35% by March 2020 and 51% by March 2021 were moved on by 12 months due to the pandemic; however York Trust is one of the few who achieved 35% by March 2020 despite the challenging climate. York Trust is developing a strategy to meet 51% by March 2022 which is likely to require investment.

Saving Babies Lives version 2 (SBLv2) care bundles were launched in March 2019 and to be included in the standard NHS contract by March 2020, these are also included in NHS Resolution maternity safety standards for 2020/21. The aim of these is to continue the work to reduce stillbirths to meet the ambition of halving rates nationally. Significant stretch has been added to these standards and an additional element which is proving challenging to implement despite approval of a business case in December 2020 to support.

Maternity and neonatal Safety Champions meet bi-monthly with the Chief Nurse who is board level Safety champion to discuss the maternity safety plan. In 2019 a non executive director joined the Maternity safety champion team.

The publication of the first part of the Ockenden report into baby deaths in Shrewsbury and Telford in December 2020 has led to a high level of focus around Maternity services which will require changes at board level to the oversight and involvement currently in place. The national implementation at Trust level of the perinatal clinical quality surveillance framework will require significant local work and board support. Commitment around ongoing investment into maternity safety is required as well as increased reporting and communication. An assurance tool with narrative has been completed and approved at board for submission to regional teams who will benchmark against standards and peers and provide support. Significant focus on LMS responsibilities and strength also comes from this report.

The complexity, acuity and dependency of women accessing services continue to rise which is challenging for services. A full birthrate plus workforce external review has been commissioned and is currently underway, this is likely to indicate significant staffing increase to meet required standards which will need Trust board support. This is a requirement of the Ockenden review that birthrate plus recommended staffing is implemented.

In line with the national trend there is a reduction in experienced middle grade doctors, along with the changes in rules regarding entrustability this is providing challenges for medical cover.

CNST maternity safety standards for 2020 were paused due to the Covid pandemic, no additional premium collected and then relaunched in October 2020; these were again revised Feb 2021. These are proving a significant challenge to implement and at the current time are under further review by NHS Resolution due to the continuing challenges of the global pandemic. There is significant risk of York Trust being unable to achieve the standards specifically due to challenges in relation to sonography capacity and difficulty recruiting.

Recommendation

The report aims to provide information to the Board of Directors on detail of activity, achievements and challenges faced by maternity services in 2020 with future plans for 2021 outlined to improve and provide a safe quality service meeting local, regional and national priorities. For the Board of Directors to review and confirm support to develop any required business cases to enact the action plans to achieve 100% supernumerary coordinator status and 100% 1:1 care in labour.

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Date: 28 February 2021

1. Introduction and Background

Maternity transformation is progressing with the Humber, Coast and Vale Local Maternity System (LMS) however, this requires further work to improve safety and outcomes, implement continuity of carer to most women by 2022 and improve perinatal mental health services. Following the publication of part one of the Ockenden report there is also significant work required to implement the perinatal clinical quality surveillance tool, make changes to the core competency training framework for all maternity staff and to meet the requirements of the CNST maternity incentive scheme.

2. Detail of Report and Assurance

Detail of activity, workforce, achievements and challenges including plans to meet national, regional and local priorities, develop the service and reduce and mitigate risk is as follows;

2.1 Maternity workforce strategy

The Obstetrics and Gynaecology Directorate submitted a strategic 5 year workforce plan in February 2017.

The Midwifery workforce has been reviewed against the nationally recognised maternity workforce tool Birthrate plus in a table top exercise in July 2020 (6 monthly review) and currently a full external birthrate plus review is underway with report and recommendations expected April 2021. The desktop review demonstrates that staffing establishments are currently meeting required ratios and the total of specialist midwifery and management roles does not exceed the 10% allowed for within the tool. The data reviewed to calculate included delivery and community activity as well as establishments for registered, non-registered staff and specialist staff. It must be noted however that the formulae for acuity and dependency within the desktop tool are dated and unlikely to be reflective of current activity. For this reason funding was requested and received for a full external review (last undertaken approximately 2012) which will provide an accurate current position. The output of this report will be provided to Board in due course to seek support in implementing any recommendations.

Midwifery staff ratios are currently 1 midwife per 25 births which is above the national recommendations of 1 midwife per 29.5 births for hospital and midwifery led units. York site now meet national recommendations whilst Scarborough site are higher than recommended levels due to the minimum level of staff required to provide a safe service.

Trust midwife ratio per births	York site	Scarborough site
1 midwife : 25 births	1: 28	1: 22

Fill rates (planned versus actual) have been affected by reduced staff availability from Covid 19 across the year. This has included shielding staff, those isolating through contact or positive status. Maternity staff have been ring-fenced from any redeployment to other trust areas due to the specialist nature of the service. The average fill rates for midwifery shifts are as follows;

- York 82% average across the year
- Scarborough 98% average across the year

Escalation policies are followed and staff moved fluidly between clinical areas and community to meet demand where full shift fill is not achieved in line with actual clinical activity to maintain safety, specialist Midwives and managers also work clinically as required according to acuity and dependency. Bank staff are also used where available, no agency staff are used.

In 2020 births have remained relatively static; there has been a slight reduction in births by 2.0%. This has improved the overall midwife to birth ratio, however the trend of rising acuity seen regionally and nationally has been echoed in York.

One to one care in labour	**York**	**Scarborough**
2018	81%	88.7%
2019	92.4%	96.35%
2020	97.5%	98.1%

Supernumerary status of the Labour Ward Co-coordinator is above 96% across the year with mitigation in place for periods of high activity.

Mitigating action;

- Labour Ward on call midwife in place to provide support in periods of high activity and acuity on York site.
- Maternity escalation plan in place to manage activity and acuity. Labour Ward staffing guidance aims for the Labour Ward Co-coordinator to remain supernumerary at all times, all planned rotas include this.
- NICE red flag staffing incidents recorded and discussed at weekly risk meeting (summarised in risk management section)

In order to meet the aim of 100% compliance with 1:1 care in Labour and supernumerary status of the Labour ward coordinators at all times the following action plan has been developed

Action	Lead	Timescale
Review and update escalation guidance to support early review of rising acuity	Labour Ward Manager	March 2021
Complete birthrate plus full workforce review to ensure staffing model accurately reflects demand	Head of Midwifery	April 2021
Seek board support to implement recommendations of Birthrate plus review	Head of Midwifery	June 2021
Implement renewed birthrate plus acuity app across Labour and ward environments to support accurate assessment	Labour ward Manager	April 2021
Continue to build Continuity of Carer on call model teams to increase received continuity	Deputy Head of Midwifery / Continuity Lead	September 2021

The age profile of midwives in 2020 demonstrates a change in age demographic compared to 2019(table below). Levels of retirement have resulted in a rise in the younger age groups which is helpful in sustainable staffing models. Recruitment of midwives has not been problematic on either site, but has led to higher numbers of more junior midwives as most are graduating students.

Midwives age range (years)	**Total midwives %** (actual numbers) 2019	**2020**	**Band 7 %** (actual numbers) 2019	**2020**
40 or less	49.4 % (115)	**50.72% (141)**	36.4% (12)	**33.67% (13)**
41 to 50	16.7% (39)	**20.14% (56)**	21.2 % (7)	**36.2% (14)**
51 to 55	21.5% (50	**14.38% (40)**	30.3% (10)	**20.72% (8)**
56 and above	12.4 % (29)	**14.75% (41)**	12.1 % (4)	**10.36% (4)**

Aspirational midwifery roles the service continues to aim to develop are:

- Consultant midwife/Advanced Midwifery Practitioner (recommended Safer childbirth 2007)
- Public health midwife and substance misuse midwife to improve outcomes (NICE and NHS long term plan to improve public health, reduce smoking in pregnancy and levels of obesity)

Roles implemented in 2020 include;

- Saving Babies lives care bundle version 2 Fetal monitoring leadslit
- Increased bereavement Midwife hours

Future Plans:

- Continue to Increase Maternity Support Workers roles on postnatal ward and in community to support the midwife role, promote healthy lifestyles, increase breastfeeding, reduce readmission of babies to children's services and enhance the patient experience.
- Implement a dedicated Neonatal support worker role on postnatal areas to deliver transitional care pathways consistently in this area. Business case approved and development of role profile and recruitment plans underway.
- Continue to analyse maternity staffing requirement to achieve 51% offer of Continuity of Carer pathway by March 2022, develop a business case to support this and access transformation funding once available.
- Due to increased requirements for mandatory training for midwives, will increase to 37.5 hours per year each, establishment to be reviewed in 2021, currently underway.
- To implement updated birthrate plus acuity app for both labour and postnatal areas.

<u>Medical Staffing</u>

With the introduction of the Care Group structure, Obstetrics and Gynecology (O&G) medical staff is now managed by a Clinical Director (CD) covering both sites, with lead

clinician (LC) on both sites. Both CD and LC are accountable to the Care Group Director. Currently, the York site LC post is vacant.

The current consultant post establishment cross site is 13 on the York site, and 9 including one on less than full time sessions on the Scarborough site. The consultants out of hours work pattern involves various combinations of non-resident and resident duties, none of which is cross site.

A regional clinical senate review of the services provided on the Scarborough site has been requested and is planned for March 2021.

Senior Medical Staff

The directorate has faced unprecedented senior medical staffing pressures and challenges in the last few months, contributed to by the following.

1. NHS Pension scheme changes affecting consultants: This has led to 3 consultants reducing their contacted clinical professional activities (PA) and a reluctance of others to undertake additional activity sessions with extra-contractual payment. This has resulted in lost clinical activity with the loss of fast track clinic capacity and leading to up to 24 weeks wait for first appointment in Gynae outpatient clinics.

2. Reducing clinical activity commitments: Some consultants nearing the age of retirement all have requested to reduce their job plan to less than full time or come off on calls. This will have a huge impact on the on call frequency (1:8 in York and 1:5 in Scarborough) and is being addressed at care group director level.

3. Sickness Absences: Of the current consultant body, one who has been off duty long term over the past 6 months following a road traffic accident, and another has stopped undertaking out of hour's duty following ongoing occupational health assessment. Both are on the Scarborough site, impacting on elective and out of hour's duty provision and cover.

Plans for additional consultants are under consideration. An additional locum consultant post is commencing on the York site in March 2021 with another in May 2021. The initial recruitment plans for the second post was for cross site duty provision including out of hours duties on the Scarborough site, but it has proved challenging and difficult to attract suitable applicants for cross site work. A locum consultant post to cover part of the current acute duties gap on the Scarborough site has just been approved and will be out for advertisement.

Following the Ockenden Report (Dec 2020) and the requirements for immediate compliance, there is additional requirements for nonresident consultants to undertake an additional physical Labour Ward round impacting significantly on the current 4 nonresident consultants covering the 1:5 rota on the Scarborough site, which will be unsustainable longer term.

There are ongoing discussion and planning for changes to the consultants work pattern with proposals for implementation in May 2021. The cost and service implications are being explored, but for longer term sustainability of acute consultant lead service

provisions in the current format on the Scarborough site, there is likely to be need for additional considerable resource investment.

Middle and Junior Grade Medical Staff

Covering the middle and junior O&G medical staff out of hours and usual routine elective duties increasingly challenging for the following reasons:

1. Specialty trainee recruitment difficulties and attrition: Nationally, there are fewer doctors applying for a career in O&G along with a higher attrition rate compared to other specialties. This has resulted in a national shortage in middle grade trainees and this is of a particular concern for this Yorkshire and Humber region.

2. Training Curriculum changes and 'Entrustability': With the implantation of a new national training curriculum introducing the concept of Entrustability, intermediate grade trainees (i.e. ST3 – ST5 training years) are no longer routinely considered to be able to undertake indirectly supervised duties by the ST3 training year. They will now continue to require direct on site senior supervision for acute duties till the ST5 training year. Similarly most will require direct supervision in maternity and Gynaecology clinics till certified entrustable at the ST5 training year. This effectively removes a level of middle grade cover that was utilized for emergency out of hour's duties and routine elective service provisions. Coupled with the impact of COVID-19 Infection Prevention Control (IPC) antenatal clinic capacity especially on the Scarborough site has been significantly impacted, with the middle grade cover usually provided for continuous service during consultant leave absence in clinics no longer available

3. Reduction in trainee allocation to Scarborough site: The regional School of Obstetrics and Gynaecology has highlighted concerns about relatively reduced training opportunities senior trainees and support for 'unentrustable' middle grade trainees on the Scarborough site. We have been informed of plans to reduce the number of O&G specialty trainees allocated to Scarborough by one, at the August 2021 rotation

Risks and plans to mitigate the risks

Consultant cover gaps for essential acute and out of hours services: Pending implementation of ongoing plans for revised consultant job plans and timetable on both sites with new ways of working under consideration, ad hoc agency and additional current consultant duty cover is utilized on the Scarborough site to cover the rota gaps and service provisions. A locum consultant post advertisement to recruit a consultant for the Scarborough site has just been released Two new locum consultant post will commence on the York site by May 2021,

Entrustability and trainee numbers concerns: The unentrustable middle grade out of hours rota duties on Scarborough site are being supported by on site additional consultant duties and locum covers. With the anticipated reduction in trainee number allocation to Scarborough in August 2021, plans are under development for a combined cross site middle grade rota to provide a balance of entrustable and unentrustable cover on both sites.

2.2 Risk Management

Risk management retains a significant high focus for maternity. The maternity Quality and Governance team undertake a weekly Maternity case review (MCR) meeting on both sites weekly with presence from paediatric teams which identifies learning and good practice which is shared via learning from slides sent to all team members.

2.2.1 NHS Resolution Maternity Incentive scheme (CNST)

NHS Resolution launched year 3 standards in December 2019 which were subsequently paused due to the Covid 19 pandemic, and later relaunched in October 2020. At the time of writing this report evidence submission dates have been extended until July 2021 and standards were revised again February 2021 to take account of the constraints of the pandemic.
This year the overall standards have remained the same, however significant stretch and detail in systems and evidence required has been added. There is significant work around Saving babies lives needed as York Trust does not have sufficient scan capacity to meet requirements, nor do sonographers currently possess the skills for full implementation of uterine artery Doppler scanning. Although business case was approved on 2 December 2020, difficulties in recruitment make this a significant risk of non-achievement. Standard 8 in relation to training also presents a significant risk as staff groups such as anaesthetics and ODP teams are required to meet 90% compliance with maternity training, their skills are currently under challenge from Covid 19 making their completion. Failure to achieve on standard means being unable to declare any compliance and forfeiting the refund of 10% premium. This additional premium was not collected in 2020 due to the pandemic, however it is currently planned to be collected in April 2021.

The care group recognise there is a significant risk of not achieving all 10 standards in 2021 due to the reasons discussed above; this remains on the risk register for CG5. The care group will continue to highlight via OPAM.

2.2.2 Maternity Dashboard

Yorkshire and Humber regional dashboard

An annual report of the dashboard 2017/8 was published in November which details where trusts in the region compare with each performance indicator.

Since December 2020 trusts have been asked to submit data to the regional dashboard as site specific data on 2 separate templates. This will now highlight site specific wins and challenges. The last quarter to be published following regional comparison is Q1 2020 (published in October 2020) to note for this quarter;

- The amount of women booked with their midwife under 13 weeks of pregnancy is a good percentage and consistently higher than the regional average of 92%.
- Assisted vaginal birth rate is higher than the regional average at 13.8% where the Y&H average sits around 10%
- Caesarean section rate for this quarter is below the regional average at 25.6%, (Y&H average 29%)

- The third and fourth degree perineal tear rate is significantly lower than the regional average on this and the previous quarter at 0.7%, Y&H average sits around 5%. (These statistics were based on the whole trusts data)

The local monthly dashboard;

York site:

Bookings more than 13weeks seen within 2 weeks, have been consistently very high all year, most months meeting 100%. This is in contrast to the position of this data a year ago, due to significant data cleansing and mandating of items on CPD.

Home birth service suspension has been significant this year with thirteen women unable to birth at home due to the service being unable to be provided. This cancellation has been largely due to staffing constraints either through sickness/isolation or escalation requiring the Community midwife to be working on the delivery suite. One occasion there were two homebirths occurring at the same time and so one mother was asked to attend the unit.

There have been three unit closures due to acuity over the course of the year.

The clinical indicators for birth have shown a consistently low normal delivery rate averaging 55% for the year (60% Y&H average) and a consistently high assisted vaginal delivery rate, 15% for the year; The Y&H average is 10-11%. The caesarean section rate at York has averaged at 29% which is the Y&H current average.
A normal birth steering group has been formed to improve birth outcomes, targeting promoting normality and starting with environmental factors and women remaining active.

The PPH rate for York site has again been consistently high, averaging at 4% for the year. The Y&H average rate is 3.4%. There has been significant focus on reducing the PPH rates with a large audit, the trial of new paperwork on the delivery suites (adopting the Wales pathway) and the introduction of altering the method of administration of one of the uterotonic drugs. The last 2 months have shown an improving trajectory and the rate (as of end Dec 2020) is now at the level of the Y&H average.

Scarborough site:

As with York site, the temporary suspensions of the home birth service has been significant with seven women unable to birth at home in light of the suspension. Again, the cause has been largely down to staffing compromise due to sickness or isolation. The unit was closed three times, due to the lack of senior medical cover and on one occasion due to the closure of SCBU.
The birth clinical indicators at Scarborough site display some very good statistics; normal birth rate has been consistently high all year and well above the regional average; averaging at 69% for the year. The instrumental birth rate is consistently low, averaging 5% for the year, where the Y&H average is 10-11%. PPH rate and perineal tear rates are considerably low 2.3% (Y&H 3.4%) and 0.5% (Y&H 7%) respectively. Similarly to York site, the caesarean section rate has at several points this year been higher than the regional average and has been consistently high between September to December.
Breast feeding initiation rates fall short of the National average consistently, with an

average rate of 60% of mother's breast feeding their babies at birth. The regional average is 67%. Also smoking at the time of delivery figures are high, averaging 18% for the year, regional figures sit 12-13%. As Scarborough site has some of the most deprived areas in the country it is understood there is a correlation here, this figure does represent a significant reduction in SATOD rates over the last five years.

Maternity dashboards are discussed at the Labour Ward Forums with highlight reports sent to the Clinical Governance meetings.

2.2.3 Incidents (Datix)

Total number of Datix reported for 2020 was 1507, demonstrating an excellent reporting culture in Maternity.

Every Datix is reviewed at the weekly Maternity Case Review (MCR) meeting including NICE red flags, duty of Candour, RCOG Each Baby Counts, NHS Resolution and Healthcare Safety Investigation Branch (HSIB) cases. Monthly highlight reports are produced, discussed at the labour ward and maternity risk forum, included in the monthly board report and circulated to all staff. Learning from communication is sent to all including a 'learning from' newsletter sent at least once a quarter.

There has been a significant increase in the amount of NICE red flag datix's reported in 2020; this in part has been down to continuing to highlight the reasons for what triggers a NICE red flag, but may reflect pandemic incurred difficulties in some cases.

York site (47):

- Missed or Delayed care such as suturing >1hour (14)
- Delay/cancellation of time critical activity such as cesareans within the dedicated time frames (20) were the highest triggers for NICE red flag datix's. All the cases are reviewed at the weekly MCR with a multi-disciplinary team and discussed in the deputy HoM monthly board report. Acuity and activity on the delivery suite has shown as the main reason for delays in care.

Scarborough site (7):

- Delay of 2 hours or more between admission and starting the induction process (3), all due to acuity and activity on the wards.
- Delay in suturing >1hour (2). Both the cases required suturing in theatre.

Top 10 Datix reported in 2020:

DATIX York
Post-partum haemorrhage >= 1500mls
Readmission of either mother or baby
Transfusion of any blood products
Unanticipated admission to SCBU
3rd/4th degree perineal tear
Born before arrival at hospital

Shoulder dystocia
Low cord (below pH7.1 venous or below 7.05 arterial)
Cold baby <36.5 degrees
LSCS at fully dilated

DATIX Scarborough
Unanticipated admission to SCBU
Readmission of either mother or baby
Post-partum haemorrhage >= 1500mls
Transfusion of any blood products
Born before arrival at hospital
Intra-uterine transfers out: lack of neonatal unit cot or gestation of pregnancy.
Any baby born < 34 weeks (SGH) or <27 weeks
Shoulder dystocia
Cold baby <36.5 degrees
Community staff brought to work in maternity unit

As previously mentioned, the PPH rate at York site has been an area of concern. A large audit was performed and presented; which showed 76% of the cases were women who had assisted/operative deliveries, and that there were areas to improve in terms of increasing the use of tranexamic acid and prophylactic drugs. We have also changed the method of administration of a routine uterotonic. Different paperwork has been used and considered and work continues with this.

There has been a rise in the number of readmissions post-natally to both sites. This was also a theme in the previous year. Case note reviews have not brought any theme in terms of reason for admission, but this will be monitored.

All unanticipated admissions to SCBU of term babies are looked at via the weekly MCR meeting (usually with paediatric and maternity presence), and also by staff undertaking ATAIN work- (a project designed to reduce the numbers of babies admitted to neonatal units).

There have been 5 serious incidents declared this year; three at York site, and two at Scarborough.
Three of the cases have yet to be concluded as they were declared in December. Reports and recommendations were produced for the other cases.

Two cases were referred to HSIB from Scarborough site earlier in the year. One of the cases has been concluded and another is awaiting the final report. Both these cases were of babies that were referred to tertiary units for cooling, both babies are doing well in the current post-natal period.

All recommendations from SI's and HSIB investigations with subsequent action plans are monitored by maternity Q&G and Governance leads.

Three themed reports based on national recommendations have been released by HSIB in relation to neonatal collapse, group B streptococcus and delays to intrapartum intervention. All three have been reviewed by teams and changes made to guidance where required. A fourth report has just been released on large babies which will be reviewed at the Obstetric governance forum in March 2021 and any changes to guidance required will be made subsequently.

2.2.3.1 Stillbirth and Neonatal deaths

In November 2017 the Secretary of State for Health announced a new maternity strategy to half rates of stillbirth by 2025. The government planned to offer independent investigations in review of cases and the Healthcare Safety Investigation Branch (HSIB) aims to standardise investigations so that the NHS learns as quickly as possible from what went wrong and shares the learning to prevent future tragedies. Since HSIB began work in York area six cases have been referred for investigation. Three cases have been concluded with minimal significant recommendations which have been implemented, one case is ongoing, and two were rejected by HSIB due to the nature of the cases.

There were 5 Neonatal deaths in 2020 which were reported to MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK), this is a slight increase on 2019 figures.

All deaths are discussed at the multidisciplinary Perinatal Mortality and Morbidity meeting and are reviewed using the national Perinatal Mortality Review Tool (PMRT) within required timescales.

All early neonatal deaths (death within 7 days of birth) are reported to RCOG each baby counts and also reviewed at the York and North Yorkshire Child Death Overview Panel (attended by the Head of Midwifery and Paediatric Consultants)

2020 figures	YORK	SCARBOROUGH
Stillbirths	8	7
NND	3	2
NND booked at our trust but died at another hospital	4	3

Stillbirths
There were two babies that died in utero which were multiple pregnancies.
One baby had known Edwards syndrome and died during labour.

NND
Two were extremely premature at 22+6 and 23 weeks gestation.
One was premature at 24+3 weeks.
One had known Edwards syndrome and died shortly after birth.
One came into ED in cardiac arrest at 24 days old.

Neonatal deaths can occur outside of York trust when they were booked to deliver within Trust. Two babies died at Martin House Hospice, one had known Edwards's syndrome and one had an ornithine transcarbamylase deficiency which is a rare X-linked genetic

disorder. Five babies were transferred out to tertiary units for specialist neonatal care either before or shortly after delivery subsequently died. In these cases perinatal mortality review is carried out jointly with that unit.

All stillbirths and neonatal deaths are offered a post-mortem or undertake a Coroner's post mortem where indicated. All deaths are discussed at the multidisciplinary Perinatal Mortality and Morbidity meeting and are reviewed using the national Perinatal Mortality Review Tool (PMRT).

Stillbirth number/rates	York	Scarborough	Trust
2014/15	14 4.1:1000	8 4.9:1000	22 4.4:1000 births
2015	7 2.0:1000	4 2.5:1000	11 2.2:1000 births
2016	9 2.6:1000	4 2.5:1000	13 2.6:1000 births
2017	11 3.45:1000	4 2.7:1000	15 3.2:1000 births
2018	7 2.2:1000	1 0.7:1000	8 1.76:1000 births
2019	2 0.45:1000	9 6.43:1000	11 1.89:1000 births
2020	8 2.75:1000	7 5.14:1000	15 3.51:1000 births

The data above shows site variation in line with the narrative above and overall a very slight rise in percentage overall. Variation is expected year on year- it is evident that trust wide a reduction has been achieved over the last five years.

Audit of fetal losses up to 23+6 weeks gestation from 01.01.2020-31.07.2020

An audit was undertaken in order to review the cases due to the higher than average cases in the first seven months of 2020. There were 41cases recorded during this period compared to the whole of last year's statistics of 39 cases (23 miscarriages, 16 terminations for abnormalities).

The UK Government implemented a range of measures in March 2020 due to the Covid 19 pandemic. This resulted in changes to how the NHS delivered maternity services across the country and each individual Trust reviewed service provision at the time and implemented changes in to how antenatal care was delivered in their area.

Miscarriage is a common outcome of pregnancy, most studies reporting 12-15% loss among recognised pregnancies by 20 weeks gestation.
The audit showed that lifestyle factors can increase the risk of miscarriage but they do not cause it. Birth defects can occur in any pregnancy but some factors increase the risk. Prevention of a miscarriage or birth defect sometimes can be accomplished by decreasing the risk factors.

It is unknown whether any lady had been exposed to Covid 19 at any time during their pregnancy, all those that were tested on admission to hospital none had a positive result. Royal College of Obstetricians and Gynaecologists guidance states there is no evidence to suggest an increased risk of miscarriage if you become infected with coronavirus and are pregnant. There are no published studies on Covid 19 in pregnancy and birth defects. So at present the increased numbers within our Trust cannot be attributed to coronavirus. No operational service changes to the antenatal process were identified as having a direct effect on the outcome of the pregnancy.

A Service change due to Covid 19 to access to post-mortems has reduced identifying possible contributing factors as to what may have led to the death of a baby between 14 and 24+5 weeks. A full postmortem service was maintained from 24+6 onwards.

The full figures for the year are shown below

Medical terminations for abnormality	Miscarriages from 14-23+6 weeks gestation
27	31

During the course of 2020 the total numbers of late miscarriages have risen by 40 percent.

<u>National bereavement care pathway (NBCP)</u>

The NHS England Yorkshire and Humber strategic clinical network stillbirth steering group have embedding the nine standards into the audit tool to address the recommendation for improving stillbirths and bereavement care in Yorkshire and Humber maternity services. Each trust within the region completes the audit, on a 6 monthly basis. Once completed and submitted, it is then shared across the region. The first round for the new audit will commence early next year.
Work continues across the Trust to engage staff with the NBCP in order to embed the national guidance into every day practice irrespective of where the bereavement occurs when a baby dies. Some of this work was put on hold due to the Covid 19 pandemic but is expected to continue early next year.

<u>Bereavement Facilities</u>

York site currently have a charitable funds appeal to create a new maternity bereavement suite.

The Butterfly Appeal so far has raised £247,173.81 of the £250,000 required.

The provisional time scale for work to commence is April 2021 after the tender process has been completed.

Perinatal Mortality rates for York Trust from 2018 MBRRACE-UK report is as follows; (released December 2020)

Type	Per 1000 births (stabilised and adjusted)	Range
Stillbirth	3.03	(2.51 to 3.44)
Neonatal	0.78	(0.45 to 1.24)
Extended perinatal both together	2.21	(3.25 to 4.61)

Main recommendations of the National report;

- Ensure staff training in consent taking for post-mortem
- Use of PMRT
- Implement national initiatives in reduction of stillbirth and NND
- Identify specific needs of BAME population
- Multi agency approach for areas of socio-economic deprivation
- Investigate modifiable factors where Trust rates are red or amber
- Ensure postmortem is discussed with parents for all stillbirth and neonatal death
- Ensure placental histology is undertaken for all unexpected admissions to neonatal unit by a specialized perinatal pathologist

All recommendations are being worked towards with a guideline change in relation placental pathology having been implemented and further staff training on consent planned in 2021. York does not fall into red or amber brackets in any category. Timely reporting of cases to MBRRACE-UK and continued initiatives to reduce smoking and obesity in pregnancy.

Serious incident investigations are triggered for all stillbirths where the baby was alive at the onset of Labour or if concern is found regarding care provided (in line with regional practice). York Trust has seen over 50% reduction of stillbirths over the last 4 years.

An MBRRACE Twins report was published in January 2021 which will have implications for how care is provided, this report will also be considered at clinical governance in March 2021 and an action plan developed to implement any required changes.

Saving Babies Lives care bundles Version 2 (SBLv2)

The second version of these care bundles was introduced in March 2019; there are now five elements as follows;

- Reducing Smoking in pregnancy
- Risk assessment, prevention and surveillance of pregnancies at risk of growth restriction
- Raising Awareness of reduced fetal Movements
- Effective Fetal Monitoring in Labour
- Reducing Preterm Births

A fixed term band 7 project lead is in post to coordinate work to meet the care bundles. Work to address individual criteria within each element is ongoing; a business case was approved on 2 December 2020 which includes investment in increased scan capacity to

address SBL. Recruitment of sonographers is significantly challenging and work reviewing all options to implement in ongoing jointly with care group 4.

York trust is engaged in completing region wide surveys of progress towards full implementation coordinated by the clinical network.

Trusts can introduce alternative interventions for the elements than those recommended, however this needs to be agreed by commissioners and clinical networks. York trust does not plan to directly adopt all interventions so liaison with commissioners and clinical networks is planned specifically in relation to uterine artery Doppler scanning, this is an approach mirrored by other Trusts in region.

Reduction of smoking rates in pregnancy remains high on the maternity services agenda both locally, regionally and nationally (NHS Long term plan January 2019)

The 2020 rates of Smoking at time of Delivery (SATOD) are as follows;

York	11.2%
Scarborough	18.1%

These rates demonstrate a static rate based on the previous year which could be due to changes from Covid 19 in cessation services, ongoing work is in place jointly with commissioners and an incentive scheme is being considered for 2021.Significant training has been undertaken for midwives and e-learning is mandated for staff.

In 2020 two additional posts of band 7 fetal monitoring leads have been created to meet national safety learning requirements, the York post is appointed to and the Scarborough post is currently under recruitment. Named consultant leads for fetal monitoring are also in place.

Since commencement in post a half day multi-disciplinary fetal monitoring training has been developed and commenced, due to Covid 19 this is currently via teams meetings. Feedback from the initially sessions has been very positive. Weekly learning from emails are sent across all staff groups from MCR meetings that are fetal monitoring specific, sections of CTG are scanned in, anonymised and then annotated highlighting learning points. These have ignited a lot of useful discussion/debate and again had positive feedback. Weekly CTG review sessions/workshops for the maternity team will also be developed in 2021. This is joint work with fetal monitoring lead consultants participating.

From an E-learning perspective, the Trust is using the K2 fetal monitoring package which is mandatory for maternity registered professionals and close monitoring of compliance is in place.

Fresh eyes compliance has been challenging, we have introduced changes to processes and continue with frequent ongoing audit to assess compliance, and improvement has been noted. Joint working with the LMS and fetal fetal monitoring leads in neighboring trusts is in place. We participate in two different fetal monitoring lead networks, which contain fetal monitoring leads from different trusts across the country. This enables sharing of learning to improve safety systems.

2.2.4 MBRRACE-UK report Saving Lives, Improving Mothers Care (published 2020)

MBRRACE report *SAVING Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016 – 2018* was launched in December 2020 and published in January 2-021, this will presented at the O&G Clinical Governance forum in March 2021.

<u>New Recommendations to Improve Care</u>

For Professional Organisations

1. Develop guidance to ensure SUDEP awareness, risk assessment and risk minimalisation is standard care for women with epilepsy before, during and after pregnancy and ensure this is embedded in pathways of care.

2. Develop guidance to indicate the need for definitive radiological diagnosis in women who have an inconclusive VQ scan.

3. Produce guidance on which beside tests should be used for assessment of coagulation and the required training to perform and interpret those tests.

4. Establish a mechanism to disseminate the learning from this report, not only to maternity staff, but more widely to GPs, emergency department practitioners, physicians and surgeons.

For Policy Makers, Service Planners/Commissioners and Service Managers

5. Develop clear standards of care for joint maternity and neurology services, which allow for:
   - Early referral in pregnancy, particularly if pregnancy is unplanned, to optimise anti-epileptic drug regime
   - Rapid referral for neurology review if women have worsening epilepsy symptoms
   - Pathways for immediate advice for junior staff out of hours
   - Prompt postnatal review to ensure anti-epileptic drug doses are appropriately adjusted

6. Ensure each regional maternal medicine network has a pathway to enable women to access their designated epilepsy care team within a maximum of two weeks.

7. Ensure all maternity units have access to an epilepsy team.

8. Establish pathways to facilitate rapid specialist stroke care for women with stroke diagnosed in inpatient maternity settings.

9. Provide specialist multidisciplinary care for pregnant women who have had bariatric surgery by a team who have expertise in bariatric disorders.

10. Use scenarios identified from review of the care of women who died for 'skills and drills' training.

11. Ensure early senior involvement in the care of women with extremely preterm prelabour rupture of membranes and a full explanation of the risks and benefits of continuing the pregnancy. This should include discussion of termination of pregnancy.

For Health Professionals

12. Regard nocturnal seizures as a Red Flag indicating women with epilepsy need urgent referral to an epilepsy service or obstetric physician.

13. Ensure that women on prophylactic and treatment dose anticoagulation have a structured management plan to guide practitioners during the antenatal, intrapartum and postpartum period.

14. Ensure at least one senior clinician takes a ‘helicopter view’ of the management of a woman with major obstetric haemorrhage to coordinate all aspects of care.

15. Ensure that response to obstetric haemorrhage is tailored to the proportionate blood loss as percentage of circulating blood volume based on a woman’s body weight.

16. Do not perform controlled cord traction if there are no signs of placental separation (blood loss and lengthening of the cord) and take steps to manage the placenta as retained.

17. Be aware that signs of uterine inversion include pain when attempting to deliver the placenta, a rapid deterioration of maternal condition and a loss of fundal height without delivery of the placenta

Work will be undertaken to ensure all recommendations are considered within York Trust guidelines.

2.2.5 Clinical claims

A dashboard of clinical claims has been developed by the Trust legal team and the directorate reviews this content at clinical governance meetings to look for themes and trends in order that any learning may be identified.

2.2.6 Risk register

The O&G Risk register is reviewed monthly at the Quality and resource group meeting. Significant work has been undertaken in 2020 to develop a risk application process, Maternity specific risks include; reduced medical workforce available due to entrustability regulations, ability to meet the MIS CNST standards particularly in relation to SBLv2 and scanning capacity.

- Nitrous Oxide exposure higher than recommended levels in 50% of rooms on Labour ward at Scarborough (Risk rating 12).This risk is also at a corporate level and a paper supporting independent assessment and possible further remedial

works has been reviewed by corporate directors. Further progress on this risk has been delayed by Covid 19 restrictions, mitigations remain in place.

- Unable to achieve 51% Continuity of Carer by March 2022.
- Risk of not achieving CNST 2020 maternity safety standards, including implementation of SBLv2.
- Changes to National curriculum in relation to entrust ability of trainees creating shortfall in medical workforce.

  Work in the care group to address these risks is ongoing, in relation to the Nitrous oxide this is being led by the Trust health and safety team.

2.3 Patient Experience and User involvement

Maternity Voices Partnership (MVP)

Service user involvement has increased in 2020. In line with recommendations from Better Births 2016, a hub and spoke model of MVP groups operates within Humber, Coast and Vale Local Maternity System (LMS).

An overarching chairperson sits with the LMS group with local groups across Humber, Coast and Vale contributing. MVP work plans continue to evolve, particularly given the challenge for maternity service users over the last year regarding the pandemic. Focus has been placed on BAME and vulnerable women, women's experiences of care during Covid 19, access to mental health support and postnatal pathways with health visiting services.

At York Trust there are three groups, York and district MVP, Coast and Country MVP and East Riding MVP. All have service user chairs and service user representative. Remuneration is provided by commissioners for those involved.

The work of the MVP has faced challenge over the last year, with fewer meetings being held due to the constraints on the Chairs and the impact of Covid 19, though towards the end of the year, this situation began to improve.

York and district MVP have recently appointed a Chair into post after the position was unfilled for most of 2020. The Deputy Head of Midwifery is currently arranging inclusion in Trust Labour Ward Forums and Clinical Governance meetings, as per LMS MVP recommendations.

Though MVP meetings have been challenging, recently moving to a virtual model, momentum continues to grow for women's voices being heard. The daily Ask A Midwife service was introduced on the Trust's 'Bump 2 Babies' Facebook page at the start of the pandemic, to offer support for women anxious about their care and accessing services. Though hugely successful, the need for this service has declined and has therefore been stepped down to a general query service. Women are developing a real sense of community on the Facebook page, offering support to other women and praising their maternity care.

A ‘Whose Shoes’ event was planned for MVP groups in 2020 with HCV LMS providing funding. This work has now been moved to 2021, in light of the pandemic. The findings of these events will be included in the directorate patient experience action plan for 2021-22 which will incorporate the results from the national maternity survey and friends and family test, as well as direct feedback from women gained at the MVP group meeting and surveys.

2.3.1 Complaints and compliments

In 2020 there were 25 formal complaints and 49 PALS enquiries in relation to maternity care. The number of complaints fell during the lockdown period of the pandemic but rose again towards the end of the year. PALS enquiries were often related to service provision changes due to the pandemic.

Staff are given support in responding to complaints from the senior midwifery and medical team and given the opportunity to reflect on situations and cases. Midwifery staff can access Professional Midwifery Advocates (PMA) for support around responding to concerns and clinical care.

Patient Advice and Liaison Services (PALS) enquiries are often resolved by speaking directly to the person. Themes from PALS include;

- concern regarding birth experience wanting debrief
- Communication issues
- attitude of staff
- post treatment complications
-

Positive feedback is also received from PALS contacts.

Women can request a formal debrief following birth and this will be provided by either the PMH midwife or one of the labour ward coordinators/leads depending on the reason for their request. Emphasis remains on continual communication with women throughout the postnatal period and taking the time to talk about the birth experience at postnatal appointments in order to negate the need for full debrief.

Complaints top five themes

	Antenatal Clinic	Hawthorn Ward	Labour Ward	Maternity Unit	Obs and Gynae Medical Team	Ward G2	Total
Communication with Patient	1	0	2	1	1	0	5
Breakdown in Communication between staff	2	1	1	0	0	1	5
Attitude of nursing staff/midwives	0	0	3	1	0	1	5
Care needs not adequately met	2	0	3	0	0	0	5
Post treatment complications	0	1	0	0	4	0	5
Total	5	2	9	2	5	2	25

PALS top five themes

	Administration Team	Antenatal Clinic	Community Midwives	Hawthorn Ward	Labour Ward	Labour Ward Triage Unit York	Maternity Unit	Obs and Gynae Medical Team	Ward G2	Ward G3	Total
Communication with Patient	0	1	2	1	1	0	1	10	2	0	18
Attitude of nursing staff/midwives	0	1	0	2	1	1	3	1	3	1	13
Care needs not adequately met	0	0	1	1	0	0	2	2	2	0	8
Policy decisions	1	1	0	1	0	0	0	2	0	0	5
Communication - Clinical Advice	0	0	0	0	0	0	0	5	0	0	5
Total	1	3	3	5	2	1	6	20	7	1	49

Learning from complaints is shared within the Maternity service, by email and directly with staff individually. A 'Learning from' bulletin is sent out to all staff.

The service has a good response rate from FFT surveys with many positive comments, a quarterly report is sent to all staff with themes and trends. FFT were disrupted this year due to Covid 19, however have now been reinstated.

Compliments

	Ante Natal Day Unit	Community Midwives	Labour Ward	Maternity Theatres	Obs and Gynae Medical Team	Total
Positive Feedback for Staff	1	2	3	1	6	13
Total	1	2	3	1	6	13

2.3.2 Perinatal Mental Health (PMH)

The need for support with perinatal mental health has intensified due to the isolation and conditions brought on by the Covid 19 pandemic. The PMH Specialist Service continues to be provided by Tees, Esk and Wear valley (TEWV) across York and Scarborough with the Hull Perinatal Service picking up the women who live in the East Riding Area. The PMH specialist midwife undertakes weekly meetings with TEWV, where possible, and works closely with the Hull service whenever we have a woman under their care. The LMS working group continues to look at bringing together services across the LMS, identifying gaps and highlighting good practice.

Prior to Covid, weekly clinics were held by the PMH midwife cross-site which included a debrief service. Unfortunately this was unable to continue so the PMH midwife is supporting women and families over the telephone and only doing face to face contacts and home visits where necessary. This change in service provision also affected IAPT who are unable to continue with their clinics at Scarborough and York so they too are supporting women over the phone or via teams (or similar).

Future plans continue to be the inclusion of involvement from TEWV in Consultant led clinics and also the PMH midwife plans to strengthen the role of the PMH champions and ensure that there is one in each team/clinic area.

2.3.3 National maternal and neonatal health safety collaborative (#MatNeo)

MatNeo is an NHS Improvement programme supported by the Academic Health Science Network (YHAHSN). The aim is to create “a national safety quality improvement movement” Safer Maternity Care: Next Steps (2017)

York Trust was involved in the programme in wave three which concluded in March 2020, the Trust project was around reducing term admissions to the neonatal unit by reducing hypoglycaemia. Although this specific project is complete work continues via the Atain project.

A system wide piece of MatNeo SIP work for Yorkshire and the Humber due to commence in 2020 was put on hold due to the pandemic – work will recommence from January 2021. The project will focus on getting the right babies, at the right gestation, born in the right place.

A recent request from the Yorkshire & Humber Matneo SIP leads has asked for support in gathering some qualitative information around services, York will provide this where possible.

Some of the work identified from the SCORE culture survey, including leadership training and a Greatix system has been deferred due to the pandemic. Some localised work around culture, at ward level has commenced and 2021 will see the introduction of Quality Councils, where staff will have a regular forum for sharing ideas and concerns and can fully engage in service and quality improvements

2.3.4 Avoiding Term Neonatal Admissions into Neonatal Units (ATAIN)

NHS Improvement published a resource pack in February 2017 to support maternity and neonatal services to improve their service and reduce separation of mothers and babies.

An action plan is in place to address all aspects of care.

Achievements;

- Transitional care models are in place on both sites to support keeping mothers and babies together. A cross-site group has been established to develop transitional care further and work towards British Association of Perinatal Medicine (BAPM) standards.
- A business case was approved on 2 December 2020 to develop neonatal support workers to further build the capacity for transitional care on ward G2 in York which has been challenging when the neonatal unit had higher acuity and dependency. Once recruited and developed this will also release capacity in parent accommodation in NNU which is currently being used for transitional care which meets BLISS requirements.
- Increased use of drugs antenatally to improve outcomes; regionally York are reported to have a good use of antenatal steroids (to reduce respiratory problems) and magnesium sulphate (for neuro protection).
- Reduction in cold babies admitted to SCBU through warm baby champion work, now monitored through maternity dashboard.
- Reduction in the term admission rates from 4.6% at the start of the project to 3.39%

Plan:

- To continue to work with pediatricians, SCBU and the neonatal ODN in Avoiding Term Neonatal Admissions into Neonatal Units (**ATAIN**)

- Continue with work around PReCePT (Preventing Cerebral palsy in pre term): a national programme aimed at increasing the numbers of eligible women offered magnesium sulphate to prevent cerebral palsy in preterm infants (NICE recommendation).

The Atain action plan (refreshed January 2021) and updates are shared with the board level safety champion and neonatal safety champion at the Bi-monthly Safety champions meetings.

2.3.5 Antenatal Day Services

Provision of Flu and Pertussis vaccines

Provision of the flu and pertussis vaccine as a secondary offer to that made by GP practices was commenced in 2017 and continues in the consultant antenatal clinics on both sites.

There is a desire to further increase uptake and the service is currently looking jointly with HCV LMS into the feasibility of vaccination being offered more routinely through maternity. The resource and logistical complications to implementing this have made development challenging.

Changes have been made to the antenatal day services pathway to widen the gestational range of women able to access services on a direct referral from a midwife to increase satisfaction in experience.

2.4 Professional Midwifery Advocates (PMA)

The PMA role is a support role for midwives, utilising the Advocating and Educating for Quality Improvement model. (A-EQUIP). In 2020 during the Covid-19 pandemic, face to face restorative clinical sessions were suspended however the new initiative of PMA of the week was embedded across the Trust. This was achieved by the PMA sending notification of availability via email to each midwife and arranging to meet with midwives virtually or over the phone if necessary.

York Teaching Hospital NHS Foundation Trust (YTHNFT) currently has six PMAs, with a further one starting the training programme in 2021. PMAs are provided with 7.5 hours PMA time each per month.

Due to the pandemic external opportunities for training were cancelled however the North East and Yorkshire PMA network has flourished and YTHNFT PMAs are represented at this forum.
One of the PMAs has had two articles published in The Practicing Midwife. Magic moments continues across the whole Trust and recognises positive aspects of work and staff.

PMAs have been present at the Newly Qualified and New Starter sessions for midwives facilitated by the Clinical Skills Midwives who are also PMAs. Alongside to the buddy scheme – all new starters are allocated a PMA as a point of contact is made.

<u>AIMS for next year;</u>

To continue to raise the visibility of PMAs across the unit by having a PMA of the week at York and Scarborough and to link to each continuity team.
To continue with the face to face group Restorative Clinical Supervision (RCS) sessions within the mandatory training and to resume evaluation of the role in order to continue to have supportive data

To continue meeting with New Starters as anecdotally we are being informed that if individual midwives had not contacted and experienced RCS with a PMA then they would

have resigned. This was in response to RCS and is supported by the ongoing work of Sonya Wallbank (2020).

https://people.nhs.uk/guides/health-and-wellbeing-conversations-support-for-facilitators/

2.5 Maternity Transformation

Humber, Coast and Vale Local Maternity System (LMS) continue working towards an LMS plan for maternity services to;

- Ensure the implementation of Better Births by 2021
- Support the Secretary of State's ambition to reduce the rate of stillbirths, neonatal and maternal deaths and brain injuries by 50% by 2025. This is now included in the long term NHS plan January 2019

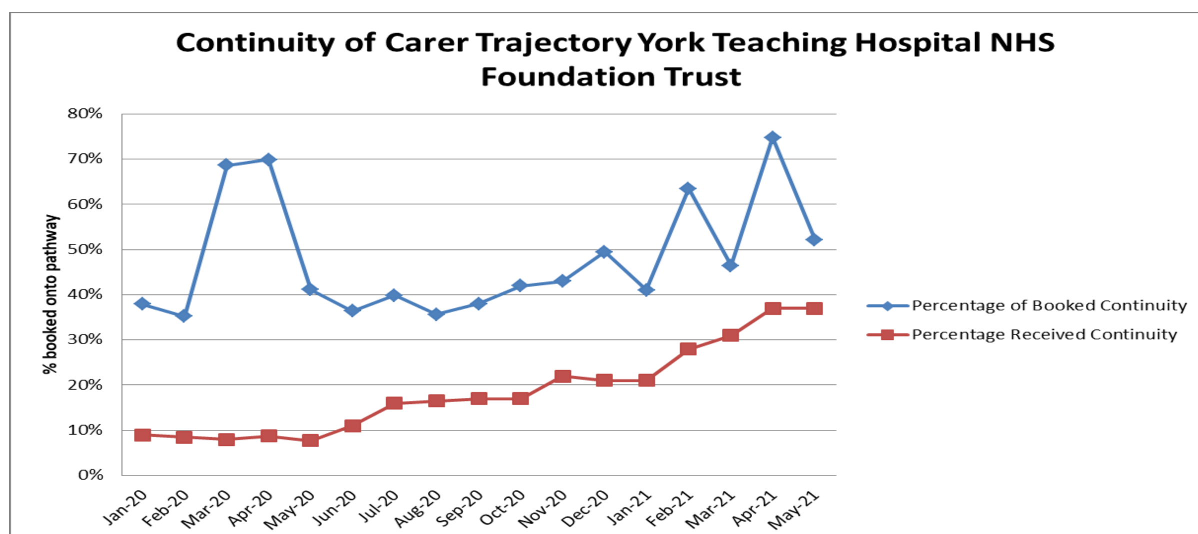
Funding was provided to the LMS senior team to support implementation of the plan. The Trust has representatives in each work stream and attendance from Head of Midwifery at LMS delivery board and the Chief Nurse at executive oversight and assurance board.

NHS planning guidance includes a trajectory to 35% of women across the LMS Continuity of Carer in antenatal, intrapartum and postnatal periods by March 2020 and 51% by March 2021. Due to the impact of Covid -19 this target has been reviewed nationally and the 51% target will now be March 2022. York Trust is required to provide reassurance to the LMS and National team that we are continuing to implement Continuity of carer and evidence continued development within the trust.

Following wholescale change on Scarborough site in January 2020, continuity has evolved and strengthened through learning and listening to both midwives and service users. We launched one team in York in March 2020, which was on hold until June 2020 due to Covid 19. It was hoped that we would be able to launch further teams on York site, however due to the impact of Covid on staffing and care, we have been unable to progress this further as yet. Plans are in discussion and following a Birth Rate plus review, will be submitted as a business case.

York Trust progress and projections are as below;

2020	SGH bookings onto CoC pathway	York bookings onto CoC pathway	Total bookings onto a continuity pathway(A)	SGH transfers onto pathway <29w	York transfers onto pathway <29w	Total transfers (B)	A + B	Total Trust wide bookings (C)	B + C	Percentage of women booked onto pathway	Total Trust Births	Percentage of Women receiving Continuity of Carer	Comments
January	185		185			0	185	488	488	37.9%	364	9%	
February	154	3	157			0	157	446	446	35.2%	329	9%	Sapphire team launched - not on call
March	166	29	195	100	36	136	331	482	618	68.7%	370	8%	
April	188	27	215	136		136	351	502	638	69.9%	326	9%	
May	139	18	157			0	157	382	382	41.1%	360	8%	
June	128	17	145			0	145	398	398	36.4%	338	11%	Sapphire team relaunch
July	168	19	187			0	187	469	469	39.9%	367	16%	Jasmine Team launch
August	137	14	151			0	151	424	424	35.6%	341	17%	
Septembe	121	18	139			0	139	366	366	38.0%	375	17%	
October	168	8	176			0	176	421	421	41.8%	381	17%	
Novembe	164	25	189			0	189	436	436	43.3%	264	22%	Malton Team Launch as on call
December	156	25	181			0	181	366	366	49.5%	333	21%	1.0 WTE to aSapphire team with caseload
2021													
January	160	21	181			0	181	441	441	41.0%	349	21%	
February	160	45	205		75	75	280	441	516	63.5%	349	28%	2nd on call team - York site (Jorvik)
March	160	45	205			0	205	441	441	46.5%	349	31%	3rd on call team - Scarborough
April	160	70	205		75	75	330	441	541	74.8%	349	37%	3rd on call team - York Site
May	160	70	230			0	230	441	441	52.2%	349	37%	



The trajectory shown is subject to financial support from the trust. Trust assurance visits received extremely positive feedback from the LMS and national team. Credit has been given to the teams for continuing to drive this transformational work forward in such challenging times. A one year virtual celebration has been planned for February 2021 with invites sent both external and internal to the trust to showcase our success. Advice and guidance has been sought by other trusts that are now planning to move forward with a wholescale approach based on the success of the wholescale approach on Scarborough site who are now displaying received continuity rates of 59%.

Plans going forward will include prioritising BAME and top decile of deprivation as per NHS Long term plan, Better births, regional and national targets for improving access to maternity care.

Digital Maturity is part of the LMS plan and the NHS long term plan. Maternity services submitted a Digital Maternity Assessment in June 2018 with input from IT.

The long term plan aims to have all women able to access their maternity notes and information through their smart phones and other devices by 2023/24.

Plan;

- Continue plans to work towards strengthening our existing continuity model and background planning for implementation of further teams as we have already exceeded our target of 35% CoC by March 2021.
- Focus on women from BAME and vulnerable groups.
- Continue to actively participate in working groups to progress the LMS plan with the LMS lead midwives, reporting progress against targets to the LMS and board monthly, including BAME and top decile of deprivation.
- Bid for any available transformation funding.
- Build a business case for York site to progress Continuity of carer to meet targets of 51% received Continuity by March 2022.

Ockenden Report part one

Part one of the Ockenden report into Shrewsbury and Telford was published in 10 December 2020, 7 immediate and essential actions with 12 urgent clinical priorities being identified. Trust were asked to make an immediate response by 21 December which York Trust did. This was followed by the launch of an assurance tool initially to be completed and returned by 15 January, an extension was then given to 15 February due to Covid 19.This purpose of this was to gather information to create a national gap and thematic analysis of the position.

The 7 IEA's are;

- Enhanced Safety
- Listening to Women and Families
- Staff working together and training together
- Managing Complex pregnancy
- Risk Assessment at each contact throughout pregnancy
- Monitoring fetal well being
- Informed consent

A series of resources have subsequently been launched to support Trusts, there is a requirement to implement the perinatal quality surveillance model- the purpose of this is to identify Trusts with issues early and prevent the need for another large scale enquiry into maternity services ever happening.

There is to be greater involvement and oversight from Trust boards, the LMS and ICS. An increased core competency framework for maternity staff has been launched and York training needs analysis has been updated accordingly. The role of the NED safety champion for maternity has been increased and there is now a minimum information requirement to go to Board monthly, this also includes direct Board review of any Maternity SI or HSIB cases.

Challenges for York Trust are as follows;

- Change and formalise process re SI and HSIB reports to Board
- Develop a standard monthly report and dedicated section on Trust Board which is fully documented in minutes
- Create independent advocate role
- Strengthen co-production and MVP role
- NED safety champion role
- Consultant led ward rounds with physical presence x2 in 24 hours
- Maintain MDT training at 90%
- Ring fencing of monies for Maternity safety and training
- Implementation of SBLv2- USS capacity
- Ensure all guidance is NICE compliant
- Evidence of formal risk assessment each contact
- Meet clinical workforce requirements and implement all BR+ recommendations
- IT system capability

Work is underway and it is anticipated that an evidence portal will open around April 2021 for Trusts to begin to submit to. An action plan will be developed to address all required areas, a standard template for reporting to board monthly will be developed, and the flow of information to board began with January information being received in February 2021.

Work continues to build on the Score culture survey and Birthrate plus full workforce review is underway. Clinical workforce review information will be submitted to board as soon as possible with a request for support for the findings. Part two of the report is expected in 12 months.

2.7 UNICEF Baby Friendly Initiative (BFI)

The maternity services have fully accredited Baby Friendly status, awarded by UNICEF. The units were assessed in December 2020 and are awaiting their final accreditation status. Many areas were passed at a high level, and the clinical skills of the midwives and support workers were excellent. We await a decision from the BFI Designation Committee for the future pathway of assessments and awards.

Achievements in 2020

The capacity of the specialist breastfeeding service at York has increased again. In response to the Covid-19 pandemic the clinic was supplied with smart phones so assessments and support could be given via video calls when face to face appointments were suspended. This element of support has been very successful and kept alongside the face to face appointments when they were reinstated. This has, again, significantly reduced waiting time.

Antenatal colostrum harvesting has become embedded within the maternity service, focusing on women whose babies are predicted to be put on the hypoglycaemia pathway. Antenatal clinic staff discuss colostrum harvesting at the 36 week appointment, provide women with the necessary information and pack, and then give her details to the Infant Feeding Co-coordinator for telephone follow-up.

Due to the Covid-19 pandemic we have stopped all breastfeeding volunteers on the wards.

Guidelines that have been updated includes weight loss management, cup and syringe feeding and all other guidelines/policies have been updated with the latest guidance from BFI.

Monthly auditing of the use of artificial supplements, readmissions of infants under 28 days old and of staff documentation continues, but now each case in investigated and feedback is to be given at the monthly Paediatric Case review meetings. The aim to provide learning opportunities across all discipline.

The 2 day BFI 'Breastfeeding and Relationship' building course was ran on four occasions (twice per hospital site) with maternity staff, Paediatric nurses and SCBU nurses as participants.

Paediatricians were registered onto the UNICEF e-learning course and received face to face training with the Infant Feeding Co-coordinator.

Plans for 2021

UNICEF reassessment of the services to achieve reaccreditation of 'Baby Friendly' status.

Increase breastfeeding rates, especially in targeted areas. Bridlington to be targeted with specific interventions antenatally and in the immediate postnatal period to support initiation rates and continued breastfeeding.

Increase specialist breastfeeding clinic support for all women to access and development a new service in SGH to compliment and support this.

Continue to ensure all new maternity staff receive the 2 day BFI course within 6 months of start date, solidify Paediatric training on infant feeding issues and implement a training programme for SCBU and Paediatric nursing staff.

2.8 Antenatal and Newborn Screening

The antenatal and newborn screening service received a PHE Screening Quality Assurance Service (SQAS) inspection report in January 2020 and developed an action plan to close the 19 recommendations for the Trust. Whilst COVID-19 has delayed the response to some actions, all actions have now been completed by the final review meeting February 2021.

The coronavirus pandemic has a significant effect on the delivery of the Newborn Hearing Screening Programme as the hearing screening team lost access to clinic spaces for babies needing to return for repeat screening and audiology assessment. The team extended their inpatient service coverage to try and increase the number of complete screens before babies were discharged home. Despite this, significant backlogs developed for babies needing further assessment. Remedial work to address these backlogs have been undertaken and the residual backlog is now minimal.

The other antenatal and newborn screening programmes were able to be maintained without backlogs during COVID-19 with changes to some pathways as guided by RCOG and PHE. This included a change in process from April to October of delaying antenatal bloods until the first face to face appointment (scan at 12 weeks) as booking appointments with a community midwife were completed via telephone. The screening team took on additional failsafe processes to ensure the bloods were completed and results were followed up.

The screening service has continued to perform well overall on the key performance indicators (KPI) for maternity and newborn screening. Of particular note is the continued success with attaining the acceptable standard for avoidable repeat newborn blood spot (standard now maintained for the last 8 quarters) and meeting the achievable KPI of <1% of samples being avoidable repeats for the first time in quarter one of 2020.

A screening safety incident was identified and reported to SQAS in December 2019 involving two missed referrals for hip ultrasound in the Newborn Infant Physical Examination (NIPE) programme. This prompted a large scale look back exercise in January 2020 identifying a further 23 cases. Duty of candour responsibilities were

completed and appropriate follow up arranged as per SQAS recommendations. A root cause analysis led to the development of additional resources to support NIPE practitioners and extra failsafe measures are now in place to help prevent further missed scans.

Another 4 screening incidents were reported to the SQAS across the year with internal management recommendations made for each of these.

2021 will bring some changes to screening team as our Scarborough screening support midwife steps up to the screening coordinator role to cover maternity leave from January. Recruitment is underway to cover the screening support midwife hours.
The screening team are also expecting updates and changes to several screening programmes from PHE next year. Planning work has commenced for changes to NIPE pathway and we are awaiting further information on the introduction of Non Invasive prenatal testing with the Fetal Anomaly Screening Programme and the enhanced Hepatitis B pathway for the Infectious Diseases Screening Programme.

3. Next Steps

Work continues to progress, develop and improve maternity services in line with national regional and local plans, making maternity care safer by;

- Following the release of the first part of the Ockenden report in December 2020, work towards implementing the perinatal clinical quality surveillance tool and ensuring York Trust meet all recommendations.
- Continued work to reduce stillbirths, reducing term admissions to SCBU and improve neonatal outcomes.
- Implementing the LMS plan to achieve recommendations in ‘Better Births’ and improve outcomes.
- Offering 51% of women continuity of carer by March 2022 to include 75% BAME women.
- Continued work on Matneo local and regional projects
- Work towards implementation of SBLv2
- Continued engagement in regional and national maternity work

4. Detailed Recommendation

The report aims to provide information to the Board of Directors on detail of activity, achievements and challenges faced by maternity services in 2020 with future plans for 2021 outlined to improve and provide a safe quality service meeting local, regional and national priorities.

For the Board of Directors to review and confirm support to develop any required business cases to enact the action plans to achieve 100% supernumerary coordinator status and 100% 1:1 care in labour.

Q3

NHS

York Teaching Hospital
NHS Foundation Trust

StarAward

A monthly award which recognises the achievements of staff and volunteers

Nominations Booklet
March 2021

StarAward

A monthly award which recognises the achievements of staff and volunteers

Nominations for March 2021

Chris Alletson
Lead Orthoptist

Bridlington Hospital

Nominated by
Fiona Bailey
A colleague

We have an amazing team of 5 AHP injectors in Bridlington but due to a combination of long term sickness and annual leave this week we have been down to one, Chris. He has rearranged his other duties and covered all the other injector sessions; often having to do the work of two people. He does this without complaint and with a smile on his face. He always puts the needs of the service and of the patients first and is a credit to the Trust. The whole team in Bridlington are excellent and I feel honoured to work alongside them. They always work tirelessly and have worked all through the pandemic in a very busy specialty. They have rallied together at this difficult time but I feel Chris deserved a special mention due to the extra pressures that have fallen on him this week.

StarAward

A monthly award which recognises the achievements of staff and volunteers

Michelle Large **Community Based** **Nominated by**
Midwife **Kerry Dobbs**
A patient

Michelle has made me feel so at ease and that she is there if I ever need her during my pregnancy, no question or worry is brushed aside and when my anxiety has gotten the better of me and I’ve been crying my eyes out she was there at the end of the phone and in person checking I’m ok never making me feel stupid or an inconvenience! Literally the nicest, most caring and supportive midwife I have ever met! Truly an amazing person!!

Jayne Whale **Community Based** **Nominated by**
Ward Clerk **Elle Harrop**
A colleague

I currently work for Track and Trace, and this lovely ward clerk couldn't do enough to help us. Jayne did her absolute best to find all the staff we needed to trace from various groups (nurses, doctors, AHP's etc). All whilst being cheerful, and doing what she could to make everything easier for us. Her bright personality put a smile on our faces and made our day a little bit better and Jayne should be recognised for how much of a difference her help made. Thank you!

Mary Welford **Community Based** **Nominated by**
District Nurse **Louise Preston**
A colleague

I would like to nominate Mary Welford because Mary has and is a power of strength. Her support throughout the pandemic is truly amazing. Mary works above and beyond and really has been thrown in the deep end, due to the fact that she only took up the Band 6 post a month before the pandemic. She is so wonderfully caring but most of all is so approachable if anyone is finding it difficult. Mary at times has found it difficult herself but puts her feelings aside to help us. I really do feel without Mary our team wouldn't be quite as good as it is. I feel she needs this award because sometimes in community we are very much left to our own to sort issues out and Mary never complains and very often is still working after her shift ends to help with patient's and complex cases. She is truly wonderful !!!

StarAward

A monthly award which recognises the achievements of staff and volunteers

Jacqui Chilcott — **Community Based** — **Nominated by**
Diabetic Eye Screener — **Julie Peacock**
A relative

My mother Mrs Joan Peacock attended a diabetic screening appointment at 2pm on 18/1/21 based that day at Northway clinic Scarborough . She has very poor mobility. The nurse who conducted the appointment was so kind and professional and had a great understanding of Mums needs. Really outstanding.

Judith Norrell and the Respiratory Specialist Nursing Team — **Community Based** — **Nominated by**
Eleanor King
A colleague

Judith and her team were asked to implement a COVID Virtual Ward to aid discharge and ongoing monitoring of patients with COVID. The timescale for this work was very short but the team rallied to the occasion superbly, reorganising rotas, amending documentation and changing their working practices as needed. With the support of colleagues from the clinical team, CCG, matrons, care group management and IT they got the ward up and running and 'seeing' patients. There is still much to be done to evaluate and develop this project but Judith and her team have taken such a positive and 'can do' approach we have no doubt they will be successful.

Fiona McHale — **Community Based** — **Nominated by**
Secretary — **Katherine Carr**
A colleague

During the pandemic lock downs Fiona has kept us all smiling over face book first every evening she would get dressed up and dance and sing putting her videos for us all to see. Then over the last lock down she has treated us all every evening to her making a different cocktail calling it raise a glass raise a smile and this continues all us community nurses look forward to watching her every evening she really has kept us smiling an inspiration.

StarAward

A monthly award which recognises the achievements of staff and volunteers

Eric Trueman	**Scarborough Hospital**	**Nominated by**
Volunteer		**Liz David**
		A colleague

Eric worked for the Trust in stores for many years up until retirement a few years ago. He now comes into the Hospital as a volunteer working on main reception one day a week and is a breath of fresh air - greeting members of staff and patients alike. He is very sincere in his work and nothing is too much trouble he even comes in to guide new volunteers that come to work on main reception. It has been a struggle with no visiting and relatives dropping patients belongings off at main reception but Eric always goes above and beyond to help. He takes the bags up to the ward for the patients as far as he is permitted to go and hands them over to whoever answers the doorbell. This is a thankless task and I feel Eric should be rewarded with a star award for his kindness and thoughtfulness regarding patients and staff.

Nigel Watkinson	**Scarborough Hospital**	**Nominated by**
Electrical Supervisor		**Maya Liversidege**

After a brief conversation in October with the Hospital's Fundraising Team, Nigel decided to make a difference at Christmas and embarked on creating a magical light display in his garden for local families to come and see, whilst raising money for the Children's Ward at Scarborough Hospital. Nigel has previously done this with his best friend at another location for other local charities, with his friend 'Radd'. Sadly Radd passed away earlier this year and Nigel took up the challenge to create the display in his own garden along with a mini steam train ride in his memory. This was no mean feat with over 10,000 LED lights to keep up, power surges, rain and of course making it all Covid safe. Over the course of December, every evening and weekend, Nigel's garden was visited by 100 local families and he conducted over 300 steam train rides for the children. Nigel went above and beyond not only to raise an incredible £1500 for the Children's Ward at Scarborough Hospital, but also by giving local families a magical experience that really brought a smile to people's faces. Nigel's hard work and time made a difference not only to the patients on the children's ward but also to many staff members families who visited and had their Christmas made that little bit better. Thank you Nigel.

StarAward

A monthly award which recognises the achievements of staff and volunteers

Penny Furness **Scarborough Hospital** **Nominated by**
Healthcare Assistant **Michelle Bailey**
A colleague

I handed over my patient over to the night staff including Penny. I had built a good rapport with an 87 years young widow (fit and healthy for her age) who had been admitted with breathlessness and was being treated for a chest infection. Sadly her cardiac blood results came back and showed she had had a heart attack (she had chest pain 2 days ago but didn't attend A&E) the cardiologist scanned her heart and found a septal valve problem that needed urgent surgery at Castle Hill Hospital via blue light transfer. My patient was understandably scared and upset and told me her daughter and her had been in tears on the phone in the last few minutes. I asked Penny to make sure the family were properly informed of the seriousness of the situation by a doctor in order for them to have the opportunity to see her. I asked Penny to look after her and I introduced them to each other and we all tried to alleviate her fears and reassure her before I went home after my shift. I hoped on such a busy night with a shortage of nurses my patient would be supported and get her surgery. Penny sat and held the patients hand for 2 hours in A&E as she started to take a turn for the worst and the transfer to Castle Hill was no longer an option. It was arranged that the patient would go to the ward for palliative care and Penny stayed with her to settle her in to the ward and see the family arrive, which helped the patient immensely in such a heart breaking situation. As a nurse of 22 years I know how hard it is to be involved in this pivotal moment in a person's life. Penny showed a very high level of dedication and compassion in order to help our patient start to accept her life was ending, To give support and palliative care at the height of a pandemic in an extremely busy and understaffed A&E department night shift firstly shows bravery in being the patients advocate especially as this role is often a specialist nursing role and secondly shows an extremely high level of compassion. She prioritised our patient's care and tried her best to support the patient throughout making sure she was comfortable and physically and emotionally supported. Penny told me afterwards that our patient became settled and more at peace when the family arrived. She told me she will visit her on the ward tonight in her own time before her night shift if she is still there. Penny has gone above and beyond the scope of her role as an HCA to deliver gold standard high quality emotional support and patient care to a frightened patient who was alone in A&E absorbing the news that she was likely to pass away that night without seeing her family. This is usually a skill learned over many years of nursing and a specialist nursing role usually orchestrated by a band 6 or 7. Penny deserves a star award because she is a star.

StarAward

A monthly award which recognises the achievements of staff and volunteers

The HPV Team	**Scarborough Hospital**	**Nominated by John Pownall and Jennifer Louth Colleagues**

This is a team that have been so flexible and unbelievably supportive. They a have supported all sites including delivering HPV at York on Christmas day. They work over to complete jobs come in early so as not to affect patients and will go out of their way to clean HPV and UV3 to ensure the bed managers have the beds they need to keep the patient flow moving. As a team they produced and implement a proactive communal toilet clean using UV technology which is known to destroy the Covid virus. The team are totally committed to ensuring wherever possible beds closed wards, flipped wards etc are back in the system asap to ensure the hospital has the beds available for patients.

Michael Glasby Radiographer	**Scarborough Hospital**	**Nominated by Jennifer Matthews A patient**

Michael performed my CT Scan on 8/1/2021 and he was unaware how frightened I was after previous bad experience. His whole manner and approach were above the normal and I feel very strongly that he should be recognised for his care and kindness and help. He is a definite star.

Freya Oliver, Debbie Hollingworth and Gillian Locking Midwives	**Scarborough Hospital**	**Nominated by Celina Taylor A colleague**

As a member of staff whom was going through mental health issues and a diagnosis of PTSD I received amazing support from management. I can't express the gratitude I feel and it shows that York Teaching Hospital has fantastic management.

Star Award

A monthly award which recognises the achievements of staff and volunteers

The Swabbing Team	**Scarborough Hospital**	**Nominated by** **The care Group 2 Matrons**

The Swabbing Team was set up very quickly in response to the first wave of Covid, a very trying time for all in the trust, the team evolved and pulled together over the months to provide all staff at Scarborough Hospital a service to be swabbed in a timely fashion to support staff to return to work safely. The teams flexibility and adaptive approach has since seen swabbing increased to cover pre-elective surgery and cancer care swabs at the Scarborough and Malton site. All the team have a "can do" attitude and epitomise the trust values working seamlessly in the background to support all care groups at the hospital. As a matron team we feel the service the Swabbing team deserves recognition for their continuous hard work and we would like to also take this opportunity to share our sincere gratitude with Edwin and his team!

The Emergency Department Team	**Scarborough Hospital**	**Nominated by** **Sarah Freer** **A colleague**

The past 10 months has been extremely challenging for all the NHS dealing with the uncertainties of the pandemic. I would like to nominate the Emergency Department team at Scarborough Hospital, as the matron for the department I have always been proud of the hard work and dedication the team demonstrate on a daily basis, however throughout the past 10 months I have been further astounded and humbled by the full teams approach to ensuring the department continues to provide safe, timely effective patient care. The department had to undergo rapid environment changes to respond to the COVID surge, which was undertaken responsively and calmly. New processes were fostered and implemented enthusiastically without judgement and temporary staff were welcomed and supported without question. The ED team are simply remarkable and deserve to be recognised for their consistent hard work and dedication! Well done team and thank you!

StarAward

A monthly award which recognises the achievements of staff and volunteers

Alison Hornsby **Service Improvement Manager**	**Scarborough Hospital**	**Nominated by** **Sarah Freer** **A Colleague**

Ali has supported the front of house team at Scarborough Hospital with numerous service improvement projects, throughout the pandemic Ali has continued to do this from home. I would like to nominate Ali for her continued support of the Emergency Assessment Unit, the pandemic saw two areas that needed to merge to provide one overall emergency assessment area, Ali was key to ensuring the improvements continued for the unit working collegiality with the clinical lead, ward leader and AHP lead to develop key metrics and improved ways of working to maximise patient pathways whilst ensuring patient safety was maintained. Ali is a credit to the Quality Improvement team and deserves to be recognised for her continued support and dedication.

Paul McGuire **Charge Nurse**	**Scarborough Hospital**	**Nominated by** **Sarah Freer** **A colleague**

I would like to nominate Paul McGuire for a Star Award in recognition of the hard work, dedication and leadership he demonstrates for his role as lead charge nurse in the Emergency Department at Scarborough Hospital. The ED is an extremely busy environment and throughout the past ten months has flexed to support all changes required to provide safe patient care to both COVID and non COVID patients. Paul has been instrumental to ensuring a calm structured process was maintained throughout, demonstrating exceptional inclusive leadership throughout. Paul has continued to promote high standards of patient care by devising and implementing measures for the team to improve the ED experience for all "high risk patients" who attend the department requiring enhanced support. Paul continues to strive for excellence and with the engagement of the ED team will always provide the best patient care! thank you.

StarAward

A monthly award which recognises the achievements of staff and volunteers

Sharon Miles **Service Manager**	**Scarborough Hospital**	**Nominated by** **Sal Katib** **A colleague**

Sharon has worked tirelessly to open a new Children's Assessment Unit in Scarborough for Children and Young People. There have been tight time restraints and challenges around staffing and Sharon has shown great resolve and forward planning throughout. She demonstrates the values of the organisation and has shown fantastic operational leadership. I have nominated Sharon for her Quality Improvement and forward thinking attitude and hard work.

The Subject Access Records Team	**Scarborough Hospital**	**Nominated by** **Rachel Stanton** **A colleague**

This team have been instrumental in supporting the work of the Safeguarding Children Team during the COVID-19 pandemic to date. The Safeguarding Children Team are involved with a significant number of cases of serious harm to children, and those cases are being considered for learning reviews as per the statutory process. The Records team have supported us in this work by being able to retrieve the relevant records from archive and produce an electronic copy of the records - in some instances for large family groups and within a 72 hour timeframe. There is a requirement for the records to be stored securely, known as being 'locked down', when a case is being considered for a serious child practice review - so having a full electronic set of the records is excellent. It has meant my team have then been able to provide the relevant response to the safeguarding children partnership within the statutory 15 working day timeframe. We simply could not have achieved this during the pandemic without their support. We are involved currently with 12 cases - during the last 10 months and previously the trust was involved with 3 cases in the previous 3 years. This increase in cases is unprecedented, combined with a relatively new rapid review process - the pressure on my team has been significant. Simply put - we literally would not have been able to achieve this without the efficiency and willingness of each member of the subject access records team in supporting us. A huge thankyou to Candice Hill Edoardo Brandabi Jacob Rear Carole Jackson Debra Blair

StarAward

A monthly award which recognises the achievements of staff and volunteers

Heather Baxter **Scarborough Hospital** **Nominated by**
Associate Practitioner **Alastair Wilson**
A patient

I was shaking and concerned about the procedure that I was having done. Heather has such a warming smile she immediately started to put me at ease with her soft and gentle voice, as well as asking questions related to the procedure, she asked about things that are important to me, showing such interest that for the rest of her time with me I forgot about what was to happen. I felt like I was the only one to be treated that day. She has great talent and I feel must be recognised and thanked in some way.

Beech Ward Team **Scarborough Hospital** **Nominated by**
Jo Blades
A colleague

Beech Ward provided care and treatment for a gentleman with a learning disability and very complex needs over a 3 month period including throughout Christmas and New Year. The gentleman developed COVID, which the ward staff nursed him through. They managed the challenges that his behaviour presented and supported him to cope with being discharged to alternative accommodation than his own home which he did not want to move to.

Sam Pickering **Scarborough Hospital** **Nominated by**
Staff Nurse **Leanne Cross**
A patient

I recently had to have emergency surgery on my bowel. While recovering on Oak Ward Sam went out of her way to make me feel comfortable. She gave me advice on the best way to recover and kept me thinking positive. She came in early for her shift and came to see me to see what kind of a night I had. Due to COVID I didn't have a hand to hold to tell me everything was going to be ok but Sam was there for me as well as the other patients on the ward. I am so thankful for all the nurses that helped me. Considering there is a pandemic going on at the moment this did not stop all the teams from looking after me. From the ED staff to Lilac Ward where the nurses looked after me while I was in so much pain to the lady who did my CT scan they were all so caring. The surgery team saved my life and I am so great full. Then I went on to the hub in Oak Ward where I had the best recovery care. Please give a shot out to all the teams who looked after me as I am very grateful. Thanks.

StarAward

A monthly award which recognises the achievements of staff and volunteers

Edwin Morgan-Sellars **Senior Healthcare Assistant**	**Scarborough Hospital**	**Nominated by** **A colleague**

I think Edwin Morgan-Sellars should be recognised for all his hard work with co-ordinating the PCR swaps for staff during the pandemic. He is professional, organised, calm and cheerful and has shown a lot of dedication to the role.

Jess Jennings **Healthcare Assistant**	**Scarborough Hospital**	**Nominated by** **Debbie Hayden** **A colleague**

We had a elderly lady on the ward who had been very poorly and had become very confused. She could be very nasty at times, but Jess saw through that and took the lady under her wing. She had a lot of patience and calmed the lady down and when she came onto her shift washed the lady's hair for her, put some rollers in , dried and styled it for her . She really pampered this little lady who thoroughly enjoyed it. Jess is a nice person and is lovely to the patients and does it because she wants to and not because it is her job.

Michelle Kirkman, **Gemma Kellerman and** **Julie Kew** **Cancer Information and Support Officers**	**Trust Wide**	**Nominated by** **Jane Archer** **A colleague**

Michelle Kirkman and Julie Kew work at York Hospital, Gemma Kellerman works at Scarborough Hospital and they perform the same function. These colleagues (within my team) have been there to support patients and family members from the very start of the pandemic and continue to provide wellbeing telephone calls to people who may be vulnerable. They have been working each day alongside clinical colleagues to find ways to help and support those in most need, sometimes with practical assistance, sometimes as a friendly reassuring person to talk to during times of loneliness and anxiety. Despite the fact that their colleagues have unfortunately been off sick during this time and that they have often been the only people in the department - each one of them has carried out their daily support role with the same enthusiasm and commitment they always do. I would like it to be recognised that they have done this during a difficult time, and I felt that a Star Award would be a nice way to do just that.

StarAward

A monthly award which recognises the achievements of staff and volunteers

The Security and car Parking Team | **Trust Wide** | **Nominated by Andy Stafford A colleague**

The Security and Car Parking team have worked tirelessly during COVID, and are often overlooked as frontline workers, in recent weeks we have had a significant level of COVID positive tests, and staff having to self-isolate as well as one member of the team having been hospitalised with COVID. The whole team have stepped up to the challenge, and provided an excellent level of support to colleagues across the whole of the Trust, and provided much needed assistance in setting up and assisting with the COVAX centres. I am very proud of them all and hope their contribution can be recognised

StarAward

A monthly award which recognises the achievements of staff and volunteers

The Volunteering Team	**Trust Wide**	**Nominated by Kim Bynoe A colleague**

I am a volunteer at York hospital. I was previously a Trust employee. This team throughout the pandemic has enthused a large cohort of volunteers. They have kept us informed throughout and made us feel empowered and important to the service. This has maintained motivation and has ensured that the band of volunteers were ready and willing to take on the task of the staff vaccination programme. As a result, I believe this has been a hugely successful, coordinated approach. Staff have been made to feel at ease and vaccinators have been supported to do their work. They have worked tirelessly - giving up days off and putting volunteers as their priority. They deserve an award!!

The Theatre Administration Team	**Trust Wide**	**Nominated by Sarah Crossland A colleague**

The Theatre Admin Team across both sites have had an extremely challenging year trying to coordinate and respond to the every changing demands on the theatre rotas due to the pandemic. All the members of the team have been extremely resilient, flexible and very helpful in making sure that all the rota/theatre and site changes are implemented and communicated out to the wider team, I am extremely proud of the way the team have reacted to such a challenging time and think they deserve recognition for all the work they are doing behind the scenes. Thank you to you all.

StarAward

A monthly award which recognises the achievements of staff and volunteers

The Team on SCBU | **York Hospital** | **Nominated by Nikki Johnstone A relative**

The care they gave my son, who was born 3 months prematurely, during his 2 month stay on SCBU, especially during the pandemic was amazing. Not only the care they gave my son but the support they gave me and my husband. The staff were so friendly and genuinely cared about the well-being of all of us. They made our time on the unit as comfortable and supportive as possible. They actively encouraged us to be as involved as we could with the care of our son and helped promote bonding in such difficult circumstances. All staff made our time on the unit enjoyable including doctors, nurses, nursery nurses, health care assistants, cleaners and ward clerks and would celebrate all milestones and achievements with us. With a special mention to Becky McClelland, Sam Ephrot, Ann Peterson and the lovely cleaner Sue. This has continued since coming home from the unit with care from the lovely Bernie Wood, the neonatal outreach sister. We cannot praise York SCBU enough.

Clare Sanders Midwife | **York Hospital** | **Nominated by Sonia Ralph A patient**

Clare was with me through most of my time on labour ward and during the birth of our daughter Annabelle. She did an amazing job of supporting both me and my husband through what was a difficult induction process which ended in what felt like a traumatic Caesarean section. She was amazing at guiding me through the pain when the epidural was wearing off and helped both of us through the section and supported us right through the entire shift. She made the whole experience much more positive and made what felt like a horrible situation at the time much better. The whole team that looked after me during my entire stay from antenatal to post-natal were amazing but Clare really stood out and it felt like she went above and beyond to guide us through the whole process.

StarAward

A monthly award which recognises the achievements of staff and volunteers

Abi Pilot **Phlebotomist**	**York Hospital**	**Nominated by** **Sally** **A patient**

After a distressing experience in another department in the hospital this lady provided me with the care and compassion I needed. I was clearly distressed (I cried a lot in her presence), Abi saw the reason for my distress on my blood form, I was suffering a loss, and she was just all I needed someone to be in that time, caring, compassionate and human! She was a true star in a time where I needed someone to just be that!

Jo Harman **Staff Nurse**	**York Hospital**	**Nominated by** **Robin Benson** **A patient**

When you are admitted as a patient not only are you feeling unwell but also vulnerable and anxious. The qualities most helpful with this in a nurse is feeling safe in their presence, confident in their abilities through their words and actions, seeing them stay calm under pressure, delivering on the actions they promise to help you with, and an overall genuine feeling of care and compassion Staff nurse Jo Harman demonstrates all of these qualities in abundance. She is skilled in her role, takes pressure in her stride and never once made me feel like my needs were not number 1 in that moment of my care. Clearly the nursing role has many priorities, emergencies, pressures and difficulties (demanding or difficult patients can no doubt be the cause of these) but care, compassion and communication should remain as important as the treatment and Staff Nurse Jo Harman exemplifies these qualities and deserves to be recognised in the York Hospital Star Awards.

Sammy Thorpe **Staff Nurse**	**York Hospital**	**Nominated by** **Pauline Ducat and Beth Finelli** **Colleagues**

We were working with Sammy in the Vascular Imaging Recovery Department, when a female patient's condition deteriorated, following a cardiac procedure. Sammy firstly identified this deterioration quickly and went on to provide first class care to the lady. She kept us, as her team, involved and included in caring for the lady. She was articulate and took control of the situation, which ensured everything ran smoothly. The way Sammy worked showed us how even on a challenging day, when high quality support is given, this can leave you going home feeling part of a fantastic team.

The See and Swab Team	**York Hospital**	**Nominated by** **Karen Cowley** **A colleague**

Since the start of the pandemic last year the patent access team have been at the forefront of the PCR swabbing service for staff and family members. This service has grown throughout the last year and most latterly the request to undertake 72 hour routine swabbing of staff involved in the York outbreak. The team had to co-ordinate

booking all staff in every 72 hours over a three week period. This equated to 700+ staff on top of the usual service. Great teamwork and staff going the extra mile in order to cover additional hours and also over the Christmas and New Year period meant this request was very successfully delivered. The team have worked tirelessly into evenings, weekends and bank holidays to contact staff, create new CPD records with a smile on their face. They are hidden away out of sight however they are the backbone of our organisation in relation to booking our outpatient services. We could not have achieved what we have achieved without their courage and conviction. To date we have booked 3,357 swabs. I am immensely proud of this team.

Peter Hall
Consultant
York Hospital
Nominated by
Paul Robinson
A relative

Dr Hall carried out an intrathecal operation on my wife just before Christmas. His manner, kindness and communication have been utterly outstanding, offering his personal time to help us. During a home visit he took the time to include our 6 year old daughter in the procedure to replace the Bolus bag on her mum. He used her as an assistant and was absolutely lovely with her. She was very, very proud. Thank you so much!

StarAward

A monthly award which recognises the achievements of staff and volunteers

Agnes Piotrak
Operating Department Practitioner

York Hospital

Nominated by
Jude Rayner
A colleague who wishes to remain anonymous
Colleagues

Jude said:
Agnes was involved with a particularly difficult situation in Resus. She attended a trauma call which was a stabbing. The patient did not speak English but did speak the same language as Agnes. Agnes translated for the doctors and the patient at a very difficult time. Unfortunately the patient's husband had also been stabbed and sadly passed away before arriving at hospital. Other family members were also involved with the assault. The police were present and due to the nature of the situation questions were time critical and extremely sensitive. Agnes supported the patient who was extremely distressed and assisted the police with some questioning. Agnes was asked to inform the patient of her husband's death. She did this with such kindness and compassion. She remained in resus to offer support to the patient for some time. Agnes went above and beyond on that day. She was a complete professional and I think she most definitely deserves this award.

Nominator two said:
Agnes attended an adult trauma call to resus, on assessment of the patient a language barrier presented. Agnes spoke the same first language as this patient. Agnes was able to interpret the patient's medical needs, the nature of the case required police presence. Agnes assisted the police with breaking devastating news to the patient and due to the time sensitive enquiry took a statement from the patient. Agnes was very professional throughout this situation and showed great empathy to the patient. Agnes showed great courage by continuing manning the crash bleep for the remainder of her shift.

StarAward

A monthly award which recognises the achievements of staff and volunteers

Bernie Wood | **York Hospital** | **Nominated by**
Outreach Sister | | **Michelle Waudby**
| | **A relative**

During the Covid-19 pandemic Bernie has been a source of consistency and reassurance for not just our family but many others. She is reliable and dependable. Where health visitors and midwives were not permitted to do home visits, neonatal outreach continued to offer them and the support was phenomenal. Despite having what I'm sure is a huge caseload (as there's only 2 of them) Bernie was always there, calm, collected and ready to offer the latest advice. No question was silly and there was never any judgement. Outside of regular appointments she was always on the other end of the phone and always got back to us. If we needed additional support she was there, any time of day or night. To think she was offering such a service to multiple families is incredible. On top of the essential requirements Bernie also took time to get involved with us on extra things , like special events like neonatal awareness, prematurity day, Christmas etc. and made us keepsakes for these that our baby will be able to keep and look back on. At a time where we couldn't access the support of friends and family in the traditional way, Bernie stepped up. She has consistently put her caseload, babies and families ahead of any anxieties she must have had with the pandemic. Ahead of our discharge she signposted us to charities, social media support groups and made referrals to allied teams. She helped us access benefits we were entitled to and made sure we had everything we needed. She's a credit to her team and trust and truly deserves recognition.

Amy Rowntree | **York Hospital** | **Nominated by**
Team Leader | | **Steven Duncalf**
| | **A colleague**

Amy is still relatively new in post and, like many of us, has had a very challenging year. However, despite all these difficulties she has been an excellent manager getting things done, sorting issues with equipment and staffing and helping everyone in the department. She was supposed to be job sharing but due her counterpart having to shield she has been left with the lion’s share of the work for much of the year. Amy somehow manages to juggle the demands of management whilst also helping her colleagues on the 'frontline', doing extra shifts when required and very much in the thick of it. Amy does all this whilst remaining upbeat and positive. She truly is a credit to the department and ensures that the service we continue to provide is of the highest quality and I know she is heavily involved in equipment procurement and training so that the service can improve even further.

StarAward

A monthly award which recognises the achievements of staff and volunteers

The Library Team | **York Hospital** | **Nominated by Domini Barrett A colleague**

As a Registered Nurse working in the Hospital this year I have been fortunate enough to have found the library. With the lockdown periods it has been of great value. I joined with the assistance of Patrick who could not have been more helpful and patient. It was a smooth easy process and being a member has shown me how many things the library can actually can offer, it's been a very positive experience. With the teams assistance I have been able to access the computer suite and use them effectively. I've borrowed books for my work which they've helped me find. They've shared book recommendations for me to use in my local book club and loaned out books that have been fun to read. It's lovely to hear their enthusiasm and that they are so keen to share their knowledge of books. I have also enjoyed the time and effort they've put into the displays they have put up in the entrance way. Very informative and relevant. Great little recipe leaflets too that I have used at home & enjoyed (including by my husband)! I've even been given a recipe book. I have found the library staff to be friendly, helpful and incredibly patient, nothing is too much. They listen and come back to you if they can't help immediately. It might be small but it's the best NHS library I've used. I believe the library staff should receive a Star Award for all they do.

Chloe Malarkey Midwife | **York Hospital** | **Nominated by Megan Godfrey A patient**

I visited the Maternity Triage Ward for the 3rd time at 30 weeks pregnant. I have extreme anxiety and with COVID my levels of this were really high. I've waited a fair few hours before plucking up the courage to ring the triage ward when my baby had reduced movements. I was told to pop down straight away. As soon as I arrived Chloe was there waiting. She has to be one of the kindest most compassionate people I've ever come across. Made me feel at ease, safe and comfortable whilst taking me through everything. Always had a smile on her face & never made you feel like you shouldn't be there. She an absolute star and asset to the maternity team. Thank you Chloe.

StarAward

A monthly award which recognises the achievements of staff and volunteers

The team on Ward 17 **York Hospital** **Nominated by John Craft A relative**

My daughter was admitted on Monday 11th January 2021 with Covid-19 and not eating or drinking. I stayed with her and was also Covid positive. The whole team were amazing and assisted me massively with my daughters care needs, as I couldn't do anything for a few days as I was so weak and struggling. When I got more unwell they arranged a prompt review in ED, thankfully got back to Kaycee within a few hours. A massive thank you to everyone. Consultant Dr Abbey and the medical team were also superb. The team ensured that my wife, who was also positive and myself were well enough prior to discharge and were happy to delay if needed. Thank you all again, what an amazing team.

Louis Horwell Materials Management Officer **York Hospital** **Nominated by Andy A colleague**

Louis has taken on the ordering for the COVID19 wards alongside his usual wards, he's always happy to help with other duties and will always try to get needed stock to wards. Throughout these challenging times he has gone above and beyond his role. He's always got a good work attitude even under pressure.

The Audiology Practitioners **York Hospital** **Nominated by Annabel Robson A relative**

I have contacted the Audiology Dept. on several occasions within the last 12 months and each time I have been highly satisfied with the outcome of my query. Prior to Christmas I called the department as my dad who lives in a care home had lost both of his hearing aids. As the details of the moulds were still on file, new hearing aids were made and posted directly to the care home. He had them back in just a couple of weeks. On a visit to dad and seeing the hearing aids were not fitting properly, I emailed photos over to the department and Cleo replied straight away. I dropped the hearing aids off for her to look at and she did what was required with them and posted them back the very same day. In this really difficult climate and the face to face appointments not being possible, having a team like this on hand to help is invaluable. Keep up the amazing work!

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A monthly award which recognises the achievements of staff and volunteers

Joy Jackson **Receptionist**	**York Hospital**	**Nominated by** **Laura Strange** **A colleague**

This lady always has a smile on her face, is polite and helpful, even with the high volume of work she gets. I work in endoscopy and am always bringing patient packs down to her and have seen her sorting out patient's property, visitors, staff, relatives as well as the things we bring down. She is always so welcoming and friendly, helpful and kind. Joy is an excellent face for patients entering the hospital and deserves praise .

The team on Ward 11	**York Hospital**	**Nominated by** **Kelly Fleming** **A colleague**

My Grandad spent just over a week on ward 11 where he sadly passed away unexpectedly the week before Christmas. My family and I would like to nominate the Ward 11 team for a star award for the fantastic care they gave my Grandad. It was a very difficult and sad time for our family and all the staff showed great respect and compassion, nothing was too much trouble for them, and although being a very busy ward they were always willing to answer any questions we had day or night. We are so grateful that despite the current pandemic you made it possible for us to spend time with my Grandad in his last days. Thank you to the whole team! Special thanks to Sister Sarah Atalay, Deputy Charge Nurse Andrew and Staff Nurse Georgia you were all a great support to us.

Donna Jack **Deputy Head of Nursing**	**York Hospital**	**Nominated by** **Jenni Walker and Mike Lee** **Colleagues**

Over the last few months, Donna's attitude and outlook have shaped the morale of many members of staff in our Care Group. She is kind, and caring, and a wise counsel. Her dedication to our patients and her team make her an inspirational leader. However, it is not just for her professional role that we nominate Donna. One of her most notable characteristics is her infectious and spontaneous laugh. Even on the most challenging of days, Donna's laugh has invoked a smile from anyone who heard it. It brings great joy, and reminds us that even in darkness, we can find light and hope and optimism in the world around us. There are many of you, who on reading this, will know and understand just how precious Donna's laugh is. Thank you Donna, for all that you do; and keep laughing - its marvellous medicine.

Imogen Dodds **Sister**	**York Hospital**	**Nominated by** **Charles Sandiland** **A colleague**

York Hospital rely on agency staff to cover absences of Health Care Assistants sometimes at very short notice. Most people, staff and patients, are civil and pleasant

to agency but there is a small minority who have a shameful attitude towards them looking down on them and undermining their efforts. One ward sister, Sister Imogen Dodds, was a brilliant example of a really good attitude, She gave encouragement and support and included the agency staff in an informal get together for snacks when things were quiet. I would suggest that all staff should be reminded of the importance of agency staff and the need to encourage and foster them. When possible a buddy system could be employed i.e. allocating a member of staff to give the agency person an induction and generally looking after them.

Jo Dea **York Hospital** **Nominated by**
Assistant Head of facilities **Andy Stafford**
A colleague

The only true words that can describe Jo are "the most professional, dedicated, caring and supportive person I have ever had the pleasure to work with". Throughout the whole of COVID she has worked tirelessly behind the scenes constantly delivering excellent levels of service through an often over-stretched and dedicated workforce. Jo does not live locally but continues to juggle family life and her dedication to her role, including evening and weekend working on top her day job.

Christy Davidson **York Hospital** **Nominated by**
Chief Audiologist **Jax Meeham**
A colleague

Christy is a devoted member of the Audiology team, however I started working in the department with my small hearing loss and she truly has helped me to understand the bigger picture. It's not only myself that has benefited from her care, she looks after all her patients and colleagues withe the same integrity and compassion. She displays all the NHS priorities with such ease and compassion.

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Adil Ibrahim | **York Hospital** | **Nominated by**
Speciality Registrar | | **Holly Craven**
| | **A relative**

Tonight (Sunday 24th Jan), I took my children to their dads house, when I arrived, he was in agony. It turned out that he had run out of his steroid eye drops. I asked if he had rung the hospital, and he hadn't, so I did. Dr Ibrahim was on the phone quickly and turned round to go back to the hospital to sort out a prescription for Tom. It was an incredibly kind thing to do - I don't think anyone has ever done anything so kind for me before - and I am really grateful. He could have told me that there was nothing he could do, He could have said he was on his way home, but he didn't. That is beyond the call of any duty as far as I am concerned and was an act of kindness that will stay with me for a very long time.

Helena Nguyen
Midwife
York Hospital
Nominated by
Dawn Avery
A patient

Helena was absolutely brilliant in supporting me and my partner with the birth of our child Max on 20/1/2021. She was so professional but also approachable, friendly and had a great sense of humour. Her communication towards us was spot on and she took her time explaining everything so we understood what was happening. She was a calming influence on me when I started to panic about birth when I was in labour. Thank you Helena. Dawn, Zak and Max

The Palliative Care Team
York Hospital
Nominated by
Claire Rutter
A relative

My dad passed away on the 3rd Jan from a 10 month battle with pancreatic cancer. He had been in York hospital for his last month. He always made a point of telling me and my brother how amazing and kind the palliative nurses were to him. We all really appreciate everything they did for him to make his last weeks more comfortable.

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York Hospital Radio And York Ball Podcast Team	**York Hospital**	**Nominated by A colleague**

I would like to nominate York Hospital radio and York Ball podcast for a Star award. Today is their 57th birthday and I think especially in these current times...they provide a valuable lifeline and company to all ages across all the wards and departments in the hospital. They provide music from the past to the dementia patients....music to mums in labour especially during the night (I was one of these mums) The company and music I listened to....helped me through my labour. They do a lot in their own time....York Hospital Ball podcast by Mr Tate, a full time DT teacher from All saints school broadcasts the York City match to the patients in Hospital over the weekends it's a life line to the patients especially at the weekend, he has been doing this for years in his own time and all weathers. I would like to nominate him and York Hospital radio for their postiveness and company during this pandemic. I think they should be given some recognition for this wonderful service they provide to our Patients at York Hospital.

Julia Goundry Maxillofacial Prosthetist	**York Hospital**	**Nominated by Paul Carr A colleague**

Julia is new to the Trust, joining in the strange Covid circumstances. She went for lunch alone to the Staff canteen, and noticed someone sat alone in a booth in the dining area. She immediately sensed that something was 'not right' with the person, and went closer to investigate. It transpired, that the person (a Staff Nurse) was in fact in anaphylactic shock and needed her Epi Pen immediately, but was unable to self-administer by that stage. Julia, is not used to dealing with this type of event, but recognised what was happening. She immediately and loudly called for assistance from some other nursing staff who were able to administer the Epi Pen correctly. In my opinion, Julia showed great awareness and perception of her surroundings and chose to investigate someone in quiet distress rather than just carry on with her own business. Julia was not seeking any special praise for her intervention, but just mentioned the dramatic event when returning from lunch. I hadn't fully appreciated the drama until I happened to meet the nurse in question today who was the centre of the drama. I feel Julia's behaviour epitomises our shared Trust values and it should be applauded.

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The Critical Care Outreach Team	**York Hospital**	**Nominated by Bethan Coombe A colleague / Patient**

On the Tuesday 20th of January I was having my lunch in Ellerbys when I started having an anaphylaxis. I was in shock and could not get my epi pen administered. Thankfully the crash team were called and got to me in time. I am so appreciative of the care received by the crash team and the outreach nurses. In particular Jen Hind's amazing memory of my allergies from when I worked a night shift with her. Some may say that they were only doing their job but as a colleague and a patient I cannot thank them enough so thankyou thank you thank you from the bottom of my heart.

Anna Morley Image Support Worker	**York Hospital**	**Nominated by Louise Simpson A relative**

Anna assisted my father in law to his ultra sound scan after suffering a stroke He is an amputee and she took great care in assisting him and explaining what was happening. She spoke to him the whole time explaining everything that would happen in the scan. She made him feel calm and relaxed and managed to stay for a chat which we are so grateful for as he hadn't had any contact with his family. He spoke of Anna very highly and wanted this to be shared. Well done Anna keep up the good work and Thank you for taking the time to make our father and father in laws stay a good one.

Vicky Wharram and Rob Ellis Skin Cancer Care Coordinator and Consultant	**York Hospital**	**Nominated by Kathryn Thomson A colleague**

Due to the needs of the trust during the COVID pandemic all three of the skin cancer nurse specialists were redeployed to work on the medical wards. They play a busy role in supporting patients through skin cancer diagnoses, running diagnoses and follow up clinics and ensuring actions and referrals recommended from the skin cancer MDT are followed through. As skin cancer coordinator Vicky has stepped up and taken on a far greater role than she had needed to previously, phoning patients ensuring investigations and pathways were carried out. She has been supported in this by my colleague Dr Rob Ellis who has taken on much of the diagnosis clinic and follow up work in addition to his normal job plan.

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The Team on Ward 18 **York Hospital** **Nominated by Abigail Booth A relative**

My 4 month old daughter Violet came in to Ward 18 to have a cannula put in for her renal scan. The staff were so lovely, they brought me a coffee while we waited and when it was time for her cannula to be put in a member of the team came in to distract her with toys and a flashy wand. Violet hates having her hands and feet moved around but she was so transfixed by the team member with her toys that she didn't even notice them doing it! It was a very relaxed and stress free experience and I'm so glad that the team are there to support my daughter throughout her childhood.

The Star award nomination form can be accessed through the Star Award link on the website and Staff Room.

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