York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors (Public) – Blue Box

29 March 2023

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Main Agenda Item	ITEM	PAGE
7. 7.1	**Chief Executive's Report** To receive the: • Chief Executive's Update & (York Joint Health and Wellbeing Strategy in Blue Box)	 03
16.	**Ockenden Report Update** To receive the report including the Perinatal Clinical Quality Surveillance report. Appendix A – E in Blue Box	 55
22. 22.1 22.2	**Governance Framework:** To receive for approval amendments to the: • Trust Standing Financial Instructions (full report in Blue Box) • YTHFM Reservation of Powers and Scheme of Delegation and Standing Financial Instructions (full report in Blue Box)	 75 128
23. 23.1 23.2 23.3	**Governance Policies:** To receive for approval: • Risk Management Strategy and Policy (policy in Blue Box) • Modern Slavery Declaration • YTHFM Health and Safety Policy (policy in Blue Box)	 214 239
24. 24.1 24.2 24.3	**Items for Information** • Executive Committee Minutes (Blue Box) • Star Award nominations (Blue Box) • TPR Mandatory Reporting	 248 265

York Joint Health and Wellbeing Strategy

2022-2032

Contents

Front cover from
Knavesmire Primary School

Introduction and Contexts

Foreword from the York Health and Wellbeing Board

As a group of senior leaders in health and care – clinicians, voluntary sector leaders, local authority directors, healthcare managers, elected members, leaders in public engagement – we want to thank you for taking the time to read our Joint Health and Wellbeing Strategy for York 2022-32.

We have worked together to develop this strategy because we believe health is precious, and we want more of it for the 200,000 people who live within our wonderful city of York.

At first glance, walking round our beautiful city might give you the impression that the job is done; we've already achieved our goal; York is already a healthy place. And we certainly can celebrate many things about the place we live. We have a strong cultural heritage, beautiful buildings, green spaces, good community roots, a thriving voluntary sector, and higher rates of physical activity and other things which keep people healthy. York certainly is a city full of health assets and strengths.

But we still have plenty of health needs and challenges, and some stark inequalities. Some may say that York is a city in ‘good health’, but this is certainly not the full story. In reality:

Our ‘good health’ is not evenly distributed
We know that in York, the 2010s were a ‘lost decade’, in which improvements in life expectancy stalled and where – in the more deprived areas of York – people are dying earlier than they should

Our ‘good health’ is not best health
We know that York's overall health outcomes, compared to our regional neighbours, often look good, but compared nationally are average: for example, York ranks 45th out of 152 local authorities on male life expectancy at birth and 76th on female mortality from preventable causes. The 2019 ONS (Office of National Statistics) Health Index ranked York the 119th most healthy area out of 307 local authorities.

45th out of 152
local authorities on male life expectancy at birth

76th
on female mortality from preventable causes

Our ‘good health’ hides uneven health
We know that there are several areas of longstanding concern for the city's health, where we don't do as well as our affluence would indicate: for instance more people are admitted to hospital with alcohol-related conditions or after an episode of self-harm than we’d like; and demand for our mental health services is growing dramatically.

Our vision over the next decade is that:

In 2032 York will be healthier, and that health will be fairer

We all know that strategies don't, on their own, achieve anything: it's the action that results from them which makes the difference. The purpose of a strategy is so that together, we pull on all the resources at our disposal in a coordinated direction, and we do it for the long haul. That's why we've set this strategy to run over 10 years.

The things we want to influence are long-term, involving the complex web of factors in society which create health, such as education, jobs, community connection, the impact of the pandemic, economic changes, healthcare services, environmental sustainability. We won't change these things overnight.

It's also why we've kept this strategy high-level. There is simply no way we will be able to articulate all the thousands of actions that will be necessary to get to where we want to get in this strategy. Our real hope with this document is that it inspires, motivates and instigates action.

Alongside regular and updated action plans that we will develop as a board, we hope that organisations, partnerships, staff and ultimately the people of York will find in this strategy a unified vision and set of goals for a healthy city, from which they can develop their own plans and priorities.

The Health and Wellbeing Board meet regularly, in public, to discuss the key issues in health and care and to collaborate on achieving our vision. We commit to you that through these meetings – and behind the scenes – we will work tirelessly to make the words you read in this strategy a reality.


BABBOE

The context for our health and wellbeing strategy

Four things key things
over the next decade:

1 York's 10-year Plan

As a city, we are following a sustainable approach to developing our ambitions for the decade ahead. The goal of sustainability is to, "create and maintain conditions, under which humans and nature can exist in productive harmony, that permit fulfilling the social, economic, and other requirements of present and future generations." or put simply - 'Enough, for all, forever'.

This means that sustainable approaches consider the interdependencies between actions that might affect the environment, society, and the economy. To this end, three strategies have been developed to inform city-wide direction over the next decade, including the proposed devolution arrangements for North Yorkshire and York. These strategies cover health and wellbeing, economic growth and climate change. Together, we now have the health, economic and environmental goals of the city aligned, and with them the building blocks for health.

2 Reforms to the Health and Care System

There are currently national reforms to the health and care system, which involve the establishment of Integrated Care Systems (ICSs) to cover every area of the country. Locally, we are working with colleagues across Humber and North Yorkshire to bring care together, increase the quality and outcomes from our health and care services, and improve population health across our region.

Much of this work will be done locally, in our York 'place' area, but in the context of a wider regional structure for our NHS and care partners. One key purpose of the strategy is to articulate York's health ambitions, our priorities, our needs and the things which matter to people living in our city. Part of the job of ICSs (in fact a statutory requirement) is to listen to local places through their Joint Health and Wellbeing Strategies and respond by working with them and giving them the appropriate resources to match their local goals.

3 Poverty and the Cost-of-Living Crisis

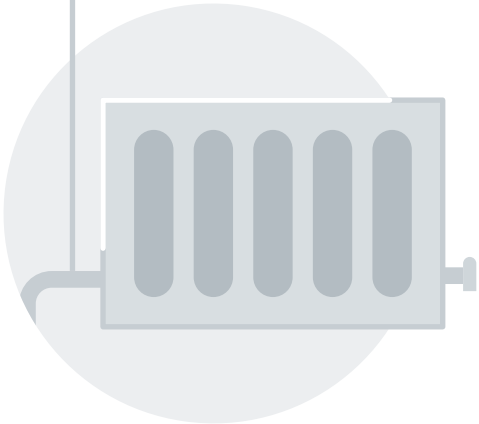
The strategy is being launched during a cost-of-living crisis affecting the whole nation. We know that there will be health consequences when people are not able to afford heating, food and housing costs. Financial exclusion, fuel poverty, debt and food crisis have short term consequences, likely to affect a large number of people in the city, for instance through higher rates of hospitalisation from chronic disease such as asthma and COPD (Chronic Obstructive Pulmonary Disease), or more people suffering mental illness due to anxiety. They also have long term consequences, leading to chronic mental health issues, adverse economic and effects and an impact on education and skills, and broad influences on community coherence. Even before this crisis, York has over 3,500 children and nearly 4,500 older people living in poverty, and over 13,000 people living in fuel poverty.

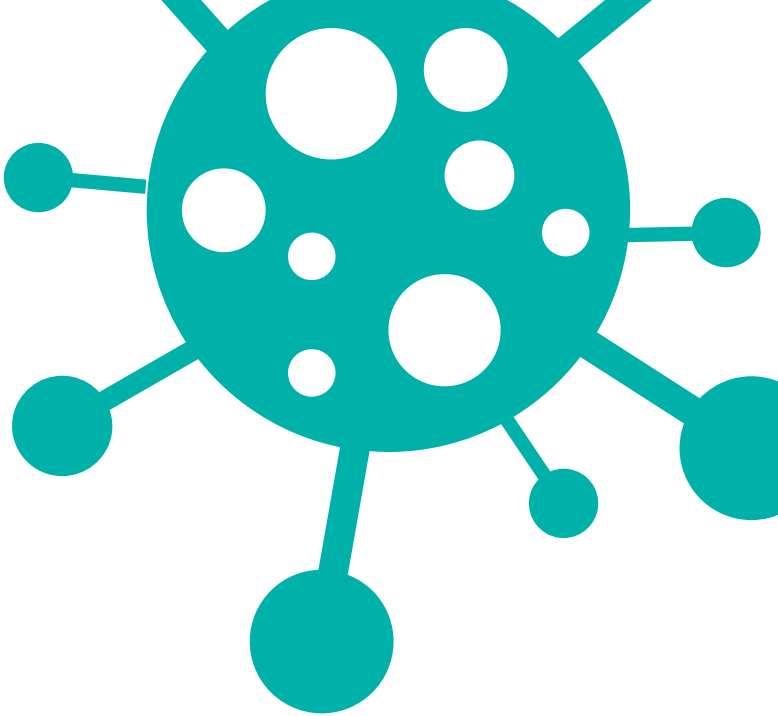
3,500

children and nearly 4,500 older people living in poverty

13,000

people living in fuel poverty





4 COVID-19 recovery

At the time of writing this strategy, we are more than two years into a global pandemic which has had a deep impact on the health of our city.

Together with the direct impact of the virus and the lives it has changed and claimed, the indirect impacts of the last two years on our physical and mental health are still emerging. It is clear that from the educational impacts of lockdown to the increased demand on mental health services and the pressures on physical health services, COVID-19 has taken a heavy toll.

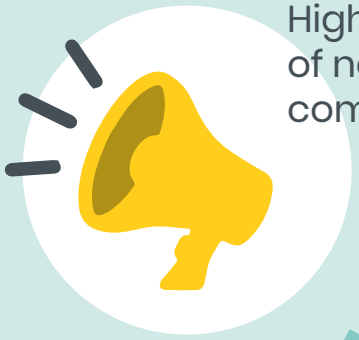
This strategy is written in light of all this, and with recovery in mind. Among many things we have learnt from the pandemic, we have, positively, seen how well a city can pull together, bureaucracy be broken down, and swift action save lives. We have also seen, negatively, how underlying inequalities in society can amplify a global shock like a pandemic virus, and how, yet again, those with less in our city were more exposed and likely to suffer harm.

Our recovery efforts, and this strategy, seek to learn these lessons by emphasising collaboration, building on the assets already present in our city, and tackling the inequalities which we know also exist.

Our Challenges

One of the Health and Wellbeing Board's key tasks is to assess and monitor the health needs of the city as a whole, and the communities within it. This means we are collecting, publishing and interpreting data on a wide range of things to do with health in the city, through the Joint Strategic Needs Assessment (JSNA), including overviews of each stage of life (Start Well, Live Well, Age Well, and Mental Health) and over twenty deeper pieces of work on specific communities. Some examples of health needs in York are illustrated in the pages overleaf

Wider determinants of health

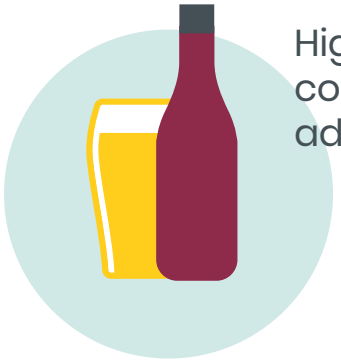


High number of noise complaints

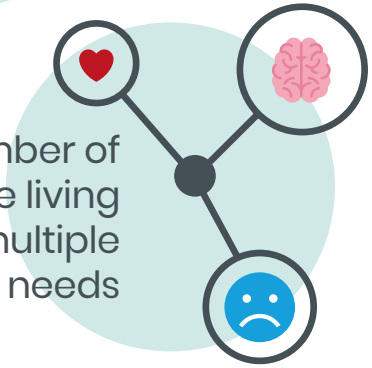
10% of children living in poverty

Housing affordability

York's 'red flags'



High levels of Alcohol consumption/ admissions



The number of people living with multiple complex needs

Drug related death

Changing Demographics

A growing and ageing population, with a 50% increase in the population over 80 in 2040.

Projected growth in healthcare use:

- 4% increase in hospital use (annually)
- 10% increase in social care (over 5yrs)
- 2.5% increase in GP use (over 5yrs)

Examples of preventable ill-health

1 in 10
people smoke

2 in 3 adults overweight or obese

1 in 7
live with depression

Widening inequality gaps

Life Expectancy/ Healthy Life Expectancy

Health of those with a learning disability

School readiness

Mental Health

Under 18s admissions for mental illness

High prevalence of some mental illness

High suicide and self-harm rate

Student Mental Health

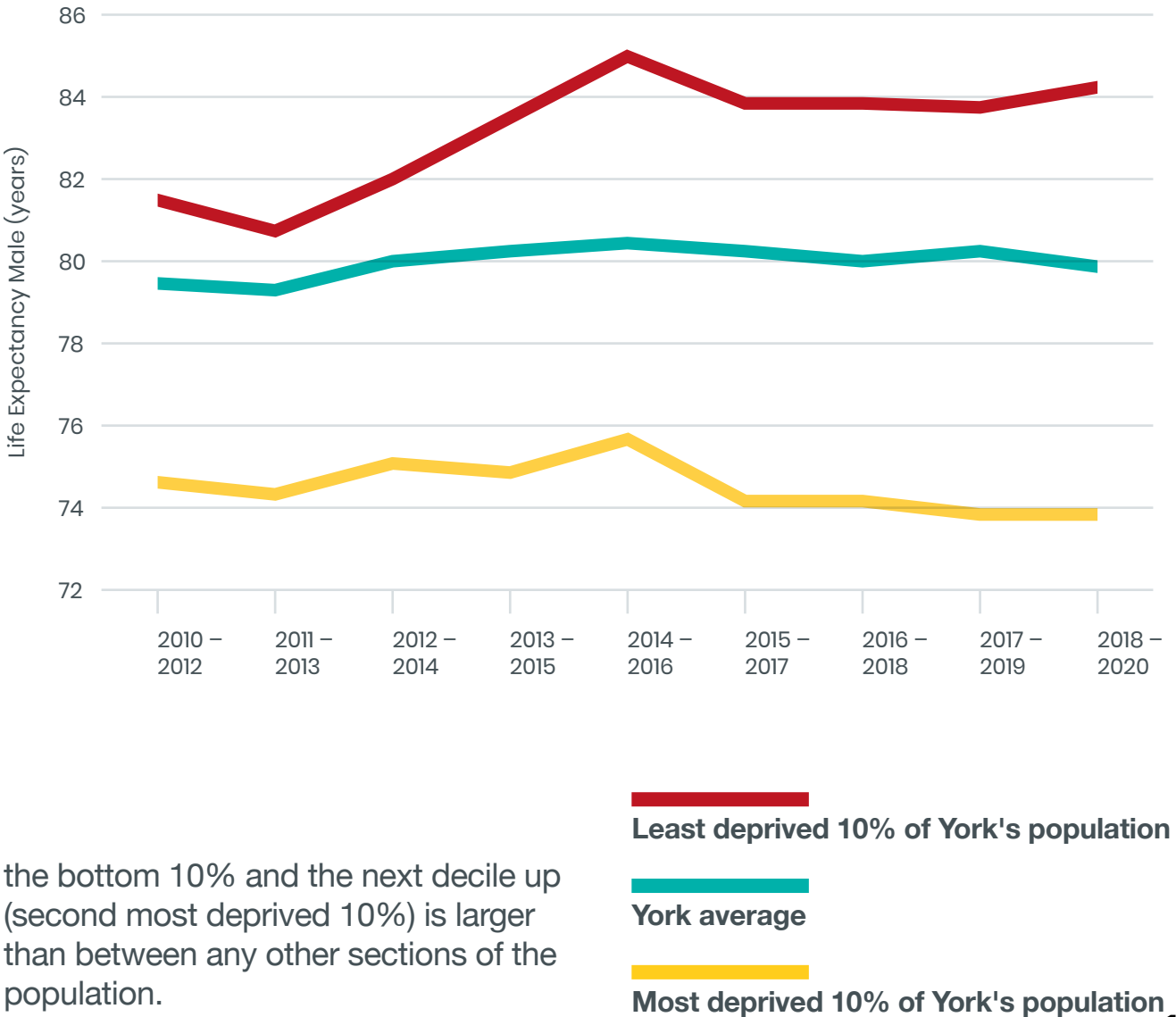
Three key trends in Life Expectancy in York since 2010'

One of the headline indicators for our health challenges is life expectancy, and it is clear that in parts of York people are dying earlier than they should, a fact which is mirrored nationally. Over the last decade there have been three clear trends.

Firstly, for all York citizens, the historical increase (seen since the Second World War) in the number of years people live has stalled.

Secondly, in the more deprived deciles of the population life expectancy declined for the first time in generations, further widening the inequalities gap (for instance in males the gap was 6.9 years in 2010 and 10.3 years in 2020 – see chart)

Thirdly, a large gap in life expectancy is emerging between the most deprived and the least deprived 10% of the population, and the gap between the bottom 10% and the next decile up (second most deprived 10%) is larger than between any other sections of the population.

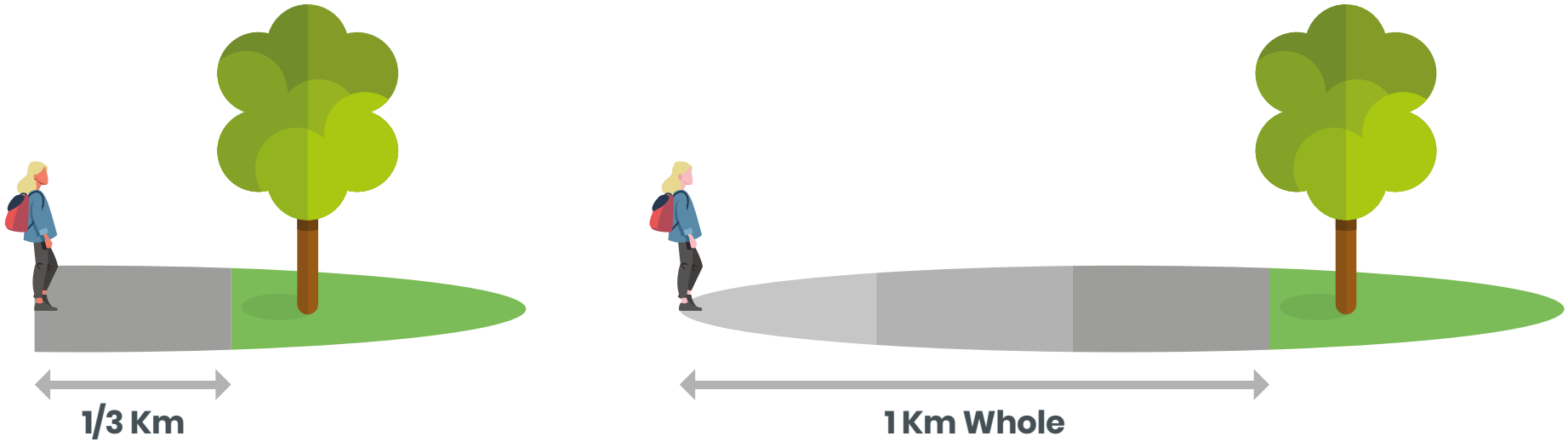


Our assets and strengths

Whilst we need to understand our health challenges, in York our approach has also been to focus on what's strong, not what's wrong. We take a strengths-based approach which sees people as valuable, not vulnerable, and recognises that everyone has gifts, talents and skills, which empower people as active citizens and gives them hope, rather than simply being a passive recipient of services.

Work which has been developed in the city over the last decade such as local area coordination or social prescribing changes the relationship between statutory services and citizens and communities, by enabling our staff and practitioners to build up a trusted relationship with a person to find out about their skills and gifts, and focus on people's goals and resources, rather than their problems.

This extends to seeing our city as full of assets to use for health. For instance, we could highlight our thriving voluntary and community sector with over 300 organisational members of our Centre for Voluntary Services (CVS); or we could highlight that the average distance to green space in York is around a third of a kilometre, versus a national average distance of a whole kilometre.



How have we made this strategy?

As part of developing this strategy we have tried to listen both to citizens of our city and to health and social care colleagues.

One way we did this was by facilitating local community groups to host conversations with people and ask them a very simple question:

What helps you to live a happy and healthy life?

We collected this information on what helps people to live a happy and healthy life; about health, care and support services; about local communities and our city; what is working well already and what needs to change.

The feedback to this exercise has been integrated throughout this strategy and shapes it in its broadest sense.

Having digested this work, the Health and Wellbeing Board also held a workshop to look at our Joint Strategic Needs Assessment and what is was telling us about the health and care needs of the York population.

They also looked at existing strategies, frameworks and partnerships in York, mindful of the fact that the Board itself will not be able to deliver our aspirations on its own, and we need the help of the rich tapestry of partnership groups and collaboratives in the city to pull with us towards the outcomes we want to achieve.

What helps you to live a happy and healthy life?

What helps in our city?

What one thing is working well?

What one thing needs to change?

What about health, care and support services

What helps in your community


Being able to go out for a walk
Having enough money to do all of these things that keep us well
Support of local people
Someone who cares about you
You can't be happy if you're afraid. You need freedom of fear
Access to suitable and affordable housing
Safety - later on in life need to have a safe space
Outdoor recreational activities such as walking the dog
Having enough money to do all of these things that keep us well
My Christian faith
Knowing where to go to get support

Consideration was also given to reports from Healthwatch York, whose job it is to represent the voice of the citizen on the Health and Wellbeing Board. These provided us with quality information on areas of health and social care residents have raised concerns about.

Once some draft principles for this strategy were established, we commenced a process of public consultation, including a public Health and Wellbeing Board, and 'Our Big Conversation: strategy consultation', together with the Economic and Climate Change Strategies.

What has emerged from this is a strategy which focuses on:

Our four big communities
These are the who; a description of four key groups in our population and how good health is built up over the life course

Our six big ambitions
This is the what: the dreams we have for the type of healthy city we want to be

Our ten big goals
This is the how: the measurable, tangible improvements in health outcomes we want to see for our population

Our Strategy: Communities, Ambitions and Goals

One Big Vision

In 2032, York will be healthier and that health will be fairer

Four Big Communities

- York's Children have **the best possible start** in life
- York's **adults** have equal access to things which produce health
- Whenever they reach the **end of life**, people in York die well
- York's older adults flourish in an **age friendly city**

All connected together through families, geographies and communities

Six Big Amibitions

- Become a health generating city
- Make good health more equal across the city
- Prevent now to avoid later harm
- Start good health and wellbeing young
- Work to make York a mentally health city
- Build a collaborative health and care system

Ten Big Goals

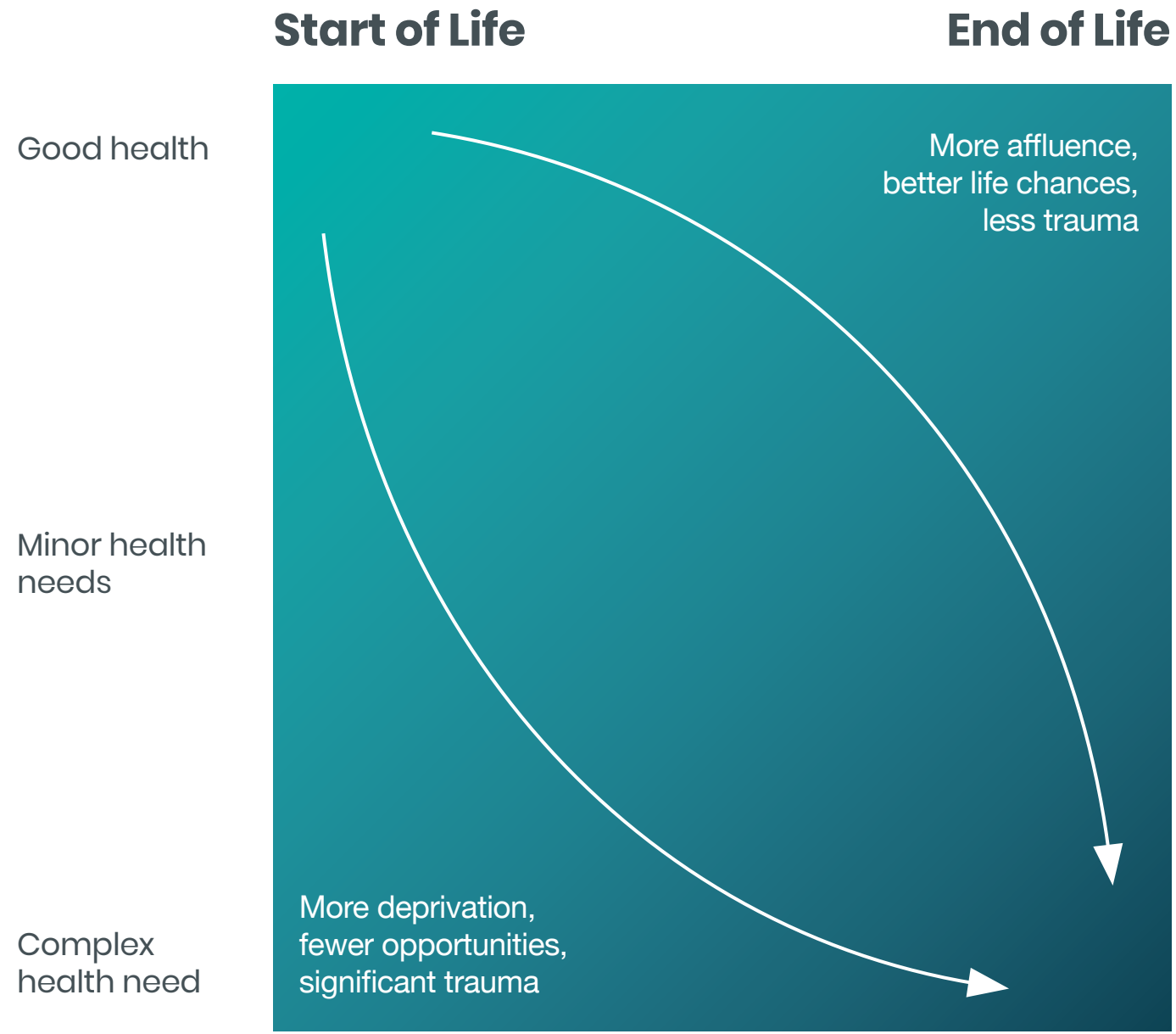
- Overarching: gap in Health Life Expectancy
- Mental wellbeing
- Smoking
- Health Weight
- Suicide / Self harm
- Physical activity
- Alcohol
- Inequality groups
- Diagnosis gaps
- Social connection

Four big communities

Through this strategy we want to improve health for all in York, as seen through the lens of the four big communities within York, our four stages of life.

Since the work of Michael Marmot in the first decade of the century, the concept of the ‘life course’ has become familiar. Central to it is the concept that disadvantage starts before birth and accumulates throughout life, with a person’s health (or the health of a population group) being the sum of all the health advantages or disadvantages its members have been exposed to. Rather than framing health as an individual’s responsibility – a consequence of their ‘choices’ – it recognises that health is created by the conditions which surround us; the conditions we experienced even before birth, and during childhood especially, shape our abilities to live healthily as adults, to age healthily in our later years, and to die well.

The journey of life takes us from young to old, and inevitably it takes us from good health to complex health needs and eventually death. However as shown by this graphic, when looking at the population as a whole we are all on the same journey, but not all take the same route:



So in York, we want our citizens to experience the best health possible in all four stages of life:

Start Well
York's children have the best possible start in life

Live Well
York's adults have equal access to things which produce health

Age Well
York's older adults flourish in an age friendly city

End Life Well
Whenever they reach the end of life, people in York die well

Crucially, whilst people are generally in just one of these stages at a time, they are all connected through families, geographies and communities. The health of our mothers in York will affect the health of our babies; the health of our teachers will affect our pupils; the health of our volunteers will affect those receiving help; the health of older people on a street in Tang Hall will affect the health of younger people on the same street; the health of carers will affect the health of those who they care for; the health of communities and organisations will affect all who participate in them. It's all connected.

We will use this concept of the 'life course' to structure our meetings as a Health and Wellbeing Board, for instances in the reports we commission and discuss. It will ensure we don't leave anyone out of the conversation.

Six big ambitions

This leads us on to the six big ambitions of our strategy, which will drive the work of the Health and Wellbeing Board and its partners. These phrases came out loud and clear in the engagement work we developed, and we hope they set the standard for all changes and developments in health services and beyond in the city over the next decade.

Become a health generating city,

where our starting point is that strong and supportive communities are the best medicine, where we build on the strengths of our people, and give our citizens the best possible chance of staying healthy, especially through three key building blocks of health: good housing, jobs and education

Prevent now to avoid later harm,

acknowledging that two thirds of the gap in healthy life expectancy in York comes from preventable diseases, and therefore ensuring that prevention is in the job description of all health and care staff in the city in order to bring healthy lifestyles within reach of all our residents

Start Good Health and Wellbeing Young,

giving special emphasis to the key formative early years of life as the best place our investment can go, creating from maternal/preconception health and beyond the conditions for our families, communities and young people to live healthy and flourishing lives

Make good health more equal across the city,

recognising that people in the poorest areas of York die ten years earlier than those in the richest areas, and to address this we need to deliver our services scaled at a level proportionate to people's need, and thereby reduce health inequalities

Work to make York a mentally healthy city,

ensuring that mental health and wellbeing is given the same attention as physical health, investing in the things which keep people happy and connected, and working together to support people quickly when they need it

Build a collaborative health and care system,

with fewer dividing lines between organisations, creating a local culture of integration built by engaged and valued staff who listen to (and involve) our citizens, so that our care can be accessed by all, and is compassionate, high quality, financially and environmentally sustainable

Ten big goals

Now we have described our communities and the ambitions we have for a healthy York, we want to set out some clear goals for this strategy – things we can measure, things which are ambitious, things which if we achieved them would mean our city truly has become healthier and fairer over the next ten years.

So we have chosen ten goals which draw upon the things which people have told us in our engagement work they want to see, and on the strengths and challenges we have identified through our JSNA process. They are not a comprehensive list of all that needs to change over the next decade, but they represent some of the most important areas that lead to early illness and death in the city, and therefore feel like the things we need to focus our minds on.

Our 10 big goals at a glance:

1 OVERARCHING GOAL: Reduce the gap in healthy life expectancy between the richest and poorest communities in York

Reducing anxiety scores and increasing happiness scores by 5%

Bring smoking rates down below 5% for all population groups

Reduce to 15% the proportion of York residents drinking no more than 14 units a week

Reverse the rise in the number of children and adults living with an unhealthy weight

Reduce health inequalities in specific groups

Reduce both the suicide rate and the self-harm rate in the city by 20%

Improve diagnosis gaps in dementia, diabetes and high blood pressure to above the national average, and detect cancer at an earlier stage

Reduce sedentary behaviour, so that 4 in every 5 adults in York are physically active

Reduce the proportion of adults who report feeling lonely from 25% to 20% of our population

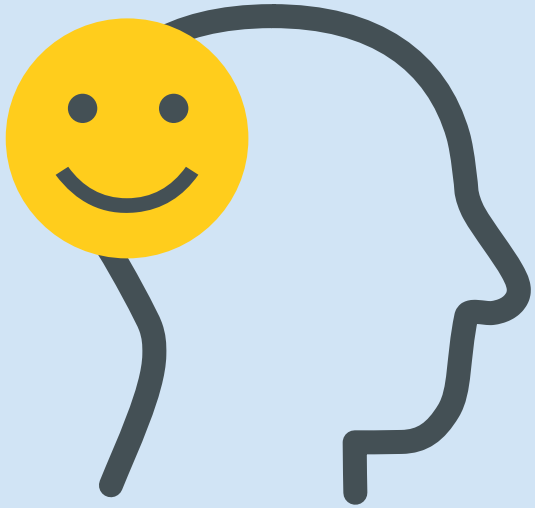
1. Overarching goal: reduce the gap in healthy life expectancy between the richest and poorest communities in york

WHY?:

Public health experts the world over tell us that the best measure of the health and fairness of a local population is the gap between the number of years lived in good health for its richest and poorest communities. When that gap is narrower, communities enjoy greater trust and cohesion, better overall physical and mental health, and are more sustainable – i.e. everyone benefits. Currently in York, the life expectancy difference between wards is a stark 10 years for men and 6 years for women (2015-19 data). Older data suggesting healthy life expectancy differences are above a decade for both men and women.

This is the ultimate goal we are trying to reach for our population, but it will only be met if the other goals are too.

2. Support more people to live with good mental health, reducing anxiety scores and increasing happiness scores by 5%



WHY?:

As well as ensuring the city has good mental health services to respond to illness, we want to raise the overall level of mental health in the city through community assets (e.g. green spaces, community connections), creating a happier population in 2032 than now. The Office for National Statistics measures four dimensions of wellbeing, and we have chosen two of them: one where we do worse than the national average (in 2020/21, 27.1% of York residents had a high anxiety score vs 24.2% nationally) and one where we do better (in the same year, 8.8% of York residents had a low happiness score vs 9.2% nationally).

3. Bring smoking rates down below 5% for all population groups

WHY?:

Smoking is the leading preventable cause of death in York, and one in every two people who smoke will die because of tobacco-related causes such as heart disease, cancer, and respiratory illness. There are still more than 20,000 smokers in the city – more than 1 in 10 people – and whilst rates have fallen over the last decade, this has mainly been in our more affluent population, meaning smoking prevalence is higher in routine and manual occupations (1 in 6 people), as well as those with a mental health problem (1 in 3) and opiate users (1 in 2). So our local approach to tobacco control sets an ambition to halve the number of people who smoke by preventing and supporting smokers to quit, and crucially we want to see this across all groups in the city, closing the gap.

4. Reduce from over 20% to 15% the proportion of York residents drinking above the Chief Medical Officer's alcohol guidelines (no more than 14 units a week)

WHY?:

Alcohol is widely available and consumed by the majority of adults in England; however its harms are often under-appreciated. It is estimated that nearly 600,000 people need speciality treatment for alcohol dependency every year, and alcohol consumption leads to nearly 25,000 deaths. Drinking at lower levels still causes harm, including liver disease, a number of types of cancer, and increased risk of cardiovascular conditions. Whilst there may be no safe level of drinking, the Chief Medical Officer advises adults drink no more than 14 units a week; however that is not the case for over 1 in 5 adults in York (21.7%), with over 1,000 residents admitted to hospital for alcohol-specific conditions in 2020/21. To decrease the population-level harm of alcohol by reducing the proportion drinking over 14 units to 15%, we need to work on the availability of alcohol, the social norms around its use, and support people to manage down drinking levels and choose alternatives. This will also have positive effects on our city life through, for instance, reducing the amount of crime, accidents and anti-social behaviour linked to alcohol.

5. Reverse the rise in the number of children and adults living with an unhealthy weight

WHY?:

Every year, more people nationally are over a healthy weight, and York is no exception. Being overweight or obese has been shown to affect virtually all bodily systems, raising the risk of mental health problems, Type 2 diabetes, stroke, cardiac conditions, cancer, asthma amongst others. In York, over 1 in 5 reception-aged children, 1 in 3 year six children and nearly 2 in 3 adults are overweight. Rates of children over a healthy weight double in primary school, increase with deprivation, and have risen year on year over the last decade. These trends are driven by complex factors: for instance the commercial determinants of health (e.g. marketing), by our food systems, and by trends in the way we travel and move about in daily life.

As an indicator which is worsening, our goal is to reverse this trend, and change the direction of travel on weight for both children and adults; this also includes avoiding stigmatisation, and helping people with an eating disorder get the care and support they need.

6. Reduce health inequalities in specific groups: people with a severe mental illness, a learning disability, those from an ethnic minority or a marginalised group, and gender inequalities in health

WHY?:

We know that certain groups experience radically worse health outcomes. Sixty-three percent of people with learning disabilities die before reaching the age of 65, compared to 15 percent in the general population, and in York you are four times more likely to die before the age of 75 if you have a severe mental illness. There are inequalities experienced in health and healthcare if you are from an ethnic minority in the city, and the health outcomes of people in marginalised groups within our community are worse too, for instance those from Gypsy, Roma or Traveller backgrounds, those who are new migrants, who are homeless or who use substances. We aspire to build proactive and inclusive services which will level off health inequalities for these groups.

7. Reduce both the suicide rate and the self-harm rate in the city by 20%

WHY?:

Death by suicide is a tragedy which affects so many people. Between 2018 and 2020, 70 people died by suicide in York, continuing a trend seen for a number of years of higher rates locally than the regional average. Males are four times more likely to die than females, and whilst complex reasons lie behind every death, there is a clear correlation with deprivation. In 2020/21 there were over 400 hospital admissions for self-harm in the city, with half of them in people aged 10-24. A large amount of human distress lies behind this data, and we want to work together to create the kind of mentally healthy city in which these trends are reversed.

8. Improve diagnosis gaps in dementia, diabetes and high blood pressure to above the national average, and detect cancer at an earlier stage

WHY?:

The early detection of long term conditions gets people treatment faster, avoids illness and saves lives. In York, we see some large delays in diagnosis: for dementia, only 53% of the population estimated to be living with the condition have a diagnosis; for diabetes it's 71%, and for high blood pressure across the Vale of York area its 60%. All of these rates are worse than national and regional comparators. For cancer, over 400 people in the Vale of York area diagnosed with the disease presented with their first symptoms in A+E in 2020/21 – a sign that earlier detection was needed. Through things like blood pressure checks, screening, and NHS Healthchecks, we hope to close these diagnosis gaps.

9. Reduce sedentary behaviour, so that 4 in every 5 adults in York are physically active

WHY?:

York has consistently been one of the most active cities in the country. Around 70% of adults are classed as ‘active’, which means meeting the Chief Medical Officer guidelines of 150 minutes physical activity per week. But this leaves many who are not meeting these guidelines – probably over 40,000 people – with national research showing a higher likelihood of being inactive if you have a disability or long term health condition, are from an ethnically diverse community, or are female. Activity levels also decline with age, and have declined dramatically during the COIVD-19 pandemic. The more we move the greater we benefit, and it is often said by medical practitioners, if physical activity were a pill it would be the most prescribed drug on the market. We think we can go further and get 4 in 5 adults in the city classed as physically active by 2032.

10. Reduce the proportion of adults who report feeling lonely from 25% to 20% of our population

WHY?:

Loneliness has been described as ‘the feeling we get when our need for rewarding social contact and relationships is not met’. It can happen at any stage in life, and in response to a national survey in 2020 25.7% of York residents reported that they feel lonely often/always or some of the time. We also know that only 2 in 5 adult social care users in York had as much social contact as they would like, and this number is similar for adult carers too, whether under or over 65. This is a larger problem in York than elsewhere, with our loneliness figures the third worst in the region. This is a problem which cannot be solved by medicine, and requires a community response, as the health effects of loneliness have been shown to significantly increase the risk of disease and premature death.

Taking it all forward

Creating the conditions to achieve our ambitions and goals

The building blocks of health, also known as the wider determinants of health, are a diverse range of social, economic and environmental factors which impact on people's health. Such factors are influenced by the local, national and international distribution of power and resources which shape the conditions of daily life.

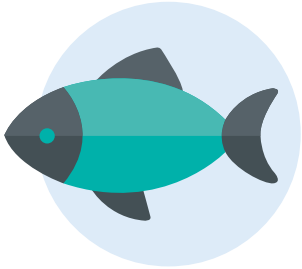
They determine the extent to which different individuals have the physical, social and personal resources to identify and achieve goals, meet their needs and deal with changes to their circumstances.

These building blocks are unevenly distributed. They are the 'causes of the causes' of health outcomes and health inequalities. We propose to create the conditions for health through all three of our city strategies, and the interdependencies between them are crucial.

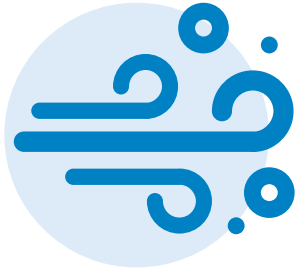
Some examples of how the Joint Health and Wellbeing Strategy, the Economic Strategy and the Climate Change Strategy all reinforce one another are shown below:

improving transport options…
to support active travel and a fitter population

an inclusive economy…
so that prosperity benefits everyone in the city



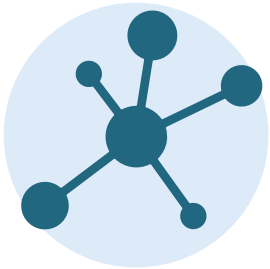
sustainable food systems…
so that healthy food is accessible and affordable



cleaner air…
leading to a reduction in respiratory disease

a healthy workforce…
Leading to more economic productivity

building liveable attractive public spaces …
by planting more trees



increasing social connection…
to maximise the potential of our citizens

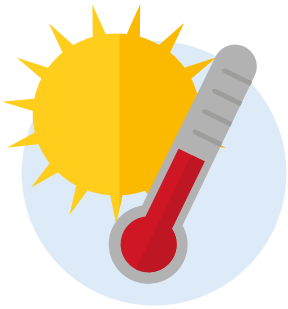
inclusion of all…
including those living with a disability

attracting green jobs…
driving down carbon emissions and pollution

a cleaner NHS…
reducing the estimated 7% of UK CO2 coming from healthcare

net zero carbon by 2030…
improving air quality and heat-related illness

high quality health and care…
getting people back into thriving work



climate resilience…
to protect businesses and health against heat/drought/flood

more high-quality jobs…
Leading to better mental health and wellbeing

Creating the actions to deliver this plan

This strategy deliberately doesn't contain a detailed action plan. As a 10-year strategy, we needed to set out a framework for our work and our aspirations which could last the distance, and be relevant across the next decade, with the many changes in national, regional and local circumstances which may occur.

So, following the publication of this strategy, we will work together as a Board to write two key documents:

- An outcomes framework, which will go into further detail about how we will measure and know we are making progress on the 6 ambitions and 10 goals
- An action plan, which will need to be refreshed a number of times over the life of this strategy, and which will set out the next set of actions the Board and its partners need to undertake to keep us on track to meet the goals and ambitions. These actions will need to be specific, assigned to key leaders in the system to own, to be achievable within our limited resources, and to align with current work programmes and priorities within, for instance the NHS.

Working as one city to deliver

The Health and Wellbeing Board will oversee this strategy, but it will only be successful by influencing the actions of a wide range of partners across the city. To illustrate how all the pieces of the puzzle fit together, here are some of the roles we think the different parts of our local system will need to play over the next 10 years:

Health and Care Organisations

- Co-produce plans for service change with service users and people with lived experience,
- Provide and commission services which support the six ‘Big Ambitions’ of the York Joint Health and Wellbeing Strategy
- In particular, lead on the sixth ambition to ‘build a collaborative health and care system’

York Health and Wellbeing Board

- Act as a public forum for engagement with this strategy
- Provide leadership and direction to the system, influencing and advocating for these ambitions and goals to be embedded in operational plans
- Hold organisations, including Integrated Care Systems, to account on how they are delivering the priorities of the York strategy

Communities and People

- Participate in the public work of the Health and Wellbeing Board, and hold organisations to a high stander on quality and equality
- Take ownership and responsibility for promoting community health and wellbeing
- Support vulnerable members of the community to be healthy and have strong social connections
- Make best use of community assets and leadership to create local solutions

Other Partnership Groups

- Take ownership on aspects of work needed to deliver the York Joint Health and Wellbeing Strategy, for instance around mental health
- Create plans and strategies which help achieve the ten ‘Big Goals’ York Joint Health and Wellbeing Strategy
- Promote partnerships wherever possible, working as one organisation for York

What our partners say

To illustrate how this might work, we asked each member of the Health and Wellbeing Board to give examples of how they and their organisation will be supporting this strategy. This is what they said.

York CVS will contribute to reducing the gap in healthy life expectancy between the richest and poorest communities in York by working with others in the health and care system, including the Voluntary and Community Sector and people in York to identify actions that will give those living in the poorest communities the opportunities and support needed to live longer and healthier lives.

York Centre for Voluntary Services

Children's Services will develop an integrated psychologically informed approach to improve our support to young people who experience early childhood trauma and/or neurodiversity.

City of York Council

We will support the strategy through the delivery of our Police and Crime Plan, working jointly as a trusted partner to prevent harm and damage, intervening early to solve problems. For example, our interventions with members of the public who are suffering from alcohol abuse, poor mental health, or a child at risk will take a holistic approach to prevention, early intervention and a whole systems approach with partners to improve their health and wellbeing and the longer-term opportunities to live a happier and healthier life.

North Yorkshire Police

The 10 goals of this strategy run right through the work of our public health department, and we will align all our work to it, whether it is helping people quit smoking, building healthy housing policy, or protecting the city from communicable disease.

Director of Public Health

We will deliver high quality care to our population, for example tackling health inequalities through annual Learning Disability Health Checks and Health Action Plans, working on Cardiovascular Disease by identifying and managing more patients with high blood pressure, personalising care with PCN's and their Social Prescribing Link Workers referring more patients into wider Community based and Voluntary Sector services, through proactive care planning to provide effective long-term condition management, and improve access to services

Humber and North Yorkshire Health and Care Partnership

We will support the strategy by continuing to work with local people and partners in primary care, secondary care, voluntary and community sectors to develop and transform local community mental health support. The Trust will build on initiatives that support people to receive the right care as quickly and as close to home as possible, which includes having dedicated mental health practitioners in GP surgeries. In addition, we will continue to co-create our services with our patients, carers, and local communities. We are one of the first NHS trusts in the country to appoint two lived experience directors who will play a key part in this, by ensuring experienced voices are heard at all levels of the organisation.

Tees, Esk and Wear Valleys NHS Foundation Trust

We will work alongside colleagues in York CVS to consider ways to support the health and wellbeing of our staff teams; we will work alongside partners to encourage more people to get involved in shaping the future of our city and raising awareness of opportunities to do this and we will work alongside our community, using our platform to amplify their voices and share what really matters to them.

Healthwatch York

As a key institution in the city, and a major employer of York citizens, we commit to taking this Health and Wellbeing Strategy to our Executive Board for adoption and development of a Trust response

York and Scarborough Teaching Hospitals NHS Foundation Trust

The York Health and Wellbeing Board

City of York Council

Healthwatch York

York CVS

NHS Humber and North Yorkshire Health and Care Partnership

NHS England

North Yorkshire Police

Independent Care Group

York and Scarborough Teaching Hospitals NHS Foundation Trust

Tees, Esk and Wear Valley NHS Foundation Trust

York Primary Care Networks

York Joint Health and Wellbeing

Strategy 2022-2032

If you would like this document in an alternative format, please contact:

(01904) 551550 **ycc@york.gov.uk**

@CityofYork **@cityofyork**

It is available in the following languages:

我們也用您們的語言提供這個信息 **(Cantonese)**

এই তথ্য আপনার নিজের ভাষায় দেয়া যেতে পারে। **(Bengali)**

Ta informacja może być dostarczona w twoim własnym języku. **(Polish)**

Bu bilgiyi kendi dilinizde almanız mümkündür. **(Turkish)**

یہ معلومات آپ کی اپنی زبان (بولی) میں بھی مہیا کی جاسکتی ہیں۔ **(Urdu)**

Printed on recycled paper from FSC certified providers

Publication date: November 2022

For further information: West Offices, Station Rise, York, Y01 6GA

Monthly Oversight of Perinatal Clinical Quality Minimum Data Set - Appendix A

York and Scarborough Teaching Hospitals NHS Foundation Trust

CQC Maternity Ratings - Scarborough Hospital Last Inspection: 16th October 2019	Overall	Safe	Effective	Caring	Responsive
	Good	Good	Good	Good	Good

CQC Maternity Ratings - York Hospital Last Inspection: October 2015	Overall	Safe	Effective	Caring	Responsive
	Good	Good	Requires Improvement	Good	Good

	2022									2023
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan
Number of reviews completed using the Perinatal Mortality Review Tool	0	4	0	1	0	1	1	3	1	3
Number of cases notified to MBRRACE	2	2	1	1	3	2	2	2	2	3
Number of cases referred to HSIB as per eligibility criteria	1	0	1	0	3	1	0	1	0	1
Number of received HSIB final reports	0	2	0	1	0	1	0	0	0	1
Number of incidents with a harm rating of Moderate or above	4	5	1	1	3	4	7	10	10	5
Number of Maternity Unit Diverts	4 SGH 4 YDH	0 SGH 2 YDH	1 SGH 3 YDH	1 SGH 8 YDH	SGH 0 YDH 7	SG 1 YH 5	4	SGH 2 YDH 1	SGH 5 YH 0	SGH 2 York 0
Number of Maternity Unit closures	0	0	2	11	14	13	7	0	0	0
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	0	2 (CQC)	1 (CQC)	1 (CQC)	1(CQC)	1(CQC)	CQC Inspection	CQC Inspection	CQC Inspection	CQC Inspection
Coroner Reg 28 made directly to Trust	0	0	0	0	0	0	0	0	0	0
Percentage of Continuity of Carer bookings	37%	34%	35%	paused	Paused	Paused	Paused	Paused	paused	paused
Of those booked for Continuity of Carer - Black, Asian and mixed ethnicity backgrounds	28%	2%	64%	paused	Paused	Paused	Paused	Paused	paused	paused
Of those booked for Continuity of Carer - Postcode for top decile for deprivation	92%	8%	90%	paused	Paused	Paused	Paused	Paused	paused	paused
Intrapartum Continutiy of Carer received - Overall	25%	25%	19%	paused	Paused	Paused	Paused	Paused	paused	paused
Intrapartum Continutiy of Carer received - Scarborough	24%	25%		paused	Paused	Paused	Paused	Paused	paused	paused
Intrapartum Continutiy of Carer received - York	11%	0.00%	11.00%	paused	Paused	Paused	Paused	Paused	paused	paused
Intrapartum Continutiy of Carer received - Black, Asian and mixed ethnicity backgrounds	0%	0%	8%	paused	Paused	Paused	Paused	Paused	paused	paused
Intrapartum Continutiy of Carer received - Postcode for top decile for deprivation	15%	23%	50%	paused	Paused	Paused	Paused	Paused	paused	paused
Safe Staffing										
1 to 1 care in Labour - Scarborough	95%	98%	100%	100%	99%	100%	99%	100%	Not provided	100%
1 to 1 care in Labour - York	94%	100%	100%	100%	100%	98%	100%	100%	Not provided	99%
L/W Co-ordinator supernumary % - Scarborough	84%	95%	99%	94%	73%	91%	100%	83%	Not provided	78%
L/W Co-ordinator supernumary % - York	100%	100%	100%	76%	90%	67%	Not avail.	100%	99%	95%
Vacancy Rate - Scarborough (excluding maternity leaves)	3%	4.60%	1.55%	0.15%	0.15%	1.89% (1.13 WTE)	1.89% (1.13 WTE)	1.97%	0.73%	0.73%
Vacancy Rate - York (excluding maternity leaves)	15%	13%	12%	13.75%	13.75%	14.77% (16.11 WTE)	14.77% (16.11 WTE)	10.97%	2.35%	2.35%

PMRT – Appendix B

PMRT Summary from Q3 2022

Quarter 3

There were four reports completed in quarter 3 which related to three antenatal stillbirths, and an intrapartum stillbirth. In two incidences, there was a delay in obtaining an ultrasound scan where indicated. Subsequently, there has been work to develop a further room for scanning, as well as the development of three midwife ultra-sonographers. The benefits of these implementations have been immediate, and as of November 2022, there was a zero- day wait for required ultrasounds. There were no highlighted concerns within the antenatal cases. The intrapartum stillbirth presented many missed opportunities for better care provision, escalation and communication. Two of the cases also did not have a Kleihauer test taken post delivery as per the guidance. This was escalated to the laboratory and communication sent to all staff reminding them of the need for this to be done.

On two occasions, there was no evidence to indicate the parents were offered the opportunity to take their baby home. A suitable action for this was for the bereavement midwife to be present on the wards to support staff in caring for women experiencing loss, so that they aware this option can be offered. Recently 15 hours have been allocated at each site for a bereavement champion, who can support the lead midwife for bereavement in supporting staff, and families, as well as disseminating learning.

Training Compliance – Appendix D

Midwifery Staff – York

Maternity Specific Training	Frequency	Measure	No Concerns (green)	Of Concern (Amber)	Concerns (Red)	Projected January	Actual January	Projected February
PROMPT - Midwives	Annual	% of staff trained	≥85%	61%-84%	≤60%	97	96	93
PROMPT - HCAs	Annual	% of staff trained	≥85%	61%-84%	≤60%	93	84	92
NLS	Annual	% of staff trained	≥85%	61%-84%	≤60%	93	93	93
Fetal Monitoring inc K2 competancies	Annual	% of staff trained	≥85%	61%-84%	≤60%	95	61	66
Personalised Care - Year 2 (2023)	3 yearly	% of staff trained	≥85%	61%-84%	≤60%	7	5	15
SBLBC - Supporting a smoke free pregnancy	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	72	N/A
SBLCB - Detection and surveillance of growth restrictions	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	72	N/A
SBLBC - Reduced Fetal Movements	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	78	N/A
SBLCB - Effective continuous fetal monitoring	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	71	N/A
SBLCB - Reducing pre-term birth	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	77	N/A
Perinatal Mental Health	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	98	N/A
Professional Midwifery Advocate	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	96	N/A
Antenatal and Newborn screening	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	87	N/A
Learning from incidents, complaints and claims	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	79	N/A
Substance misuse	3 yearly	% of staff trained	≥85%	61%-84%	≤60%	N/A	94	N/A
Student Midwife support and supervision	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	63	N/A
Bereavement	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	89	N/A
Bereavement - HCAs	One off	% of staff trained	≥85%	61%-84%	≤60%	N/A	57	N/A
Infant Feeding	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	93	N/A
2 Day BFI - Midwives/MSW/HCA	One off	% of staff trained	≥85%	61%-84%	≤60%	N/A	85	N/A

Midwifery Staff - Scarborough

Maternity Specific Training	Frequency	Measure	No Concerns (green)	Of Concern (Amber)	Concerns (Red)	Projected January	Actual January	Projected February	A Feb
PROMPT - Midwives	Annual	% of staff trained	≥85%	61%-84%	≤60%	95	87	75	
PROMPT - HCAs	Annual	% of staff trained	≥85%	61%-84%	≤60%	74	63	58	
NLS	Annual	% of staff trained	≥85%	61%-84%	≤60%	89	87	79	
Fetal Monitoring inc K2 competancies	Annual	% of staff trained	≥85%	61%-84%	≤60%	97	44	66	
Personalised Care - Year 2 (2023)	3 yearly	% of staff trained	≥85%	61%-84%	≤60%	8	7	25	
SBLBC - Supporting a smoke free pregnancy	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	71	N/A	
SBLCB - Detection and surveillance of growth restrictions	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	75	N/A	
SBLBC - Reduced Fetal Movements	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	79	N/A	
SBLCB - Effective continuous fetal monitoring	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	68	N/A	
SBLCB - Reducing pre-term birth	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	78	N/A	
Perinatal Mental Health	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	87	N/A	
Professional Midwifery Advocate	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	81	N/A	
Antenatal and Newborn screening	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	66	N/A	
Learning from incidents, complaints and claims	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	66	N/A	
Substance misuse	3 yearly	% of staff trained	≥85%	61%-84%	≤60%	N/A	97	N/A	
Student Midwife support and supervision	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A		N/A	
Bereavement	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	59	N/A	
Bereavement - HCAs	One off	% of staff trained	≥85%	61%-84%	≤60%	N/A		N/A	
Infant Feeding	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	76	N/A	
2 Day BFI - Midwives/MSW/HCA	One off	% of staff trained	≥85%	61%-84%	≤60%	N/A		N/A	

Medical Staff - York

Maternity Specific Training	Frequency	Measure	No Concerns (green)	Of Concern (Amber)	Concerns (Red)	Projected January	Actual January	Projected February
PROMPT - Consultants	Annual	% of staff trained	≥85%	61%-84%	≤60%	93	93	80
PROMPT - Other medical staff	Annual	% of staff trained	≥85%	61%-84%	≤60%	68	68	84
Fetal Monitoring inc K2 competancies - Consultants	Annual	% of staff trained	≥85%	61%-84%	≤60%	100	60	93
Fetal Monitoring inc K2 competancies - Other medical staff	Annual	% of staff trained	≥85%	61%-84%	≤60%	68	37	47
Risk assessments and Personalised care - Consultants	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	100	N/A
Risk assessments and Personalised care - Other medical staff	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	63	N/A
SBLBC - Supporting a smoke free pregnancy - Consultants	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	87	N/A
SBLBC - Supporting a smoke free pregnancy - Other medical staff	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	63	N/A
SBLCB - Detection and surveillance of growth restrictions - Consultants	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	87	N/A
SBLCB - Detection and surveillance of growth restrictions - Other medical staff	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	63	N/A
SBLBC - Reduced Fetal Movements - Consultants	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	93	N/A
SBLBC - Reduced Fetal Movements - Other medical staff	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	74	N/A
SBLCB - Effective continuous fetal monitoring - Consultants	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	87	N/A
SBLCB - Effective continuous fetal monitoring - Other Medical staff	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	58	N/A
SBLCB - Reducing pre-term birth - Consultants	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	87	N/A
SBLCB - Reducing pre-term birth - Other medical staff	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	74	N/A
Perinatal Mental Health - Consultants	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	93	N/A
Perinatal Mental Health - Other medical staff	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	63	N/A
Antenatal and Newborn screening - Consultants	One off	% of staff trained	≥85%	61%-84%	≤60%	N/A	87	N/A
Antenatal and Newborn screening - Other medical staff	One off	% of staff trained	≥85%	61%-84%	≤60%	N/A	53	N/A
Learning from incidents, complaints and claims - Consultants	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	100	N/A
Learning from incidents, complaints and claims - Other medical staff	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	58	N/A

Medical Staff – Scarborough

Maternity Specific Training	Frequency	Measure	No Concerns (green)	Of Concern (Amber)	Concerns (Red)	Projected January	Actual January	Projected February	F
PROMPT - Midwives	Annual	% of staff trained	≥85%	61%-84%	≤60%	95	87	75	
PROMPT - HCAs	Annual	% of staff trained	≥85%	61%-84%	≤60%	74	63	58	
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SBLBC - Supporting a smoke free pregnancy	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	71	N/A	
SBLCB - Detection and surveillance of growth restrictions	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	75	N/A	
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SBLCB - Reducing pre-term birth	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	78	N/A	
Perinatal Mental Health	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	87	N/A	
Professional Midwifery Advocate	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	81	N/A	
Antenatal and Newborn screening	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	66	N/A	
Learning from incidents, complaints and claims	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	66	N/A	
Substance misuse	3 yearly	% of staff trained	≥85%	61%-84%	≤60%	N/A	97	N/A	
Student Midwife support and supervision	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A		N/A	
Bereavement	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	59	N/A	
Bereavement - HCAs	One off	% of staff trained	≥85%	61%-84%	≤60%	N/A		N/A	
Infant Feeding	Annual	% of staff trained	≥85%	61%-84%	≤60%	N/A	76	N/A	
2 Day BFI - Midwives/MSW/HCA	One off	% of staff trained	≥85%	61%-84%	≤60%	N/A		N/A	

Appendix D: Medical Staffing (January 2023)

Obstetrics – Scarborough

A summary of the staffing challenges through January 2023 for Scarborough are highlighted below:

Issue	Mitigation	Assurance
1 x Consultant post vacancy	Advertisement to be progressed to recruit substantively Currently covered through locum Consultant	Dedicated Rota Manager in post - as per attached workforce paper presented to QRAG 2nd March 23
2 x registrar vacancy	2x SHO moving up into the registrar vacancies On-call gaps currently mitigated by locum cover	Dedicated Rota Manager in post - as per attached workforce paper presented to QRAG 2nd March 23
2 x SHO vacancy	1 x SHO contract extended 1 x to go out to advert	Dedicated Rota Manager in post - as per attached workforce paper presented to QRAG 2nd March 23

Appendix D: Medical Staffing (January 2023)

Obstetrics – York

A summary of the staffing challenges through January 2023 for York are highlighted below:

Issue	Mitigation	Assurance
2 x registrars due to go on maternity leave in June 2023 - **1.8 WTE**	Plans to mitigate to be discussed regarding recruitment with the tri-team	Dedicated Rota Manager in post – daily operational oversight and escalation via Ops Team as per attached workforce paper presented to QRAG 2nd March 23
1 x registrar currently off sick currently unknown expected return date	On-call mitigated as before sickness wasn't contributing to the on-call Rota.	Daily absence monitoring as a CG5 and clear escalation across site as required if any future surge in absence.
1 x SHO vacancy since 5th February 2023	On-calls mitigated with replacement starting 1st March 2023	Dedicated Rota Manager in post - daily operational oversight and escalation via Ops Team as per attached workforce paper presented to QRAG 2nd March 23
1 x Consultant long term sick – unknown expected return date	On-calls mitigated through colleagues and locum cover Governance lead role covered by colleague 6 month locum consultant post to go out to advert	Dedicated Rota Manager in post - a daily operational oversight and escalation via Ops Team s per attached workforce paper presented to QRAG 2nd March 23

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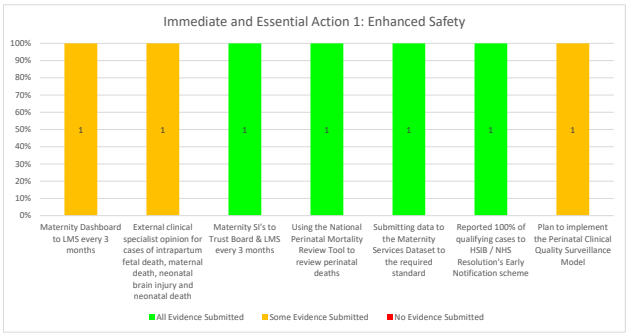
Question Number	Category	Question Number	All Evidence Submitted	Some Evidence Submitted	No Evidence Submitted	December 2021 action plans	leads & timeframe
IEA1	Q1	Maternity Dashboard to LMS every 3 months		1		confirm dashboards are submitted to LMS - ?paper required	Q&G team - ongoing oversight
IEA1	Q2	External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death		1		Audit to demonstrate this takes place - to audit the year (2021). Policy or SOP which is in place for involving external clinical specialists in reviews.	JF - March 2022
IEA1	Q3	Maternity SI's to Trust Board & LMS every 3 months	1				
IEA1	Q4	Using the National Perinatal Mortality Review Tool to review perinatal deaths	1				
IEA1	Q5	Submitting data to the Maternity Services Dataset to the required standard	1				
IEA1	Q6	Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme	1				
IEA1	Q7	Plan to implement the Perinatal Clinical Quality Surveillance Model		1		Full evidence of full implementation of the perinatal surveillance framework by June 2021.LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS.Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed of via the trust governance structure.	SCH - March 2022
IEA2	Q11	Non-executive director who has oversight of maternity services		1		NED JD required to be maternity specific	TR to obtain JD and liaise with SG, action to be picked up by LB - March 2022
IEA2	Q13	Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services	1				
IEA2	Q14	Trust safety champions meeting bimonthly with Board level champions		1		SOP that includes role descriptors for all key members who attend by-monthly safety meetings.	ML - to add into doc re.SOP. March 2022 (?TOR for SafCh)
IEA2	Q15	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.	1			One matron linked to each MVP (once new one into post), to collate evidence	SCH - March 2022
IEA2	Q16	Non-executive director support the Board maternity safety champion		1		Role descriptors - NED JD	(as above) TR to obtain JD and liaise with SG, action to be picked up by LB - March 2022
IEA3	Q17	Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year.		1		A clear trajectory in place to meet and maintain compliance as articulated in the TNA. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	SCH to forward figures to JF who will escalate and support medical staff with training- January 2022
IEA3	Q18	Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward.	1			Observe audits cross-site and speak with LM managers	ML - audits to chase and paper requested

IEA3	Q19	External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only		1		Confirmation from Directors of Finance. Evidence from Budget statements.Evidence that additional external funding has been spent on funding including staff can attend training in work time.MTP spend reports to LMS	SCH to pick up with RP
IEA3	Q21	90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session		1		A clear trajectory in place to meet and maintain compliance as articulated in the TNA. Attendance records - summarised	Q&G team - March 2022 (attendance records will need anonymising). Training highlight report to clinical governance
IEA3	Q22	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	1				
IEA3	Q23	The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place		1		A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	(as above) Q&G team - March 2022 (attendance records will need anonymising). Training highlight report to clinical governance
IEA4	Q24	Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre			1	Audit that demonstrates referral against criteria has been implemented that there is a named consultant lead, and early specialist involvement and that a Management plan that has been agreed between the women and clinicians. SOP that clearly demonstrates the current maternal medicine pathways that includes: agreed criteria for referral to the maternal medicine centre pathway.	LF - March 2022
IEA4	Q25	Women with complex pregnancies must have a named consultant lead		1		SOP that states that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead.	DS to undertake audit for compliance - March 2022
IEA4	Q26	Complex pregnancies have early specialist involvement and management plans agreed			1	Audit of 1% of notes, where women have complex pregnancies to ensure women have early specialist involvement and management plans are developed by the clinical team in consultation with the woman.SOP that identifies where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the teams.	LF- March 2022
IEA4	Q27	Compliance with all five elements of the Saving Babies' Lives care bundle Version 2	1			evidence of Co monitoring at 36/40. audits and action planning	DS and JH - Feb 2022
IEA4	Q28	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.		1		SOP that states women with complex pregnancies must have a named consultant lead.	DS to undertake audit for compliance - March 2022

IEA4	Q29	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres			1	Agreed pathways. Criteria for referrals to MMC. The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs.	LF - March 2022
IEA5	Q30	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional		1		Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above. SOP that includes definition of antenatal risk assessment as per NICE guidance.	HN to support DS - January 2022
IEA5	Q31	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.		1		Evidence of referral to birth options clinics. Out with guidance pathway.Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	HN to support DS - January 2022
IEA5	Q33	A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.		1		Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above.	HN to support DS - January 2022
IEA6	Q34	Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring		1		Copies of rotas / off duties to demonstrate they are given dedicated time. Incident investigations and reviews	JF to send to ML JD and job plan for medical leads - January 2022
IEA6	Q35	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health		1		Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g clinical supervision. Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.	BA and JF - March 2022
IEA6	Q36	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	1			evidence of Co monitoring at 36/40. audits and action planning	(as above)ML - audits to chase and paper requested
IEA6	Q37	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?		1		A clear trajectory in place to meet and maintain compliance as articulated in the TNA.Attendance records - summarised	Q&G team - March 2022 (attendance records will need anonymising). Training highlight report to clinical governance
IEA7	Q39	Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery	1			Website requires updating	ML to support JH to work with MVP once fully in post - March 2022
IEA7	Q41	Women must be enabled to participate equally in all decision-making processes			1	An audit of 1% of notes demonstrating compliance.CQC survey and associated action plans. SOP which shows how women are enabled to participate equally in all decision making processes and to make informed choices about their care. And where that is recorded.	SCH to support action planning between matron (DS) and obstetrician (JF) - March 2022 (see below)

IEA7	Q42	Women's choices following a shared and informed decision-making process must be respected			1	An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction.SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded.	SCH to look at CQC survey with matrons and support action planning between matron (DS) and obstetrician (JF). Audit and SOP to include 41 and 42 - March 2022
IEA7	Q43	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	1				
IEA7	Q44	Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.		1		Co-produced action plan to address gaps identified. Gap analysis of website against Chelsea & Westminster conducted by the MVP	ML to support JH to work with MVP once in post - March 2022
WF	Q45	Demonstrate an effective system of clinical workforce planning to the required standard		1		Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan	BA - March 2022
WF	Q46	Demonstrate an effective system of midwifery workforce planning to the required standard?	1			Workforce paper underway. CoC paper to Board in January	SCH - January 2022
WF	Q47	Director/Head of Midwifery is responsible and accountable to an executive director	1				
WF	Q48	Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care:			1	Action plan where manifesto is not met. Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care	SCH - March 2022
WF	Q49	Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate.			1	Audit to demonstrate all guidelines are in date.Evidence of risk assessment where guidance is not implemented. SOP in place for all guidelines with a demonstrable process for ongoing review.	Q&G team - March 2022


Immediate and Essential Action 1: Enhanced Safety
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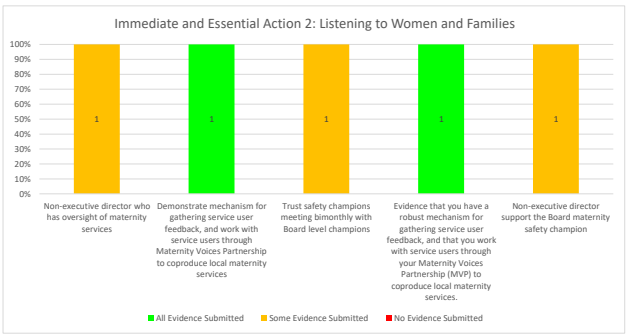
Maternity Dashboard to LMS every 3 months
External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death
Maternity SI's to Trust Board & LMS every 3 months
Using the National Perinatal Mortality Review Tool to review perinatal deaths
Submitting data to the Maternity Services Dataset to the required standard
Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme
Plan to implement the Perinatal Clinical Quality Surveillance Model
All Evidence Submitted
Some Evidence Submitted
No Evidence Submitted


Immediate and Essential Action 2: Listening to Women and Families
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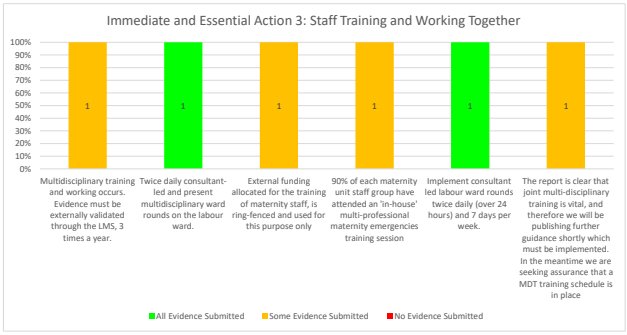
Non-executive director who has oversight of maternity services
Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services
Trust safety champions meeting bimonthly with Board level champions
Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.
Non-executive director support the Board maternity safety champion
All Evidence Submitted
Some Evidence Submitted
No Evidence Submitted


Immediate and Essential Action 3: Staff Training and Working Together
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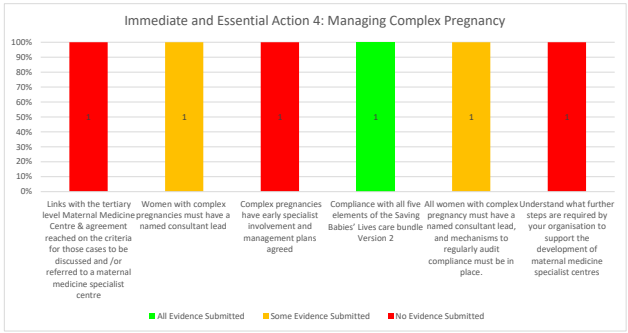
Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year.
Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward.
External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only
90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session
Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place
All Evidence Submitted
Some Evidence Submitted
No Evidence Submitted


Immediate and Essential Action 4: Managing Complex Pregnancy
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Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre
Women with complex pregnancies must have a named consultant lead
Complex pregnancies have early specialist involvement and management plans agreed
Compliance with all five elements of the Saving Babies' Lives care bundle Version 2
All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.
Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres
All Evidence Submitted
Some Evidence Submitted
No Evidence Submitted


Immediate and Essential Action 5: Risk Assessment Throughout Pregnancy
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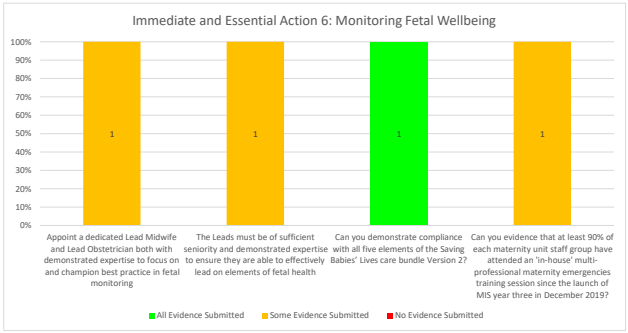
All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional
Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.
A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.
All Evidence Submitted
Some Evidence Submitted
No Evidence Submitted


Immediate and Essential Action 6: Monitoring Fetal Wellbeing
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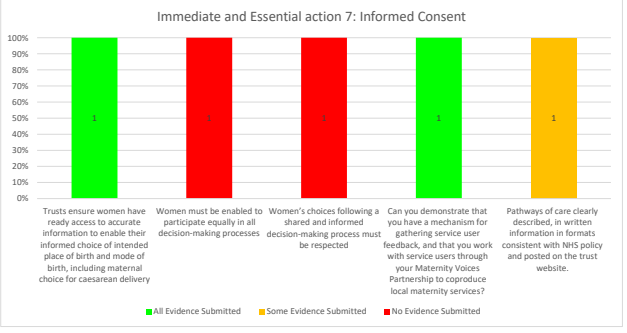
Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring
The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health
Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?
Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?
All Evidence Submitted
Some Evidence Submitted
No Evidence Submitted


Immediate and Essential action 7: Informed Consent
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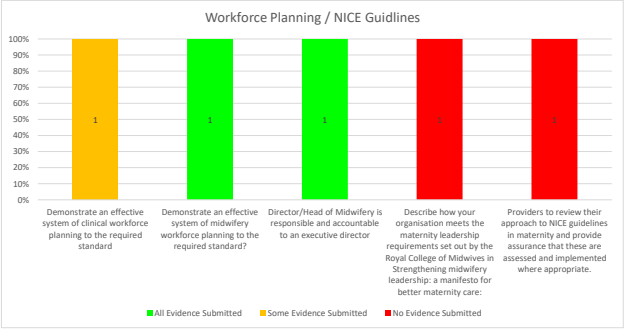
Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery
Women must be enabled to participate equally in all decision-making processes
Women's choices following a shared and informed decision-making process must be respected
Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?
Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.
All Evidence Submitted
Some Evidence Submitted
No Evidence Submitted


Workforce Planning / NICE Guidlines
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Demonstrate an effective system of clinical workforce planning to the required standard
Demonstrate an effective system of midwifery workforce planning to the required standard?
Director/Head of Midwifery is responsible and accountable to an executive director
Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care:
Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate.
All Evidence Submitted
Some Evidence Submitted
No Evidence Submitted

Reuslts of Phase 2 Audit **York and Scarborough Teaching Hospitals NHS Foundation Trust**

IEA	Question	Action	Evidence Required	York and Scarborough Teaching Hospitals NHS Foundation Trust	Action owner	Leads
IEA1	Q1	Maternity Dashboard to LMS every 3 months				
			Dashboard to be shared as evidence.	100%		
			Minutes and agendas to identify regular review and use of common data dashboards and the response / actions taken.	100%		
			SOP required which demonstrates how the trust reports this both internally and externally through the LMS.	100%		
			Submission of minutes and organogram, that shows how this takes place. Does this refer to the submission to LMS, what organogram is this referring to, and what does "how this takes please" mean?	0%	Sarah Ayre	
		Total		75%		Q&G team oversight
	Q2	External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death				
			Audit to demonstrate this takes place.	0%	Sarah Gallagher	
			Policy or SOP which is in place for involving external clinical specialists in reviews.	100%		
		Total		50%		Joe Freites
	Q3	Maternity SI's to Trust Board & LMS every 3 months				
			Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion	100%		
			Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed	100%		
			Submit SOP	100%		
		Total		100%		
	Q4	Using the National Perinatal Mortality Review Tool to review perinatal deaths				
			Audit of 100% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.	100%		
			Local PMRT report. PMRT trust board report. Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance.	100%		
		Total		100%		
	Q5	Submitting data to the Maternity Services Dataset to the required standard				
			Evidence of a plan for implementing the full MSDS requirements with clear timescales aligned to NHSR requirements within MIS.	100%		
		Total		100%		
	Q6	Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme				
			Audit showing compliance of 100% reporting to both HSIB and NHSR Early Notification Scheme.	100%		
		Total		100%		
	Q7	Plan to implement the Perinatal Clinical Quality Surveillance Model				
			Full evidence of full implementation of the perinatal surveillance framework by June 2021.	100%		
			LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS.	0%	Caroline Johnson	
			Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed of via the trust governance structure.	0%	Caroline Johnson	
		Total		33%		Sue Glendenning
IEA1 Total				75%		

IEA2	**Q11**	**Non-executive director who has oversight of maternity services**				
			Evidence of how all voices are represented:	0%	Lorraine Boyd	
			Evidence of link in to MVP; any other mechanisms	100%		
			Evidence of NED sitting at trust board meetings, minutes of trust board where NED has contributed	100%		
			Evidence of ward to board and board to ward activities e.g. NED walk arounds and subsequent actions	100%		
			Name of NED and date of appointment	100%		
			NED JD	0%	Lorraine Boyd	
		Total		67%		Tina Ramsey
	Q13	**Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services**				
			Clear co-produced plan, with MVP's that demonstrate that co production and co-design of service improvements, changes and developments will be in place and will be embedded by December 2021.	100%		
			Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)	100%		
			Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.	100%		
		Total		100%		
	Q14	**Trust safety champions meeting bimonthly with Board level champions. Who attends on behalf of CGS?**				
			Action log and actions taken.	100%		
			Log of attendees and core membership.	100%		
			Minutes of the meeting and minutes of the LMS meeting where this is discussed.	100%		
			SOP that includes role descriptors for all key members who attend by-monthly safety meetings.	0%	Caroline Johnson	
		Total		75%		ML
	Q15	**Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.**				
			Clear co produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	100%		
		Total		100%		Sue Glendenning
	Q16	**Non-executive director support the Board maternity safety champion. Who is this?**				
			Evidence of participation and collaboration between ED, NED and Maternity Safety Champion, e.g. evidence of raising issues at trust board, minutes of trust board and evidence of actions taken	100%		
			Name of ED and date of appointment	100%		
			Role descriptors	0%	Lorraine Boyd	
		Total		67%		Tina Ramsey
IEA2 Total				76%		
IEA3	**Q17**	**Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year.**				
			A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	0%	Nic English	
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data.	100%		
			Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session.	100%		

			Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.	100%		
			Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. Clarification as to what this action is referring to? Training?	0%	Nic English	
		Total		60%		Sue Glendenning
	Q18	**Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward.**				
			Evidence of scheduled MDT ward rounds taking place since December, twice a day, day & night. 7 days a week (e.g. audit of compliance with SOP)	100%		
			SOP created for consultant led ward rounds.	100%		
		Total		100%		ML
	Q19	**External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only**				
			Confirmation from Directors of Finance	0%	Laura Banks	
			Evidence from Budget statements.	0%	Laura Banks	
			Evidence of funding received and spent.	100%		
			Evidence that additional external funding has been spent on funding including staff can attend training in work time.	0%	Laura Banks	
			MTP spend reports to LMS	0%	Laura Banks	
		Total		20%		Sue Glendenning
	Q21	**90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session**				
			A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	0%	Nic English	
			Attendance records - summarised	0%	Nic English	
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	100%		
		Total		33%		Q&G team
	Q22	**Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.**				
			Evidence of scheduled MDT ward rounds taking place since December 2020 twice a day, day & night; 7 days a week (E.G audit of compliance with SOP)	100%		
		Total		100%		
	Q23	**The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place**				
			A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	0%	Nic English	
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation described as checking the accuracy of the data.	100%		
		Total		50%		Q&G team
IEA3 Total				50%		
IEA4	**Q24**	**Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre**				
			Audit that demonstrates referral against criteria has been implemented that there is a named consultant lead, and early specialist involvement and that a Management plan that has been agreed between the women and clinicians	0%	Sarah Gallagher	
			SOP that clearly demonstrates the current maternal medicine pathways that includes: agreed criteria for referral to the maternal medicine centre pathway.	0%	Sarah Gallagher	

		Total		0%		LF
	Q25	**Women with complex pregnancies must have a named consultant lead**				
			Audit of 1% of notes, where all women have complex pregnancies to demonstrate the woman has a named consultant lead.	100%		
			SOP that states that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead.	0%	Ben Adekanmi	
		Total		50%		DS
	Q26	**Complex pregnancies have early specialist involvement and management plans agreed**				
			Audit of 1% of notes, where women have complex pregnancies to ensure women have early specialist involvement and management plans are developed by the clinical team in consultation with the woman.	0%	Sarah Gallagher	
			SOP that identifies where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the teams.	0%	Ben Adekanmi	
		Total		0%		LF
	Q27	**Compliance with all five elements of the Saving Babies' Lives care bundle Version 2**				
			Audits for each element.	100%		
			Guidelines with evidence for each pathway	100%		
			SOP's	100%		
		Total		100%		DS and JH
	Q28	**All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.**				
			SOP that states women with complex pregnancies must have a named consultant lead.	0%	Sarah Gallagher	
			Submission of an audit plan to regularly audit compliance	100%		
		Total		50%		DS
	Q29	**Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres**				
			Agreed pathways	0%	Ben Adekanmi	
			Criteria for referrals to MMC	0%	Ben Adekanmi	
			The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs.	0%	Sarah Gallagher	
		Total		0%		LF
IEA4 Total				36%		
IEA5	**Q30**	**All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional**				
			How this is achieved within the organisation.	100%		
			Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	0%	Sarah Gallagher	
			Review and discussed and documented intended place of birth at every visit.	100%		
			SOP that includes definition of antenatal risk assessment as per NICE guidance.	0%	Ben Adekanmi	
			What is being risk assessed.	100%		
		Total		60%		HN to support DS
	Q31	**Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.**				
			Evidence of referral to birth options clinics	0%	Sarah Gallagher	
			Out with guidance pathway.	0%	Ben Adekanmi	
			Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	0%	Sarah Gallagher	
			SOP that includes review of intended place of birth.	100%		
		Total		25%		HN to support DS

	Q33	A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.				
			Example submission of a Personalised Care and Support Plan (It is important that we recognise that PCSP will be variable in how they are presented from each trust)	100%		
			How this is achieved in the organisation	100%		
			Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above.	0%	Sarah Gallagher	
			Review and discussed and documented intended place of birth at every visit.	100%		
			SOP to describe risk assessment being undertaken at every contact.	100%		
			What is being risk assessed.	100%		
		Total		83%		HN to support DS
IEA5 Total				60%		
IEA6	Q34	Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring				
			Copies of rotas / off duties to demonstrate they are given dedicated time.	0%	Ben and Bev	
			Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs.	100%		
			Incident investigations and reviews	0%	Datix team	
			Name of dedicated Lead Midwife and Lead Obstetrician	100%	Ben and Bev	
		Total		50%		JF to send to ML JD and job plan for medical leads
	Q35	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health				
			Consolidating existing knowledge of monitoring fetal wellbeing	100%		
			Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g clinical supervision	0%	Bev Waterhouse	
			Improving the practice & raising the profile of fetal wellbeing monitoring	100%		
			Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.	0%	Bev Waterhouse	
			Job Description which has in the criteria as a minimum for both roles and confirmation that roles are in post	100%		
			Keeping abreast of developments in the field	100%		
			Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.	0%	Bev Waterhouse	
			Plan and run regular departmental fetal heart rate (FHR) monitoring meetings and training.	100%		
		Total		63%		Ben Adekanmi and JF
	Q36	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?				
			Audits for each element	100%		
			Guidelines with evidence for each pathway	100%		
			SOP's	100%		
		Total		100%		ML
	Q37	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?				
			A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	0%	Nic English	
			Attendance records - summarised	0%	Nic English	
			Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.	100%		

		Total		33%		Q&G Team
IEA6 Total				61%		
IEA7	**Q39**	**Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery**				
			Information on maternal choice including choice for caesarean delivery.	100%		
			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	100%		
		Total		100%		ML to support JH
	Q41	**Women must be enabled to participate equally in all decision-making processes**				
			An audit of 1% of notes demonstrating compliance.	0%	Sarah Gallagher	
			CQC survey and associated action plans	0%	Sarah Gallagher	
			SOP which shows how women are enabled to participate equally in all decision making processes and to make informed choices about their care. And where that is recorded.	0%	Ben Adekanmi	
		Total		0%		Sue Glendenning
	Q42	**Women's choices following a shared and informed decision-making process must be respected**				
			An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction.	0%	Sarah Gallagher	
			SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded.	0%	Ben Adekanmi	
		Total		0%		Sue Glendenning
	Q43	**Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?**				
			Clear co produced plan, with MVP's that demonstrate that co production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	100%		
			Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)	100%		
			Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.	100%		
		Total		100%		
	Q44	**Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.**				
			Co-produced action plan to address gaps identified	0%	Sue Gallagher	
			Gap analysis of website against Chelsea & Westminster conducted by the MVP	0%	Ben Adekanmi	
			Information on maternal choice including choice for caesarean delivery.	100%		
			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	100%		
		Total		50%		ML
IEA7 Total				50%		
WF	**Q45**	**Demonstrate an effective system of clinical workforce planning to the required standard**				
			Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan	0%	Nic English	

			Evidence of reviews 6 monthly for all staff groups and evidence considered at board level.	100%		
			Most recent BR+ report and board minutes agreeing to fund.	100%		
		Total		67%		Ben Adekanmi
	Q46	**Demonstrate an effective system of midwifery workforce planning to the required standard?**				
			Most recent BR+ report and board minutes agreeing to fund.	100%		
		Total		100%		Sue Glendenning
	Q47	**Director/Head of Midwifery is responsible and accountable to an executive director**				
			HoM/DoM Job Description with explicit signposting to responsibility and accountability to an executive director	100%		
		Total		100%		
	Q48	**Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care:**				
			Action plan where manifesto is not met	0%	Sue Gallagher	
			Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care	0%	Sue Gallagher	
		Total		0%		Sue Glendenning
	Q49	**Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate.**				
			Audit to demonstrate all guidelines are in date.	0%	Sue Gallagher	
			Evidence of risk assessment where guidance is not implemented.	0%	Sue Gallagher	
			SOP in place for all guidelines with a demonstrable process for ongoing review.	0%	Sue Gallagher	
		Total		0%		Q&G Team
WF Total				40%		

York and Scarborough Teaching Hospitals
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

Author:	**Deputy Finance Director**
Owner:	**Finance Director**
Publisher:	**Finance Director**
Date of Issue:	
Version:	**v17**
Approved By:	**Board of Directors**
Review date:	**December 2023 (annually, along with Standing Orders and Reservation of Powers and Scheme of Delegation)**

CONTENTS

1. INTRODUCTION

1.1 General

1.1.1 The Code of Accountability requires that each NHS Foundation Trust shall give, and may vary or revoke, Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. These Standing Financial Instructions (SFIs) are issued in accordance with the Code. They shall have effect as if incorporated in the Standing Orders (SOs).

1.1.2 These Standing Financial Instructions detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board of Directors and the Scheme of Delegation adopted by the Trust.

1.1.3 These Standing Financial Instructions identify the financial responsibilities that apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. **All financial procedures must be approved by the Finance Director.**

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Finance Director **must be sought before acting**. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

1.1.5 **FAILURE TO COMPLY WITH STANDING FINANCIAL INSTRUCTIONS AND STANDING ORDERS IS A DISCIPLINARY MATTER WHICH COULD RESULT IN DISMISSAL.**

1.1.6 Overriding Standing Financial Instructions - if for any reason these Standing Financial Instructions are not complied with full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Group Audit Committee for referring action or ratification. All members of the Board of Directors and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Finance Director as soon as possible.

1.2 Terminology

1.2.1 Any expression to which a meaning is given in the National Health Service Act 1977, National Health Service and Community Care Act 1990, the Health and Social Care (Community Health and Standards) Act 2003, the Health and Social Care Act 2012, the Health and Care Act 2022 and other Acts relating to the National Health Service or in the Financial or other Regulations made under the Acts or in the Authorisation or Constitution shall have the same meaning in this interpretation and in addition:

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

"**Authorisation" means the authorisation of the Trust by NHS England, the Independent Regulator for the NHS**

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

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

"**Budget Holder**" means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

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

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

"**Commissioning**" means the process for determining the need for and for obtaining the supply of healthcare and related services from the Trust

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

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

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

"**Contracting and Procuring**" means the system for obtaining the supply of goods, materials, manufactured items, services, building and

engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

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

"**Finance Director**" means the chief finance officer of the Trust.

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

"**Legal Adviser**" means the properly qualified person appointed by the Trust to provide legal advice.

"**NHS England** means the Independent Regulator for the NHS.

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

"**Non-Executive Director**" means a director who is not an officer of the Trust and who has been appointed in accordance with the Constitution. This includes the Chair of the Trust.

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

"**Provider Licence**" means the licence issued by NHS Improvement.

"**Secretary of State Directions**" means the NHS Counter Fraud Authority's Requirements to meet the Government Functional Standard GovS013: counter fraud. Each NHS body is required to take necessary steps to counter fraud in the NHS in accordance with these Directions and the Chief Executive and Finance Director are mandated to monitor and ensure compliance with these Directions

"**SFIs**" means Standing Financial Instructions.

"**SOs**" means Standing Orders.

"**Trust**" means York & Scarborough Teaching Hospitals NHS Foundation Trust.

"**Vice-Chair**" means the non-executive director appointed by the Council of Governors to take on the duties of Chair if the Chair is absent for any reason.

1.2.2 Wherever the title Chief Executive, Finance Director, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

1.2.3 Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

1.3 Responsibilities and Delegation

1.3.1 The Board of Directors exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

(d) defining specific responsibilities placed on members of the Board of Directors and employees as indicated in the Reservation of Powers and Scheme of Delegation document.

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

1.3.3 The Board of Directors will delegate responsibility for the performance of its functions in accordance with the Reservations of Powers and Scheme of Delegation document adopted by the Trust.

1.3.4 Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board of Directors, and as Accountable Officer for ensuring that the Board of Directors meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chair and the Board of Directors for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.3.5 The Chief Executive and Finance Director will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

1.3.6 It is a duty of the Chief Executive to ensure that existing members of the Board of Directors and employees and all new appointees are notified of, and understand, their responsibilities within these Instructions.

1.3.7 The Finance Director is responsible for:

(a) implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, to disclose, with reasonable accuracy, the financial position of the Trust at any time.

and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Finance Director include:

(d) the provision of financial advice to other members of the Board of Directors and employees;

(e) the design, implementation, and supervision of systems of internal financial control; and

(f) the preparation and maintenance of such accounts, certificates, estimates, records, and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.3.8 All members of the Board of Directors and employees, severally and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources; and

(d) conforming to the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

1.3.9 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.3.10 For any and all members of the Board of Directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board of Directors and employees discharge their duties must be to the satisfaction of the Finance Director.

2 AUDIT

2.1 Group Audit Committee

2.1.1 In accordance with Standing Orders the Board of Directors shall formally establish a Group Audit Committee, with clearly defined terms of reference, which will provide an independent and objective view of internal control by:

(a) overseeing Clinical Audit, Internal and External Audit services;

(b) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;

(c) review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives

(d) monitoring compliance with Standing Orders and Standing Financial Instructions;

(e) reviewing schedules of losses and compensations and making recommendations to the Board of Directors;

(f) approval of non-audit services by External Audit.

2.1.2 Where the Group 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 Group Audit Committee should raise the matter at a full meeting of the Board of Directors. Exceptionally, the matter may need to be referred to NHS England & Improvement.

2.1.3 It is the responsibility of the Finance Director to ensure an adequate internal audit service is provided and the Group Audit Committee shall be involved in the selection process when there is a proposal to review the provision of internal audit services.

2.2 Finance Director

2.2.1 The Finance Director is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;

(b) ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities;

(d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board of Directors. The report must cover:

(i) a clear opinion on the effectiveness of internal control in accordance with current controls assurance guidance, including for example compliance with control criteria and standards,

(ii) major internal financial control weaknesses discovered,

(iii) progress on the implementation of internal audit recommendations,

(iv) progress against plan over the previous year,

(v) strategic audit plan covering the coming three years,

(iv) a detailed plan for the coming year.

2.2.2 The Finance Director and designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises, members of the Board of Directors or employees of the Trust;

(c) the production of any cash, stores or other property of the Trust under a member of the Board of Directors or employee's control; and

(d) explanations concerning any matter under investigation.

2.3 Role of Internal Audit

2.3.1 Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the suitability of financial and other related management data;

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences,

(ii) waste, extravagance, inefficient administration,

(iii) poor value for money or other causes.

(e) Internal Audit shall also independently verify the controls assurance statements in accordance with relevant guidance.

2.3.2 Whenever a matter arises that involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Finance Director must be notified immediately.

2.3.3 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Chief Executive of the Trust.

2.3.4 The Head of Internal Audit shall be accountable to the Finance Director. The reporting system for internal audit shall be agreed between the Finance Director, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Manual. The reporting system shall be reviewed at least every 3 years.

2.3.5 The reporting process agreed is that the Internal Audit department will issue a formal written audit report to the appropriate Directors of Clinical and Functional Directorates at the conclusion of each piece of audit work, within an appropriate timescale. Outstanding audit reports will be reviewed by the Finance Director who will initiate immediate remedial action.

2.3.6 Managers in receipt of audit reports referred to them have a duty to take appropriate remedial action within the timescales specified in the report. The Director of Finance shall identify a formal review process to monitor the extent of compliance with audit recommendations. Changes implemented must be maintained in the future and not viewed as merely satisfying an immediate audit point.

2.3.7 A summary of reports and an annual report will be presented to the Audit Committee.

2.3.8 The Head of Internal Audit has the right to report directly to the Chief Executive of the Board of Directors if, in his/her opinion, the circumstances warrant this course of action.

2.4 Fraud and Corruption

2.4.1 In line with their responsibilities, the Trust Chief Executive and Finance Director shall monitor and ensure compliance with NHS Counter Fraud Authority's Requirements to meet the Government Functional Standard GovS013: counter fraud.

2.4.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the Department of Health Fraud and Corruption Manual and guidance.

2.4.3 The Local Counter Fraud Specialist shall report to the Trust Finance Director and shall work with staff in the NHS Counter Fraud Authority in accordance with the NHS counter fraud manual.

2.5 External Audit

2.5.1 The external auditor is appointed by the Council of Governors from an approved list recommended by the Group Audit Committee and paid for by the Trust. The Group Audit Committee must ensure a cost-efficient service. Should there appear to be a problem then this should be raised with the external auditor and referred on to the Council of Governors. If the issue cannot be resolved by the Council of Governors it should be reported to NHS England.

3 BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

3.1 Preparation and Approval of Business Plans and Budgets

3.1.1 The Chief Executive will compile and submit to the Board of Directors an annual business plan which takes into account Foundation Trust financial requirements, including compliance with forecast income and expenditure plans and cash resources. The annual business plan will contain:

(a) a statement of the significant assumptions and risks on which the plan is based;

(b) details of major changes in workload, delivery of services or resources required to achieve the plan.

3.1.2 Prior to the start of the financial year the Finance Director will, on behalf of the Chief Executive, ensure annual budgets are prepared. Such budgets will:

(a) be in accordance with the aims and objectives set out in the annual business plan as submitted to NHS England;

(b) accord with workload and manpower plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available funds; and

(e) identify potential risks.

3.1.3 The Finance Director shall monitor financial performance against budget and business plan, periodically review them, and report to the Board of Directors.

3.1.4 All budget holders must provide information as required by the Finance Director to enable budgets to be compiled and monitoring reports to be prepared.

3.1.5 The Finance Director has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully in accordance with the Budget section of the Trust Finance Manual.

3.2 Budgetary Delegation

3.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be

in writing, reflecting the Scheme of Delegation, and be accompanied by a clear definition of:

(a) the amount of the budget;

(b) the purpose(s) of each budget heading;

(c) individual and group responsibilities;

(d) authority to exercise virement;

(e) achievement of planned levels of service; and

(f) the provision of regular reports.

3.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total set by the Board of Directors.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive.

3.3 Budgetary Control and Reporting

3.3.1 The Finance Director will devise and maintain systems of budgetary control. These will include:

(a) regular financial reports to the Board of Directors in a form approved by the Board of Directors containing:

(i) income and expenditure to date showing trends and forecast year-end position;

(ii) movements in working capital;

(iii) movements in cash;

(iv) capital project spend and projected outturn against plan;

(v) explanations of any material variances from plan;

(vi) details of any corrective action where necessary and the Chief Executive's and/or Finance Director's view of whether such actions are sufficient to correct the situation;

(vii) an updated assessment of financial risk;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and manpower budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers.

3.3.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board of Directors;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

(c) no employees are appointed without the approval of the Chief Executive. Further details of the approval limits are included with the Reservation of Powers and Scheme of Delegation.

3.3.3 The Chief Executive is responsible for identifying and implementing cost improvements, cost reductions and efficiencies and income generation initiatives in accordance with the requirements of the Annual Business Plan.

3.4 Capital Expenditure

3.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI Section 10.)

3.5 Monitoring Returns

3.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation e.g. NHS England.

4 ANNUAL ACCOUNTS AND REPORTS

4.1 The Finance Director, on behalf of the Trust, will prepare financial returns and reports in accordance with the accounting policies and guidance laid down within International Financial Reporting Standards, as modified by the guidance given by NHS England with the approval of HM Treasury.

4.2 The Trust's annual accounts must be audited by the external auditor appointed by the Council of Governors. The Trust's audited annual accounts must be approved by the Board of Directors and presented to a public meeting of the Council of Governors and made available to the public.

4.3 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with NHS England FT Annual Reporting Manual (FT ARM).

5 BANK ACCOUNTS, INVESTMENT AND EXTERNAL BORROWING

5.1 General

5.1.1 The Finance Director is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account NHS England and NHS Improvement guidance/directions.

5.1.2 The Board of Directors shall approve the banking arrangements.

5.2 Bank Accounts

5.2.1 The Finance Director is responsible for:

(a) the operation of bank accounts;

(b) establishing separate bank accounts for the Foundation Trust's non-exchequer/charitable funds;

(c) ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made; and

(d) reporting to the Board of Directors all instances where bank accounts may become or have become overdrawn, together with the remedial action taken.

5.3 Banking and Investment Procedures

5.3.1 The Finance Director will prepare detailed instructions on the operation of bank accounts that must include:

(a) the conditions under which the bank accounts are to be operated;

(b) the limit to be applied to any overdraft; and

(b) those authorised to sign cheques or other orders drawn on the Trust's accounts.

5.3.2 The Finance Director must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.4 Investments

5.4.1 The Finance Director will comply with the Treasury Management Policy, as approved by the Audit Committee, when borrowing and investing surplus funds.

5.5 External Borrowing

5.5.1 The Finance Director will advise the Board of Directors concerning the Trust's ability to pay interest on, and repay, both Public Dividend Capital and any proposed new borrowings.

5.5.2 Any application for a loan or overdraft will only be made by the Finance Director or by an employee so delegated by him/her.

5.5.3 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position.

5.5.4 All long-term borrowings must be consistent with the plans outlined in the current Business Plan and be approved by the Board of Directors.

5.6 Tendering and Review

5.6.1 The Finance Director will review the commercial bank arrangements of the Foundation Trust at regular intervals to ensure that they reflect best practice and represent best value for money.

6 INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 Income Systems

6.1.1 The Finance Director is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 The Finance Director is also responsible for the prompt invoicing and banking of all monies received.

6.2 Fees and Charges

6.2.1 The Trust shall follow NHS England guidance when entering into contracts for patient services.

6.2.2 The Finance Director is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health's "Commercial Sponsorship – Ethical standards in the NHS" shall be followed.

6.2.3 The Finance Director shall determine the appropriate charges or fees for the provision of all services provided to other organisations and individuals.

6.2.4 It is the responsibility of all employees to inform the Finance Director promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.3 Debt Recovery

6.3.1 All staff have an overriding responsibility to collect fees due for the provision of chargeable services thus ensuring the minimisation of debts.

6.3.2 The Finance Director is responsible for the appropriate recovery action on all outstanding debts.

6.3.3 Income not received should be dealt with in accordance with losses procedures. (See section 12.)

6.3.4 Overpayments should be detected (or preferably prevented) and recovery initiated.

6.4 Security of Cash, Cheques and other Negotiable Instruments

6.4.1 The Finance Director is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

6.4.2 Official money shall not under any circumstances be used for the encashment of private cheques.

6.4.3 All cheques, postal orders, cash etc., shall be banked promptly and intact. Disbursements shall not be made from cash received, except under arrangements approved by the Finance Director.

6.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

6.4.5 Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be monitored and recorded within the Finance Department. Any significant trends should be reported to the Finance Director and Internal Audit via the incident reporting system. Where there is prima facie evidence of fraud or corruption this process should follow guidance provided by the NHS Counter Fraud Authority. Where there is no evidence of fraud or corruption the loss should be dealt with in line with the Trust's Losses and Special Payments procedures.

7 NHS SERVICE CONTRACTS FOR PROVISION OF SERVICES

7.1 The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable legally binding service contracts with service commissioners for the provision of NHS services.

7.2 All service contracts should aim to implement the agreed priorities contained within the Integrated Business Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- the Provider Licence from NHS England
- the standards of service quality expected;
- the relevant national service framework (if any);
- the provision of reliable information based on national and local tariffs, and underlying reference costs
- the National Institute for Health and Care Excellence Guidance
- the National Standard Local Action – Health and Social Care Standards and Planning Framework
- that service contracts build where appropriate on existing partnership arrangements;
- that service contracts are based on integrated care pathways.

7.3 A good service contract will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The service contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

7.4 The Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided to the Board of Directors detailing actual and forecast income from the service contract. This will include information on costing arrangements.

8 TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE BOARD OF DIRECTORS AND EMPLOYEES

8.1 Remuneration and Terms of Service

8.1.1 In accordance with Standing Orders the Board of Directors shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

8.1.2 The Remuneration Committee will:

(a) determine the appropriate remuneration and terms of service for the Chief Executive, and Corporate Directors employed by the Trust including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars; and

(iii) arrangements for termination of employment and other contractual terms

(b) determine the terms of service for the Chief Executive, and Corporate Directors to ensure they are fairly rewarded for their individual contribution to the Trust – having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

(c) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking accounts of such national guidance as is appropriate.

8.1.3 The Board of Directors will after due consideration and amendment if appropriate approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees not covered by the Committee.

8.1.4 The Trust will pay allowances to the Chair and Non-Executive Directors of the Board of Directors and said allowances will be approved by the Council of Governors.

8.2 Funded Establishment

8.2.1 The workforce plans of the Trust will be reconciled with the funded establishments on expenditure budgets, to ensure affordability of appropriate staffing levels.

8.2.2 The funded establishment of any department may not be varied recurrently without the approval of the Chief Executive, on the advice of the Director of Workforce and Organisational Development.

8.3 Staff Appointments

8.3.1 No officer may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Executive; and

(b) within the limit of the approved budget and funded establishment.

(c) The hire of agency staff and locums must comply with the guidelines laid out in the Reservation of Powers and Scheme of Delegation

8.3.2 The Board of Directors will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

8.4 Processing Payroll

8.4.1 The Finance Director is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances (in conjunction with the Director of Workforce and Organisational Development);

(c) making payment on agreed dates; and

(d) agreeing method of payment.

8.4.2 The Finance Director will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of payment available to various categories of employee and officers;

(h) procedures for payment by cheque or bank credit to employees and officers;

(i) procedures for the recall of cheques and bank credits;

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) separation of duties of preparing records; and

(m) a system to ensure the recovery from leavers of sums of money and property due by them to the Trust.

8.4.3 Appropriately nominated managers have delegated responsibility for:

(a) Submitting a signed copy of the notification of starter/variation in contract forms and other such documentation as may be required immediately upon an employee commencing duty;

(b) submitting time records and other notifications in accordance with agreed timetables;

(c) completing time records and other notifications in accordance with the Finance Director's instructions and in the form prescribed by the Finance Director; and

(d) submitting termination forms in the prescribed form **immediately** upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Finance Director must be informed immediately.

(e) taking responsibility for managing staff costs within the available resources and engaging staff in accordance with Trust policies and procedures.

8.4.4 Regardless of the arrangements for providing the payroll service, the Finance Director shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

8.5 Contracts of Employment

8.5.1 The Board of Directors shall delegate responsibility to managers

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Director of Workforce and Organisational Development and which complies with employment legislation; and

(b) dealing with variations to, or termination of, contracts of employment.

9 NON-PAY EXPENDITURE

9.1 Delegation of Authority

9.1.1 As part of the approval of annual budgets, the Board of Directors will approve the level of non-pay expenditure and the Chief Executive will determine the level of delegation to budget managers as part of the Reservation of Powers and Scheme of Delegation.

9.1.2 The Chief Executive, as the Accountable Officer, will determine:

(a) prime budget holders who are authorised to place requisitions for the supply of goods and services; and

(b) the maximum level of each requisition and the system for authorisation above that level (See Reservation of Powers and Scheme of Delegation document)

9.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

9.1.4 The Chief Executive will determine the level of delegation in respect of entering into contracts (refer to Reservation of Powers and Scheme of Delegation for delegated limits).

9.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

9.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the York Hospitals Facilities Management LLP or Purchasing department shall be sought. Where this advice is not acceptable to the requisitioner, the Finance Director (and/or the Chief Executive) shall be consulted.

9.2.2 The Finance Director shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

9.2.3 The Finance Director will:

(a) advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; current thresholds are set out in 9.5 below;

(b) prepare procedural instructions on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of Board Directors/employees (including specimens of their signatures) authorised to certify invoices.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

(iii) A timetable and system for submission to the Finance Director of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts (where providing good value for money) or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

9.2.4 Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%);

(b) the appropriate Corporate Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) the Finance Director will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the UK public procurement rules where the contract is above a stipulated financial threshold); and

(d) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or Chief Executive if problems are encountered.

9.2.5 Official orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Finance Director;

(c) state the Trust's terms and conditions of trade; and

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

9.2.6 Managers and officers must ensure that they comply fully with the guidance and limits specified by the Finance Director and that:

(a) all contracts, leases, tenancy agreements and other commitments which may result in a liability are notified to the Finance Director in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with UK 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 2020-21 NHSE determined the threshold for this to be £50,000.

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

Refer to the national guidance contained in "Standards of Business Conduct for NHS Staff"

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Finance Director on behalf of the Chief Executive;

(f) all goods, services, or works are ordered on an official order except purchases from petty cash or on purchase cards;

(g) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(h) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(i) changes to the list of directors/employees and officers authorised to certify invoices are notified to the Finance Director;

9.3 Petty Cash

9.3.1 Purchases that will be reimbursed from petty cash are restricted in value and by type, in accordance with instructions issued by the Finance Director.

9.3.2 All reimbursements must be supported by receipt(s) and certified by an authorised signatory.

9.3.3 Petty cash records are maintained in a form as determined by the Finance Director.

9.4 Building and Engineering Transactions

9.4.1 The Finance Director shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and

property transactions comply with the guidelines and requirements of the DHSC frameworks (e.g. Procure 22 & 23 or successor arrangements) or other equivalent public sector frameworks that may be utilised to procure building work and related services. All works and related contracts (e.g. architects services) should utilise and comply with recognised forms of contract. The technical audit of these contracts shall be the responsibility of the relevant Director.

9.5 Tendering Quotation and Contract Procedure

9.5.1 The Trust shall ensure competitive tenders are invited for the supply of goods and materials, manufactured articles and services, for the design, construction and maintenance of buildings and engineering works and for disposals.

9.5.2 Formal tendering procedures may be waived by officers for whom powers have been delegated by the Chief Executive through the Scheme of Delegation where one or more of the following applies:

(a) The estimated expenditure or income does not, or is not reasonably expected to, exceed £50,000 (this figure is reviewed annually). It is a breach of the UK Public Contracts 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 (including VAT) not annual costs;

(b) A contract which was sourced by competitive selection or via a framework either by the Trust or by agencies such as the Crown Commercial Service, NHS Supply Chain or another commercial procurement collaborative acting on behalf of a NHS organisation;

(c) Where the supply of the proposed goods or service is under special arrangements by any Government Agency (e.g. Procure22 as it applies to construction contracts).

(d) Where specifically excluded under Regulation 10 of the UK Public Contracts Regulations 2015.

- E.g. rental of land, existing buildings or immovable property, legal services or advice (where there are court proceedings or likely court proceedings) and employment contracts (but not services of employed persons).
- ~~(c)~~ Where this derogation places a subsequent obligation on the Trust this too shall be deemed to be specifically excluded under the SFI's. e.g. The rental or lease of property often means that the terms include a clause to accept the landlord's cleaning, maintenance and or security services.

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9.5.3 The negotiated procedure without the prior publication of a contract notice (a Single Tender Action waiver - 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);

(b) For reasons of extreme urgency brought about by events **unforeseeable** by, and not attributable to, the Trust, e.g. flood, fire or system failure. Failure to plan properly is not a justification for single tender;

(c) Specialist expertise / equipment is required and it is only available from one source. (i.e. for technical, artistic reasons or connected to the protection of exclusive rights).

(d) There is clear benefit to be gained from maintaining continuity where:

(i) the goods are a partial replacement for, or in addition to, existing goods or an installation; and

(ii) to obtain the goods from another supplier would oblige the Trust to acquire goods having different technical characteristics which may result in incompatibility and/or disproportionate technical difficulties in the operation or maintenance of the existing. This must be more than familiarity. This continuity must outweigh any potential financial advantage to be gained by competitive tendering.

Where a responsible officer decides that competitive tendering is not applicable and should be waived by virtue of the above, details should be recorded on the Single Tender Approval Form (available on the intranet) and submitted to the Chief Executive for approval. Responsible officers must follow the single tender action guidance available from the Procurement Department. Details of these approvals will be reported to the Group 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 Where the formal tendering procedures are waived under 9.5.2 above (i.e. below £50,000) but the value of the goods / services or works is greater than £~~10,000~~30,000 (inc VAT) then at least 3 suppliers shall be invited to quote with the results of these quotes to be recorded. Ideally the quotation process used should be done using any 'quick quote' process and using an appropriate ~~eprocurement~~ eProcurement tool. (e.g. In-Tend or Atamis).

9.5.7 All quotations should be treated as confidential and should be retained for inspection.

9.5.8 The Chief Executive or his nominated officer should evaluate the quotations and select the one which gives best value for money. If this is not the lowest, then this fact and the reasons why the lowest quotation was not chosen should be in a permanent record.

9.5.9 Where tenders or quotations are not required the Trust shall procure goods and services in accordance with procurement procedures approved by the Board of Directors.

9.5.10 The Chief Executive shall be responsible for ensuring the best value for money can be demonstrated for all services provided under contract or in-house. The Board of Directors may also determine from time to time that in-house services should be market tested by competitive tendering. (Standing Order 9)

9.5.11 The competitive tendering or quotation procedure shall not apply to the disposal of:

(a) Items with an estimated sale value of less than £~~10,000~~30,000 (inc VAT);

(b) Any matter in respect of which a fair price can be obtained only by negotiation or sale by auction;

(c) Obsolete or condemned articles and stores; which may be disposed of in accordance with the procurement policy of the Trust;

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10 CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

10.1 Capital Investment

10.1.1 The Chief Executive:

a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

c) shall ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges.

10.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case is produced, in line with the limits set out in the Reservation of Powers and Scheme of Delegation, setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; and

(ii) appropriate project management and control arrangements;

(iii) the involvement of appropriate Trust personnel and external agencies; and

(b) that the Finance Director has certified professionally to the costs and revenue consequences detailed in the business case.

10.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of "CONCODE".

The Finance Director shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

The Finance Director shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

10.1.4 The approval of a capital programme shall not constitute approval for the initiation of expenditure on any scheme.

10.1.5 The Finance Director shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender;

(c) approval to accept a successful tender.

10.1.6 The Finance Director shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures will:

(a) be designed to ensure that each project stays within estimated/budgeted costs at each milestone;

(b) be issued to project managers and other employees/persons involved in capital projects;

(c) incorporate simple checklists designed to ensure that important requirements are complied with on each project.

10.2 Private Finance (including leasing)

10.2.1 The Trust may test for PFI when considering a major capital procurement.

10.2.2 When the Trust proposes to use finance the following procedures shall apply:

(a) The Finance Director shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

(b) The proposal must be specifically agreed by the Board of Directors.

(c) Any finance or operating lease must be agreed and signed by the Finance Director or any individual with delegated authority specifically agreed by the Finance Director.

10.3 Asset Registers

10.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Finance Director concerning the form of any register and the method of updating, and arranging for a physical check of assets.

10.3.2 The Trust shall maintain an Asset Register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the guidance issued by Monitor.

10.3.3 Additions to the Fixed Asset Register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and

(c) lease agreements in respect of assets held under a finance lease and capitalised.

10.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

10.3.5 The Finance Director shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on Fixed Asset Registers.

10.3.6 The value of each asset shall be depreciated using methods and rates in accordance with NHS Improvement FT ARM.

10.4 Security of Assets

10.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

10.4.2 Asset control procedures, (including both purchased and donated assets) must be approved by the Finance Director. These procedures shall make provision for:

(a) recording of managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to assets recorded;

(f) identification and reporting all costs associated with the retention of an asset.

10.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Finance Director.

10.4.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board Directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS Foundation Trust property as may be determined by the Board of Directors. Any breach of agreed security practices must be reported in accordance with instructions.

10.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Directors and employees in accordance with the procedure for reporting losses.

10.4.6 Where practical, assets should be marked as Trust property.

10.4.7 Equipment and other assets may be loaned to or from the Trust. Employees and managers must ensure that the Trust's management procedure is followed, in particular conditions attaching to the loan are documented and the assets identified. Assets loaned to the Trust must not be entered in the Trust's asset register.

11 STORES AND RECEIPT OF GOODS

11.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

11.2 Subject to the responsibility of the Finance Director for the systems of control, overall responsibility for the control of stores shall be delegated to the Trust's Head of Procurement. The day-to-day responsibility may be delegated by him/her to departmental employees and stores managers/keepers. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated Estates Manager.

11.3 A number of principles apply to the operation of all stores; managers of stores and stock are responsible for ensuring that:-

(a) stocks are kept to a minimum, commensurate with delivery and cost effective purchasing;

(b) delegation of responsibility must be clearly defined and recorded. The Finance Director may require access to the record in writing;

(c) the designated manager must be responsible for security arrangements; the custody of keys etc. must be clearly defined in writing;

(d) security measures, including marking as Trust property, must be commensurate with the value and attractiveness of the stock;

(e) stocktaking arrangements are agreed with the Finance Director and a physical check undertaken at least once a year;

(f) the system of store control, including receipt and checking of delivery notes etc. is agreed with the Finance Director;

(g) there is a system, approved by the Finance Director, for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods;

(h) any evidence of significant overstocking and of any negligence or malpractice shall be reported to the Finance Director;

(h) losses and the disposal of obsolete stock are reported to the Finance Director

11.4 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Finance Director.

11.5 For goods supplied via the NHS Supply Chain central warehouses and in accordance with the Reservation of Powers and Scheme of Delegation, the Chief Executive shall identify those authorised to requisition and accept goods from the store, and issue appropriate guidance for checking receipt of goods.

12 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

12.1 Disposals and Condemnations

12.1.1 The Finance Director must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

12.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Finance Director of the estimated market value of the item, taking account of professional advice where appropriate. The Finance Director shall ensure that the arrangements for the sale of disposable assets maximise the income to the Trust.

12.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Finance Director;

(b) recorded by the Condemning Officer in a form approved by the Finance Director that will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Finance Director.

12.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Finance Director who will take the appropriate action.

12.2 Losses and Special Payments

12.2.1 The Finance Director must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The Finance Director must also prepare a Fraud and Corruption Policy that sets out the action to be taken both by the persons detecting a suspected fraud and those persons responsible for investigating it.

12.2.2 Any employee or officer discovering or suspecting a loss, which is not fraud must either immediately inform their head of department, who must immediately inform the Chief Executive and the Finance Director or inform an officer charged with responsibility for responding to concerns involving loss confidentially. This officer will then appropriately inform the Finance Director and/or Chief Executive. Where a criminal offence is suspected, the Finance Director must immediately inform the police if theft or arson is involved.

When an employee discovers or suspects fraud or corruption it must be immediately reported to the Trust's Local Counter Fraud Specialist or Finance Director. Alternatively, employees can contact the NHS Fraud and

Corruption Reporting Line – 0800 028 40 60. In cases of fraud and corruption or of anomalies that may indicate fraud or corruption, the Local Counter Fraud Specialist will inform the NHS Counter Fraud Authority.

12.2.3 The Finance Director or Local Counter Fraud Specialist must notify the NHS Counter Fraud Authority and both the Internal and External Auditor of all frauds.

12.2.4 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Finance Director must immediately notify:

(a) the Board of Directors,

(b) the External Auditor, and

(c) the Head of Internal Audit.

12.2.5 The Audit Committee shall receive a report of losses and Special Payments. The delegated limits for approval of all losses and special payments are set out in the Reservation of Powers and Scheme of Delegation document. Authorising officers must undertake fuller reviews of systems to reduce the risk of similar losses occurring in the future and seek advice where they believe a particular case raises issues of principle.

12.2.6 For any loss, the Finance Director should consider whether any insurance claim could be made.

12.2.8 The Finance Director shall maintain a Losses and Special Payments Register in which write-off action is recorded. This register will be reviewed by the Audit Committee on an annual basis.

12.2.9 No special payments exceeding delegated limits shall be made without the prior approval of the Treasury.

12.3 Bankruptcies, Liquidation and Receiverships

12.3.1 The Finance Director shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

12.3.2 When a bankruptcy, liquidation or receivership is discovered, all payments should cease pending confirmation of the bankruptcy, etc. As a matter of urgency, a statement must be prepared listing the amounts due to and from the Trust.

13 COMPUTERISED FINANCIAL SYSTEMS

13.1 The Finance Director, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's financial data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

(b) ensure that adequate (reasonable) controls exist over financial data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the financial computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the financial computerised system and that such computer audit reviews as he/she may consider necessary are being carried out.

13.2 The Finance Director shall satisfy him/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

13.3 In the case of computer systems which are proposed General Applications (i.e. including those applications which the majority of NHS bodies in the locality/region wish to sponsor jointly) all responsible directors and employees will send to the Finance Director:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

13.4 The Finance Director shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

13.5 Where another health organisation or any other agency provides a computer service for financial applications, the Finance Director shall periodically seek assurances that adequate controls are in operation.

13.6 Where computer systems have an impact on corporate financial systems the Finance Director shall satisfy him/herself that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that an audit trail exists;

(c) Finance Director staff have access to such data; and

(d) such computer audit reviews are being carried out as are considered necessary.

14 PATIENTS' PROPERTY

14.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

14.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets,
- hospital admission documentation and property records,
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

14.3 The Finance Director must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money.

14.4 Where Department of Health instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the Finance Director.

14.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

14.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

14.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

14.8 Where a deceased patient is intestate and there is no lawful next-of-kin, details of any monies or valuables should be notified to the Treasury Solicitor.

14.9 Any funeral expenses necessarily borne by the Trust in respect of a deceased patient shall be reimbursed from any of the patient's monies held by the Trust.

15 CHARITABLE FUNDS

15.1 Introduction

15.1.1 Charitable funds are those funds which are held in the name of the Trust separately from other funds and which arise principally from gifts, donations, legacies and endowments made under the relevant charities legislation.

15.1.2 Standing Orders state the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust and define how those responsibilities are to be discharged. They explain that although the management processes may overlap with those of the organisation of the Trust, the trustee responsibilities must be discharged separately and full recognition given to its dual accountabilities to the Charity Commission for charitable funds held on trust and to NHS Improvement for all funds held on trust.

15.1.3 The reserved powers of the Board of Directors and the Charitable Funds Scheme of Delegation make clear where decisions regarding the exercise of discretion in terms of the disposal and use of funds are to be taken and by whom. Directors and officers must take account of that guidance before taking action. SFIs are intended to provide guidance to persons who have been delegated to act on behalf of the corporate trustee.

15.1.4 As management processes overlap most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust. This section covers those instructions which are specific to the management of funds held on trust.

15.1.5 The over-riding principle is that the integrity of each trust must be maintained and statutory and trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

15.2 Income

15.2.1 All gifts and donations accepted shall be received and held in the name of the Trust's registered charity and administered in accordance with the Charity's' policy, subject to the terms of the specific charitable funds.

15.2.2 All managers/employees who receive enquiries regarding legacies shall keep the Finance Director, or person nominated by him, informed and shall keep an appropriate record. After the death of a benefactor all correspondence concerning a legacy shall be dealt with on behalf of the Trust by the Finance Director.

15.2.3 The Finance Director shall advise the Board of Directors on the financial implications of any proposal for fund raising activities which the Trust may initiate, sponsor or approve.

15.2.4 New charitable funds will only be opened where the wishes of benefactors cannot be accommodated within existing funds and in all cases must comply with the requirements of the Charity Commission.

15.3 Expenditure

All expenditure from charitable funds, with the exception of legitimate expenses of administering and managing those funds and expenditure for research purposes must be for the benefit of the NHS.

15.3.1 Expenditure of any charitable funds shall be conditional upon the goods and services being within the terms of the appropriate charitable fund and upon the proviso that the expenditure does not result in further payments by the Trust which have not been agreed and funded.

15.4 Investments

15.4.1 Charitable funds shall be invested by the Finance Director on behalf of the Fund Manager in accordance with the Trust's policy and statutory requirements.

15.4.2 In managing the investments the Trust shall take due account of the written advice received from its duly appointed Investment Advisors.

16 ACCEPTANCE OF GIFTS BY STAFF

16.1 The Finance Director shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. This policy should follow the guidance contained in the Department of Health Standards of Business Conduct for NHS Staff.

17 RETENTION OF DOCUMENTS

17.1 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained in accordance with Department of Health guidelines " Records Management: NHS Code of Practice".

17.2 The documents held in archives shall be capable of retrieval by authorised persons.

17.3 Documents held in accordance with Department of Health guidelines shall only be destroyed at the express instigation of the Chief Executive and records shall be maintained of documents so destroyed. All the above shall be in compliance with the requirements of the Freedom of Information Act and the Trust's policy for document management and retention.

18 RISK MANAGEMENT

18.1 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with the terms of the licence issued by Monitor. This programme will be approved and monitored by the Board of Directors.

18.2 The programme of risk management shall include:

a) a process for identifying and quantifying principal risks and potential liabilities, existing controls, additional controls as identified in the corporate risk register;

b) engendering among all levels of staff a positive attitude towards the control of risk as described in the Trust Risk Management Strategy;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;

e) review arrangements including; external audit, internal audit, clinical audit, health and safety review;

f) receive and review annual plan at Board of Directors.

The existence, integration and evaluation of the above elements will assist in providing a basis to make a statement on the effectiveness of Internal Control within the Annual Report and Accounts as required by the guidance issued NHS England.

18.3 The Audit Committee shall review insurance arrangements for the Trust.

APPENDIX 1 UK Thresholds

The Public Procurement (Agreement on Government Procurement) (Thresholds) (Amendment) Regulations 2021

Note a change under the Regulations, whereby the estimated value of procurements (under all the above-mentioned regulations) will be calculated on the total amount of the procurement **inclusive of VAT** rather than net of VAT.

These thresholds apply from **1 January 2022**.

Contract type	**Current threshold**	**New threshold**
	Net of VAT	**Inclusive of VAT**
Public works	£4,733,252	£5,336,937
Public service and supply awarded by central government authorities, and their design contests	£122,976	£138,760
Public service and supply awarded by sub-central contracting authorities, and their design contests	£189,330	£213,477

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Time Limits (Minimum Timescales

MINIMUM TIME	**IF ELECTRONIC TENDER PERMITTED**	**IF URGENT**	**WHERE PIN PUBLISHED***
Open Procedure (1 stage progress) Minimum time limit for receipt of tenders: 35 days	Minimum time limit for receipt of tenders: 30 days	Minimum time limit for receipt of tenders: 15 days	Minimum time limit for receipt of tenders: 15 days
Restricted Procedure			

(2 stage process) Minimum time limit for requests to participate: 30 days	-	Minimum time limit for requests to participate 15 days	Minimum time limit for requests to participate 30 days
Minimum time limit for tenders: 30 days	Minimum time limit for receipt of tenders: 25 days	Minimum time limit for tenders: 10 days	Minimum time limit for tenders: 10 days
Competitive Negotiated Procedure/ Innovation Partnerships Minimum time limit for requests to participate: 30 days		Minimum time limit for requests to participate: 15 days	Minimum time limit for requests to participate: 30 days
Minimum time limit for initial tenders: 30 days	Minimum time limit for receipt of initial tenders: 25 days	Minimum time limit for tenders: 10 days	Minimum time limit for tenders: 10 days
Competitive Dialogue Minimum time limit for requests to participate: 30 days No explicit time limits for submission of initial/subsequent tenders			

Help choosing the right procedure

The choice of procedure requires a careful balancing act. Often, you may be able to use an existing framework agreement but, if not, then the open procedure or the restricted procedure is often the most appropriate. The table on the next page indicates some of the key considerations.

For any uncertainty, or for further guidance on which procedure is likely to be appropriate for your needs please ask any questions via purchasingenquiries@york.nhs.uk and we'll do our best to help.

	Open procedure	*Restricted procedure*	*Competitive dialogue OR Competitive procedure with negotiation*	*Dynamic purchasing system*	*Innovation partnerships*
Few bidders expected	✓	(✓)	✓	✓	✓

One-off purchases	✓		✓		✓		✗	✓
Low cost/effort to bidding	✓		✓			✗	(✓)	✗
Commodity products	✓		(✓)			✗	✓	✗
Adaptation of available	(	✗	(✓)		✓		(	✗	(✓)	
Frequent similar purchases	✓		(✓)			✗	✓	✗
Many bidders expected		✗	✓		✓		(	✗	✓	
Complex projects	(	✗	(✓)		✓			✗	✓	
Research and development needed		✗		✗	✓			✗	✓	
Specification cannot be set		✗		✗	✓			✗	✓	

NHS Guide to Procurement, Foot Anstey LLP, 2015

Key: ✓ Yes, No, (✗) means probably not, (✓) means probably yes.

York Teaching Hospital Facilities Management

York Teaching Hospital Facilities Management LLP

RESERVATION OF POWERS

AND

SCHEME OF DELEGATION

Author: Foundation Trust Secretary
Owner: YTHFM Managing Director
Publisher: Compliance Unit
Date of Issue: August 2021
Reviewed By: Penny Gilyard, Director of Resources (YTHFM Company Secretary)
Version: 4
Approved By: Management Group, Group Audit Committee and Board of Directors
Review date: December 2023~~2~~

Table of content

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 & Scarborough Teaching Hospitals 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 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 and those delegated to other directors or officers. All powers delegated by the Managing Director can be re-assumed by them 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 YTHFM 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 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.

1.3 The Scheme of Delegation shows only the top level of delegation within YTHFM. The Scheme is to be used in conjunction with the YTHFM's Members Agreement, Schedule of Matters Reserved to the Board, Standing Financial Instructions including the system of budgetary control and other established policies and procedures.

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 may be exercised by the Director of Resources.

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 NHSE 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 YTHFM's corporate governance framework, which is the regulatory framework for the business conduct of the YTHFM within which all YTHFM officers are expected to comply. The aim is not to create bureaucracy but to protect YTHFM'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, 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 Resources.
- 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 YTHFM by means of the receipt of reports as it sees fit from Directors, Committees and Officers of YTHFM.

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 YTHFM or any of its assets unless it shall have become insolvent.
3. Any decision for YTHFM 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 YTHFM.
5. Any change in status of the YTHFM as a limited liability partnership.
6. The allocation of any further profit share in YTHFM 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 YTHFM other than in accordance with the Business Plan (including any refinancing of the YTHFM).
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 YTHFM 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 YTHFM.
18. The making of loans or advances, or the grant of any credit, in excess of {£5,000} by YTHFM (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 YTHFM 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 YTHFM 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 YTHFM.

25. Sale or transfer of a member's share in YTHFM outside of the original Members.
26. The acquisition or disposal by the YTHFM of any partnership interest, share capital or other securities in a body corporate or any merger or consolidation of YTHFM or its assets, property and business.
27. The formation by YTHFM 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 YTHFM other than in pursuit of debts or damages to which YTHFM 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 YTHFM.
29. Any material departure from the principle that staff transferring to the YTHFM 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 YTHFM has the capacity to provide).
30. The engagement of any consultant by YTHFM 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 YTHFM of any encumbrance over the whole or any part of the Business, undertaking or assets of YTHFM 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 YTHFM 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 YTHFM 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~~.~~6.1~~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 (Group Audit Committee, Group Remuneration Committee).
- Through the Group Remuneration Committee the appointment, remuneration, appraisal of the Managing Director (VSM), ~~and~~ the disciplinary procedures of the Trust.
- The appointment of any representative body outside the organisation. Define and approve the strategic aims and objectives of YTHFM.
- 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 YTHFM budgets.
- Approve proposals for action on litigation against or on behalf of the YTHFM.
- 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 Group Audit Committee.

Summary of Delegated Authorities

Delegated matters in respect of decisions which may have a far reaching effect must be reported to the YTHFM 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 YTHFM Resources	Managing Director and Members Representatives	Full	Membership Agreement
	Ensure the expenditure by YTHFM 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, YTHFM Company Secretary Associate Director Corporate Governance ~~Company Secretary YTHFT~~		
Declaration of Interests	The keeping of a declaration of YTHFM Senior Officers and Members Representatives interests	YTHFM Company Secretary		
Receipt of Gifts and Hospitality	Receipt or provision of hospitality and gifts	All YTHFM 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	YTHFM Company Secretary		
	Approval of receipt of both individual and collective hospitality	Prime budget holder		

Financial Procedures and YTHFM accounting policies	Approve and communicate all financial procedures and YTHFM accounting policies	Director of Resources	All	FReM and NHSE~~I~~ guidance SFI 1.1.3

Asset Register	Maintenance of the Asset Register	Managing Director	All	SFI 10.23
Investment of funds	Investments – agreed by the Board of Directors	Board of Directors	All	Treasury Management Policy
Capital Investment and Business Cases	Backlog Maintenance element of the Capital Programme	Capital Programme Management Group (CPMG) - delegated authority from Capital Programme Executive Group (CPEG)~~Capital Programme Executive Group~~	£5k to £50k~~Up to £100k~~	SFI 10
		Chief Executive or Group Finance Director through Capital Programme Executive Group (CPEG)	£50k~~100~~k- £500k	
		Executive Board	£500k - £1m	
		Board of Directors	Over £1m and all PFI proposals	
All Business Cases revenue investment (planned increases in expenditure or income from existing approved levels)	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 £10k must be advertised under UK procurement legislation. Further advice should be sought from procurement)	Delegated budget holder (Heads of Service)	Up to £2550k	Business Case Guidance Manual
		Prime budget holder (Directors)	Up to £50k	
		Managing Director	Up to £100k	
		Management Group	Over £100k- £1m	
		Board of Directors	Over £1m All PFI proposals	

Planning & Budgetary Control	Prepare and submit a Business Plan including any in year adjustment to the Business Plan	Managing Director		SFI 3
	Management of budgets for the totality of services	Managing Director		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 (Directors)		YTHFM 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 (Heads of Service)		YTHFM Finance Manual Section 8
	Virement (planned transfer) of resources between department budgets (per annum): A register of all virements should be kept	Director of Resources		SFI 3.2.3 YTHFM Finance Manual Section 8.2.3
	Non pay requisitions – Decisions to rent or lease in preference to outright purchase	Group Head of Corporate Finance on behalf of the YTHFM		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)	Prime budget holders are expected to set delegated limits for delegated budget holders and advise the Deputy~~Assistant~~ Director of Finance – Financial Management for inclusion in the authorised signature list	SFI Section 9 YTHFM Finance Manual Section 5.2

	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		~~SFI 9.2.6(e)~~
	Purchasing Cards: Authority to issue purchasing cards and setting of limits	Director of Resources		
Non clinical income credit notes		Prime budget holder~~Managing Director~~	Up to £50k	
		Group Head of Financial Management ~~Assistant Director of Finance – Financial Management~~ on behalf of YTHFM	£50k to £500k	
		Group Deputy Finance Director on behalf of the YTHFM	Over £500k to £1m	
		Group Finance Director on behalf of the YTHFM	Over £1m	
~~Credit notes to correct posting errors~~Credit notes / refunds to correct posting errors and duplicate payments		Group Accounts Receivable Team Leader on behalf of YTHFM	Up to £1k	
		Group Financial Accountant/Payroll Manager on behalf of YTHFM	£1k to £5~~10~~k	Payroll Manager for payroll invoices up to £5k

		Group Deputy Head of Corporate Finance on behalf of YTHFM	£5k ~~10k~~ to £25~~500~~k	
		Group Head of Corporate Finance on behalf of YTHFM	£25k to £500k	
		~~Head of Corporate Finance on behalf of YTHFM~~ Group Deputy Finance Director on behalf of the YTHFM	£500k to £1m	
		Group Finance Director ~~Deputy Finance~~ Director on behalf of the YTHFM	Over £1m	
Write offs Write offs – excluding workforce remuneration over payments		Managing Director ~~or~~ Director of Resources	Up to £10,000	
		Management Group	Over £10,000	
Write offs – workforce remuneration over payments	Please note it is not YTHFM policy to write off any workforce remuneration overpayments – Any agreed write off will only be approved as an absolute exception	Director of Resources	Up to £1k	
		Managing Director Director of Resources	Over £1k	

		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 YTHFM LLP turnover	
		Board of Directors	More than 1% of YTHFM 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 £3025~~k~~~~K~~	Head of Procurement on behalf of the YTHFM	Over £3025~~k~~	
	Waiving of quotations and tenders subject to SFIs and SOs (including approval of single tenders)	Head of Procurement on behalf of YTHFM Managing Director or~~and~~ Director of Resources	Under £50k Over £50k	~~SFI 9.5.2~~9
	Opening tenders – manual	Managing Director or Director of Resources		~~SFI 9.5~~9

	Opening tenders – electronically the system prevents quotes/tenders from being opened before the deadline	Head of Procurement on behalf of YTHFM		
	Acceptance of quotations/ permission to consider late Quotations	Head of Procurement on behalf of YTHFM	Under £50k	
	Acceptance of tenders/permission to consider late tenders	Managing Director	Over £50k	~~SFI 9.5~~9
	Accepting contracts and signing relevant documentation	Head of Procurement on behalf of YTHFM Director of Resources or 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~~ Review of all statutory compliance legislation and health and safety statute including primary and secondary legislation	Group Head of Safety & Security ~~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		
Petty cash disbursements	Expenditure	Petty cash holder	Up to £50 per item	

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		Director of Resources	Over £50 per item	
	Reimbursement of patient monies	Delegated budget holder	Up to £250	
		Prime budget holder	Over £250	
Property transactions	Disposal and acquisition of Trust land and buildings	Group Chief Executive, Group Finance Director Capital Programme Executive Group	Up to £500k	SFI 9,10,12
		Executive Committee~~Board~~	£500k - £1m	
		Board of Directors	Above £1m	
	Lets and Leases			
	Preparation and signature of all Tenancy Agreements/ licenses for all staff subject to Trust Policy on accommodation for staff	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 Group Audit Committee annully.	Group Audit Committee		
	Maintain a losses and special payments register	Director of Resources		

	Non-clinical cases	Managing Director Group Finance Director	~~Up to £500k~~ Up to £150k	
		Group Chief Executive ~~Director~~	£150k - £500k	
		Executive Committee~~Board~~	£500k-£1m	
		Board of Directors	Over £1m	
	Review schedules of losses and compensations and make recommendations to the Management Group	Group Audit Committee		
	Special payments – outside the terms of any contract Obligation	Treasury approval		
Condemning and disposal – YTHFM 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		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 Director of Resources		SFI ~~6.2.3~~
	Signing agreement with other organisations and individuals			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	Group Audit Committee		

Annual Report and Accounts	Receive and approve the Accounts	Management Group		
	Sign the annual statements including the annual	Members Representatives		

	accounts on behalf of the Management Group			
	Implementation of internal and external audit recommendations	Director of Resources		SFI 2
	Receive and approve the YTHFM sections of the Group Annual Report	Management Group		
Retention of Records	Maintaining archives of records to be retained	Managing Director		SFI 15
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		
	Authority to fill funded post on the establishment with permanent staff	Managing Director/ Director of Resources Vacancy Control		
	Authority to appoint staff to post not on the formal Establishment	Director of Resources 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 YTHFM in conjunction with Director of Resources	All subject to compliance with A4C regulations	
	~~Above policy level~~ Granting of additional increments to staff outside of the starting salaries process	Managing Director		
	Managing Director (VSM)	Chair of the Trust as Chair of the Remuneration Committee ~~Remuneration Committee~~		
	Non-executive Directors and Chair	Council of Governors~~Nominations and Remuneration Committee~~		SO 2.2
	Upgrading and re-grading Subject to compliance with A4C matching process	Managing Director in conjunction with HR		SFI 8.~~3~~

	Uplift to starting salary in line with policy (AfC staff only) Outside of Policy	Line manager in conjunction with HR Group Director of Workforce and OD		
	Authorising overtime (within approved resource)	Delegated budget holder		SFI 8.4.3
	Authorising travel and subsistence	Line Manager and Delegated budget		

		holder		
	Approval of annual leave	Line Manager ~~Delegated budget holder~~		Annual Leave and Bank Holiday Policy and Procedure
	Annual leave – approval of carry forward	Line Manager~~Delegated budget holder~~	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~~	~~Up to 5 days~~	~~Special Leave Guidance~~
		~~Prime budget holder in consultation with HR~~	~~Up to 10 days~~	
	Special leave	Line Manager ~~Delegated budget holder~~	As detailed in Special Leave Guidance	Special Leave Guidance
		~~Delegated budget holder~~	~~Other~~	

		~~Delegated budget holder~~	~~Maternity leave~~	
		~~Delegated budget holder~~	~~Leave without pay~~	
		~~Delegated Budget Holder~~	~~Time off in lieu~~	
		Line Manager~~Delegated budget holder~~	Flexible working arrangements	Flexible Working Policy
		Group 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
		Budget Holder	Extension of paid return to work beyond policy limit	
	Study Leave	Line Manager~~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 budget holder ~~Director of Resources~~	Up to £6,000	Relocation Expenses Policy
		Managing Director, Director of Resources Group Deputy Director of Workforce & OD	£6,000 - £8,000	

	Requests for new posts to be authorised as car users or mobile phone users	Prime budget holders~~Director of Resources, Director of Facilities, Director of Property & Asset Management~~		Lease Car and Mobile Communication

				Equipment Policies
	Renewal of fixed term contracts – must be linked to business needs and available funding	Director of Resources/ Vacancy Control		
	Authorisation of retirement on the grounds of ill health	Group 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 Resources, Group Director of Workforce & OD		Redundancy Policy
		Group Finance Director on behalf of YTHFM (with HM Treasury approval where required)	Any termination settlement	
	Authority to suspend staff	Prime budget holder, Group 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~~e.g. Head of service (or		

		designated deputy)		
	Engagement of staff not on the establishment supported by a business case	Management Group		

Booking of bank and agency staff	Booking of all bank and agency staff	Delegated -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	Group Chief Executive		
	Where an offence is suspected	Head of Security & Car Parking and Local Security Management Specialist (theft)/ Trust Local Counter-Fraud Specialist (fraud)	Criminal offence of a violent or clinical nature Where fraud or theft is involved	
	Authority for the issue of ID and security badges and car park passes	Delegated budget holder		ID Badge Policy
Complaints	Overall responsibility for ensuring that all complaints are dealt with effectively	Managing Director, Head of Patient Experience ~~Patient Experience Team Lead~~		Concerns and Complaints Policy and Procedure
	Agreement of financial compensation	Deputy Finance Director on behalf of the YTHFM~~LLP~~		Losses procedure
Engagement of Solicitors		Managing Director, Director of Resources/ LLP Company Secretary, Director of Facilities, Director of Property & Asset Management		

York Teaching Hospital
Facilities Management

STANDING FINANCIAL INSTRUCTIONS

Author:	**Director of Resources**
Owner:	**Managing Director**
Publisher:	**Director of Resources**
Date of Issue:	**August 2021(To amend when issued)**
Version:	**43**
Approved By:	**Management Group, Group ~~Trust~~ Audit Committee and Board of Directors**
Review date:	**December 2023~~2~~ (annually, with Reservation of Powers and Scheme of Delegation)**

CONTENTS

1. INTRODUCTION

1.1 General

1.1.1 York Teaching Hospital Facilities Management (hereafter referred to as the YTHFM) was incorporated in England and Wales as a limited liability partnership on 7 March 2018 under the Limited Liability Partnerships Act2000; and is a wholly owned subsidiary of York & Scarborough Teaching Hospitals 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 YTHFM. 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~~ 1.1.3These Standing Financial Instructions detail the financial responsibilities,policies and procedures to be adopted by the YTHFM. They are designed to ensure that YTHFM's financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with YTHFM's Reservation of Powers & Scheme of Delegations, 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 YTHFM.

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~~1.1.3~~ 1.1.4These Standing Financial Instructions identify the financial responsibilities that apply to everyone working for YTHFM 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.**

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~~1.1.4~~ 1.1.5Should any difficulties arise regarding the interpretation or application ofany of the Standing Financial Instructions then the advice of the Director of Resources **must be sought before acting**. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of YTHFM's Members Agreement.

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~~1.1.5~~ **1.1.6FAILURE TO COMPLY WITH STANDING FINANCIAL INSTRUCTIONS AND THE TRUST'S STANDING ORDERS IS A DISCIPLINARY MATTER WHICH COULD RESULT IN DISMISSAL.**

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1.1.~~6~~7 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.

1.1.87 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 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, the Health and Social Care Act 2012, the Health and Care Act 2022 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 YTHFM. They~~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 England, the Independent Regulator for the NHS.

Board of Directors means the Chair, Non-executive Directors and the Executive Directors 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 forthe purpose of carrying out, for a specific period, any or all of the functions of YTHFM. This can be income, capital or revenue expenditure.

Budget Holder" means the Managing Director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of YTHFM.

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.

Committee means a committee appointed by the Board of Directors.

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

Commissioning means the process for determining the need for and for obtaining the supply of Estates & Facilities Management related services from YTHFM.

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.

Director of Resources (YTHFM) means the lead officer with responsibility for the Resources directorate which includes finance within YTHFM.

Group Finance Director means the chief finance officer of the Trust.

Legal Adviser means the properly qualified person appointed by YTHFM to provide legal advice.

Management Group means the Management Group of YTHFM 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 HospitalFacilities Management. The Management Group comprises 43 representatives from York & Scarborough Teaching Hospitals NHS Foundation Trust, which includes thea ~~nindependent C~~chair; and 1 representative from Northumbria Healthcare Facilities Management Limited.

Managing Director means the chief officer of YTHFM.

Master Services Agreement means an agreement entered into between the Trust and YTHFM 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.

Member's means York & Scarborough Teaching Hospitals NHS Foundation Trust and Northumbria Healthcare Facilities Management Limited, and any other person admitted from time to time as a member of YTHFM, who wish to participate as members in YTHFM for the purposes of carrying on the Business.

NHS England~~and Improvement~~" means the Independent Regulator of NHS. ~~commissioning and provider organisations.~~

Nominated Officer means an officer charged with the responsibility for discharging specific tasks within Trust's Standing Orders and YTHFM's Standing Financial Instructions.

Officer means employee of YTHFM or any other person who exercises functions for the purposes of YTHFM other than as a representative of YTHFM.

Secretary of State Directions means the NHS Counter Fraud Authority's Requirements to meet the Government Functional Standard GovS013: counter fraud. Each NHS body is required to take necessary steps to counter fraud in the NHS in accordance with these Directions and the Chief Executive and Finance Director are mandated to monitor and ensure compliance with these Directions

SFIs means Standing Financial Instructions.

MA~~'s~~ means Members Agreement.

Representative 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 & Scarborough Teaching Hospitals NHS Foundation Trust.

The Trust means York & Scarborough Teaching Hospitals NHS Foundation Trust who is a 'Member' of ~~with a 95% shareholding in~~ YTHFM LLP.

YTHFM 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.

1.2.2 Wherever the title Managing 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 itshall be deemed to include employees of third parties contracted to YTHFM when acting on behalf of the YTHFM.

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 YTHFM may only be exercised by the Board of Directors informal session. These are set out in the Reservation of Powers and Scheme of Delegation document.

1.3.3 With regard to the operation of YTHFM, 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 YTHFM.

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 YTHFM's 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 YTHFM's 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 is responsible for:

(a) implementing the YTHFM's financial policies and for co-ordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, to disclose, with reasonable accuracy, the financial position of YTHFM at any time.

and, without prejudice to any other functions of YTHFM, and employees of the YTHFM, the duties of the Director of Resources 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 YTHFM 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 YTHFM;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources; and

(d) conforming to the requirements of Members Agreement, 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 YTHFM to commit YTHFM 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.

2 AUDIT

2.1 Group Audit Committee

2.1.1 In accordance with the Members Agreement the Board of Directors shall formally establish an Audit Committee, with clearly defined terms of reference, which will provide an independent and objective view of internal control of YTHFM 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 YTHFM's activities, that supports the achievement of YTHFM's objectives;

(d) monitoring compliance with the Members Agreement 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

2.2.1 The Director of Resources is responsible for:

(a) ensuring there are arrangements to review, evaluate and reporton 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,

(vi) a detailed plan for the coming year.

2.2.2 The Director of Resources and designated auditors are entitled without necessarily giving prior notice to require and receive:

(e) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(f) access at all reasonable times to any land, premises, members of the Management Group or employees of YTHFM;

(g) the production of any cash, stores or other property of YTHFM under a member of the Management Group or employee's control; and

(h) explanations concerning any matter under investigation.

2.3 Role of Internal Audit

2.3.1 Internal Audit will review, appraise and report upon:

(i) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(j) the adequacy and application of financial and other related management controls;

(k) the suitability of financial and other related management data;

(l) the extent to which YTHFM 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.

(m) 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 must be notified immediately.

2.2.3 The Head of Internal Audit will normally attend Group Audit Committee meetings and has a right of access to all Group 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 Group 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 YTHFM 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 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 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 Group 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 shall monitor and ensure compliance with NHS Counter Fraud Authority's Requirements to meet the Government Functional Standard GovS013 counter fraud~~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~~5~~ The Local Counter Fraud Specialist shall report to the Group Finance Director and shall work with staff in the NHS Counter Fraud Authority 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 YTHFM. 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 YTHFM's 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 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 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 to enable budgets to be compiled and monitoring reports to be prepared.

3.1.5 The Director of Resources 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 YTHFM 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 authorized 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.

33 Budgetary Control and Reporting

3.3.1 The Director of Resources will devise and maintain systems of budgetary control. These will include:

(a) regular financial reports to the Management Group~~Board~~ in a form approved by the Management Group 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 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. Further details of the approval limits are included within the Reservation of Powers and Scheme of Delegation.

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.

34 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 6~~10~~).

35 Monitoring Returns

~~3.5.1~~ The Managing Director is responsible for ensuring that appropriate support is leant to YTHFM 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 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 HMTreasury.

4.2 YTHFM's annual accounts must be audited by the external auditor appointed by the Trust's Council of Governors. YTHFM's audited annual accounts must be approved by the Members and presented at the Annual General Meeting.

4.3 YTHFM 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 is responsible for managing the YTHFM banking arrangements and for advising YTHFM on the provision of banking services and operation of accounts. This advice will take into account NHS England guidance/directions.

5.1.2 The Management Group shall approve the banking arrangements.

5.2 Bank Accounts

5.2.1 The Director of Resources is responsible through the management of the reverse service level agreement with the Trust's finance team for:

(a) the operation of bank accounts;

(b) establishing separate bank accounts for YTHFM 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 GroupBoard 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 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

(cb) those authorised to sign cheques or other orders drawn on the YTHFM accounts.

5.3.2 The Director of Resources must advise YTHFM 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 Group 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 Group Finance Director ~~Director of Resources~~ will review the commercial bank arrangements of YTHFM 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 through the management of the reverse service level agreement with the Trust's finance team ~~Director of Resources~~ is responsible for:

- designing, maintaining andensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due
- for the prompt invoicing and banking of all monies received.

6.2 Fees and Charges

6.2.1 The Director of Resources 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.

6.2.2~~3~~ The Director of Resources shall determine the appropriate charges or fees for the provision of all services provided to other organisations and individuals.

6.2.3It is the responsibility of all employees to inform the Director of Resources promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements andother 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 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 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 YTHFM.

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 Resources.

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 YTHFM is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving YTHFM 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 Director of Resources 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 Counter Fraud Authority. Where there is no evidence of fraud or corruption the loss should be dealt with in line with the YTHFM's 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 YTHFM enters into suitable legally binding service contracts with service commissioners for the provision of NHS services.

7.2 The form of contract between YTHFM 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 knowledgeof local needs and inequalities. This will require the Managing Director toensure that YTHFM 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 YTHFM 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 the Trust's 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 Group Remuneration Committee will:

(e) determine the appropriate remuneration and terms of service for the Managing Director employed by YTHFM 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

(f) determine the terms of service for the Managing Director to ensure they are fairly rewarded for their individual contribution to YTHFM – having proper regard to YTHFM's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

(g) 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.

8.1.4 YTHFM will pay an allowance to the Chair of YTHFM Management Group and said allowances will be approved by the Council of Governors.

8.2 Funded Establishment

8.2.1 The workforce plans of YTHFM 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.

~~55~~

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)~~(h) unless authorised to do so by the Managing Director; and

~~(b)~~(i) within the limit of his approved budget and funded establishment.

~~(c)~~(j) 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 is responsible for:

~~(d)~~(k) specifying timetables for submission of properly authorised time records and other notifications;

~~(e)~~(l) the final determination of pay and allowances (in conjunction with the Trust's Director of Workforce & OD);

~~(f)~~(m) making payment on agreed dates; and

~~(g)~~(n) agreeing method of payment.

8.4.2 The Director of Resources will issue instructions regarding:

~~(h)~~(o) verification and documentation of data;

~~(i)~~(p) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

~~(j)~~(q) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

~~(k)~~(r) security and confidentiality of payroll information;

~~(l)~~(s) checks to be applied to completed payroll before and after payment;

~~(m)~~(t) authority to release payroll data under the provisions of the Data Protection Act;

~~(n)~~(u) methods of payment available to various categories of employee and officers;

~~(o)~~(v) procedures for payment by cheque or bank credit to employees and officers;

~~(p)~~(w) procedures for the recall of cheques and bank credits;

~~(q)~~(x) pay advances and their recovery;

~~(r)~~(y) maintenance of regular and independent reconciliation of pay control accounts;

~~(s)~~(z) separation of duties of preparing records; and

~~(t)~~(aa) a system to ensure the recovery from leavers of sums of moneyand property due by them to the Trust.

8.4.3 Appropriately nominated managers have delegated responsibility for:

~~(u)~~(bb) 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;

~~(v)~~(cc) submitting time records and other notifications in accordance with agreed timetables;

~~(w)~~(dd) completing time records and other notifications in accordance with the Director of Resources instructions and in the form prescribed by the Director of Resources; and

~~(x)~~(ee) submitting termination forms in the prescribed form immediatelyupon 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 must be informed immediately.

~~(y)~~(ff) taking responsibility for managing staff costs within the available resources and engaging staff in accordance with YTHFM policies and procedures.

8.4.4 Regardless of the arrangements for providing the payroll service, the Director of Resources shall ensure that the chosen method is supportedby 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.

8.59 Contracts of Employment

8.5.19.1 The Management Group shall delegate responsibility to managers:

(z)(gg) 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

(aa)(hh) dealing with variations to, or termination of, contracts of employment.

910

NON-PAY EXPENDITURE

910.1 Delegation of Authority

910.1.1 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.

910.1.2 The Managing Director, as the Accountable Officer, will determine:

~~(bb)~~ (ii) prime and delegated budget holders who are authorised to place requisitions for the supply of goods and services; and

~~(cc)~~ (jj) the maximum level of each requisition and the system for authorisation above that level (See Reservation of Powers and Scheme of Delegation document)

910.1.3 The Managing Director shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

910.1.4 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).

910.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

910.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for YTHFM. In so doing, the advice of the Property & Asset Management or Purchasing department shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Resources (and/or the Managing Director) shall be consulted.

910.2.2 The Director of Resources through the reverse service level agreement with the Trust's finance team 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.

910.2.3 The Director of Resources:

~~(dd)~~ (aaa) 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 109.5 below;

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~~(ee)~~ (bbb)prepare procedural instructions on the obtaining of goods, works and services incorporating the thresholds;

~~(ff)~~ (ccc)be responsible for the prompt payment of all properly authorised accounts and claims;

~~(gg)~~ (ddd)be responsible for designing and maintaining a system ofverification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of YTHFM 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 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.

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~~(hh)~~ (eee)be responsible for ensuring that payment for goods and servicesis only made once the goods and services are received, (except as below).

910.2.4 Prepayments are only permitted where exceptional circumstances apply. In such instances:

~~(ii) Prepayments are only permitted where the financial advantages outweigh the disadvantages (ie. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%);~~

~~(jj)~~ (fff)the appropriate YTHFM 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 YTHFM if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

~~(kk)~~ (ggg)the Director of Resources will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the UK public procurement rules where the contract is above a stipulated financial threshold); and

~~(ll)~~ (hhh)the budget holder is responsible for ensuring that all items dueunder a prepayment contract are received and he/she must immediately inform the Managing Director if problems are encountered.

910.2.5 Official orders must:

~~(mm)~~ (a)be consecutively numbered;
~~(nn)~~ (b)be in a form approved by the Director of Resources;
~~(oo)~~ (c)state the LLP's terms and conditions of trade; and
~~(pp)~~ (d)only be issued to, and used by, those duly authorised by theManaging Director.

910.2.6 Managers and officers must ensure that they comply fully with the guidance and limits specified by the YTHFM Director and that:

~~(qq)~~ (iii)all contracts, leases, tenancy agreements and other commitments which may result in a liability are notified to the Director ofResources in advance of any commitment being made;

~~(rr)~~ (jjj) ~~c~~contracts above specified thresholds are advertised, awarded and reported in accordance with UK regulations on public procurement (thresholds and regulations together with the consequences of breaching these regulations are attached at **Appendix 1**).

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~~(ss)~~ (kkk)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.

~~(tt)~~ (lll)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)~~ (e)isolated gifts of a trivial character or inexpensive seasonalgifts, such as calendars;

~~(ii)~~ (f)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"

~~(uu)~~ (g)no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director ofResources on behalf of the Managing Director;

~~(vv)~~ (h)all goods, services, or works are ordered on an official order except purchases from petty cash or on purchase cards;

~~(ww)~~ (i)orders are not split or otherwise placed in a manner devised soas to avoid the financial thresholds;

~~(xx)~~ (j)goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

~~(yy)~~ (k)changes to the list of directors/employees and officers authorised to certify invoices are notified to the Director of Resources;

9~~10~~.3 Petty Cash

9~~10~~.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 Resources.

9~~10~~.3.2 All reimbursements must be supported by receipt(s) and certified by an authorised signatory.

9~~10~~.3.3 Petty cash records are maintained in a form as determined by the Director of Resources.

~~5.6~~ 9.4 Building and Engineering Transactions

9.4~~5.5~~.1 The Group Finance Director shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidelines and requirements of the DHSC frameworks (e.g. Procure 22 & 23 or successor arrangements) or other equivalent public sector frameworks that may be utilised to procure building work and related services. All works and related contracts (e.g. architects services) should utilise and comply with recognised forms of contract. The technical audit of these contracts shall be the responsibility of the relevant Director.

~~5.7~~ 9.5 Tendering Quotation and Contract Procedure

~~5.7.2~~ 9.5.1 YTHFM 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.

~~5.7.3~~ 9.5.2 Formal tendering procedures may be waived by officers for whom powers have been delegated by the 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;~~ the life of the equipment or service (including VAT) not annual costs;

(b) A contract which was sourced by competitive selection or via a framework either by YTHFM, the Trust or by agencies such as the Crown Commercial Service, NHS Supply Chain or another commercial procurement collaborative acting on behalf of a NHS organisation;

~~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;~~

~~(a)~~ (c) Where the supply of the proposed goods or service is under special arrangements by any Government Agency (e.g. Procure2~~21~~ as it applies to construction contracts).

(d) Where specifically excluded under Regulation 10 of the UK Public Contracts Regulations 2015.

- E.g. rental of land, existing buildings or immovable property, legal services or advice (where there are court proceedings or likely court proceedings) and employment contracts (but not services of employed persons).
  - Where this derogation places a subsequent obligation on the Trust this too shall be deemed to be specifically excluded under the SFI's. e.g. The rental or lease of property often means that the terms include a clause to accept the landlords cleaning, maintenance and or security services.

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~~5.7.4~~ 9.5.3The negotiated procedure without the prior publication of a contract notice (the STA) may be used in the following circumstances but shouldnot be used to avoid competition or for administrative convenience:

~~(a)~~ (i))There is an absence of suitable tenders. (ie. The goods/services/works having been appropriately advertised using theopen procedure or the restricted procedure);

~~(b)~~ (ii)——For reasons of extreme urgency brought about by events unforeseeable by, and not attributable to, YTHFM, e.g. flood, fire or system failure. Failure to plan properly is not a justification for single tender;

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~~(c)~~ (iii)Specialist expertise / equipment is required and it is only available from one source. (ie. for technical, artistic reasons or connected to the protection of exclusive rights).

~~(d)~~ (iv)There is clear benefit to be gained from maintaining continuity where;

~~(i)~~ (a)the goods are a partial replacement for, or in addition to, existing goods or an installation; and

~~(ii)~~ (b)to obtain the goods from another supplier would oblige YTHFM toacquire 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 anypotential 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 Group Audit Committee.

~~5.7.5~~ 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.

~~5.7.6~~ 9.5.5The firms/individuals invited to tender (and where appropriate quote) should be as set out in the tendering procedures.

~~5.7.7~~ 9.5.6Quotations are required where the formal tendering procedures are waived under 5. 6.3 ~~9.5.2~~ above.

~~5.7.8~~ 9.5.7All quotations should be treated as confidential and should be retained for inspection.

9.5.8The Managing Director or his nominated officer should evaluate the quotations and select the one which gives best value for money. If this isnot the lowest, then this fact and the reasons why the lowest quotation was not chosen should be in a permanent record.

~~5.7.9~~ 9.5.9Where tenders or quotations are not required YTHFM shall procure goods and services in accordance with procurement procedures approved by the Management Group.

~~5.7.10~~ 9.5.10The Managing Director shall be responsible for ensuring the best valuefor money can be demonstrated for all services provided under contract

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or in-house. The Management Group may also determine from time to time that in-house services should be market tested by competitive tendering.

~~5.7.11~~ 9.5.11The competitive tendering or quotation procedure shall not apply to the disposal of:

~~(a)~~ (i))Items with an estimated sale value of less than £15,000;

~~(b)~~ (ii))Any matter in respect of which a fair price can be obtained only by negotiation or sale by auction;

~~(c)~~ Obsolete or condemned articles and stores; which may be disposed of in accordance with the procurement policy of the Trust (adopted by YTHFM). ~~LLP;~~

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~~6~~ 10CAPITAL PROJECTS, private financing, FIXED ASSET REGISTERS AND SECURITYOF ASSETS

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~~6.4~~ 10.1Capital Projects delivered by YTHFM for the Trust

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~~6.4.2~~ 10.1.1The Managing Director:

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a) shall ensure that there is an adequate process in place that enables YTHFM 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 YTHFM present to the Trust appropriate information including capital cost schedules at key stages of the capital project process for the Trust to approve. YTHFM will not proceed past defined points in the capital projects process until it has received a formal approval from the Trust to do so.

~~6.4.3~~ 10.1.2For every capital expenditure proposal the Managing Director shall ensure:

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~~(a)~~ that YTHFM in delivering a capital project for the Trust:

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~~(i)~~ (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

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~~(ii)~~ (ii)sets out appropriate project management and control arrangements;

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~~(iii)~~ (iii)involves appropriate Trust personnel and external agencies; and

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~~(b)~~ (iv)that the Director of Resources has certified professionally to thecapital costs detailed in the option appraisal.

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~~6.4.4~~ 10.1.3For 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”.

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The Group Director of Finance ~~Director of Resources~~ 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 shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

~~6.4.5~~10.1.4The approval of a capital programme by the Trust shall not constitute approval for the initiation of expenditure on any project by YTHFM. YTHFM will only proceed with a project once it has received formal approval from the Trust.

~~6.4.6~~10.1.5The Group Director of Finance ~~Director of Resources~~ shall issue to the manager responsible for any scheme:

~~(a)~~ (i)specific authority to commit expenditure;

~~(b)~~ (ii)authority to proceed to tender;

~~(c)~~ (iii)approval to accept a successful tender.

~~(d)~~ (iv)Authority to enter into framework contracts using *DHSCP21+/P22frameworks or other design and minor works frameworks.*

~~6.4.7~~ 10.1.6The Group Director of Finance ~~Director of Resources~~ shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures will:

~~(a)~~ (i)be designed to ensure that each project stays within estimated/budgeted costs at each milestone;

~~(b)~~ (ii)be issued to project managers and other employees/personsinvolved in capital projects;

~~(c)~~ (iii)incorporate simple checklists designed to ensure that importantrequirements are complied with on each project.

~~10.3~~ 10.2Asset Registers

~~10.3.1~~ 10.2.1Where YTHFM~~the LLP~~ has its own assets, the Managing Director is responsiblefor the maintenance of registers of assets, taking account of the advice of the Director of Resources concerning the form of any register and the method of updating, and arranging for a physical check of assets.

~~10.3.2~~ 10.2.2YTHFM ~~The LLP~~ shall maintain an Asset Register recording fixed assets. The minimum data set to be held within these registers shall be as specifiedin the guidance issued by NHSE.~~guidance issued by NHSE/I.~~

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~~10.3.3~~ 10.2.3Additions 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~~ 10.2.4Where 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~~ 10.2.5The Director of Resources shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on FixedAsset Registers.

~~10.3.6~~ 10.2.6The value of each asset shall be depreciated using methods and ratesin accordance with NHS Improvement FT ARM.

~~10.4~~ 10.3Security of Assets

~~10.4.1~~ 10.3.1Where YTHFM has its own assets, the overall control of fixed assets isthe responsibility of the Managing Director.

~~10.4.2~~10.3.2 Asset control procedures, (including both purchased and donated assets) must be approved by the Director of Resources. 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.

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~~10.4.3~~10.3.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Resources.

~~10.4.4~~10.3.4 Whilst each employee and officer has a responsibility for the security of property of YTHFM, it is the responsibility of Management Group and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS Foundation Trust property as maybe determined by the Management Group. Any breach of agreed security practices must be reported in accordance with instructions.

~~10.4.5~~10.3.5 Any damage to YTHFM 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~~10.3.6 Where practical, assets should be marked as YTHFM property.

~~10.4.7~~10.3.7 Equipment and other assets may be loaned to or from YTHFM. Employees and managers must ensure that YTHFM management procedure is followed, in particular conditions attaching to the loan are documented and the assets identified. Assets loaned to YTHFM must not be entered in YTHFM asset register.

~~76~~ 11.STORES AND RECEIPT OF GOODS

~~74~~ 11.1Stores, defined in terms of controlled stores and departmental stores (forimmediate 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.

~~75~~ 11.2Subject to the responsibility of the Director of Resources for the systems of control, overall responsibility for the control of stores shall be delegatedto 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.

~~76~~ 11.3A 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 andcost effective purchasing;

(b) delegation of responsibility must be clearly defined and recorded. The Director of Resources 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 definedin writing;

(d) security measures, including marking YTHFM property, must be commensurate with the value and attractiveness of the stock;

(e) stocktaking arrangements are agreed with the Director of Resources 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;

(g) there is a system, approved by the Director of Resources, 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;

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(h) any evidence of significant overstocking and of any negligence or malpractice shall be reported to the Director of Resources;

(~~i~~h) losses and the disposal of obsolete stock are reported to the Director of Resources.

~~77~~ 11.4Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Resources.

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~~78~~ 11.5For goods supplied via the NHS Supply Chain central warehouses and inaccordance 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 checkingreceipt of goods.

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8 12.DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIALPAYMENTS

~~8~~4 12.1Disposals and Condemnations

~~8.4.2~~ 12.1.1The Director of Resources must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

~~8.4.3~~ 12.1.2When it is decided to dispose of a YTHFM asset, the head of department or authorised deputy will determine and advise the Director of Resources of the estimated market value of the item, taking account of professional advice where appropriate. The Director of Resources shall ensure that the arrangements for the sale of disposable assets maximise the incometo YTHFM.

~~8.4.4~~ 12.1.3The disposal of Trust assets will be the subject of the Trust's approval hierarchy.

~~8.4.5~~ 12.1.4All unserviceable articles shall be:

~~(a)~~1. condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Resources;

~~(b)~~2. recorded by the Condemning Officer in a form approved by the Director of Resources 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 authorized for the purpose by the Director of Resources.

~~8.4.6~~ 12.1.5The Condemning Officer shall satisfy himself as to whether or not there isevidence of negligence in use and shall report any such evidence to theDirector of Resources who will take the appropriate action.

~~8~~5 12.2Losses and Special Payments

12.2.1The Director of Resources must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. YTHFM has adopted the Trust's ~~The Director of Resources must also prepare a~~ Fraud and Corruption Policy that sets out the action to be taken both by the personsdetecting a suspected fraud and those persons responsible for investigating it.

12.2.2Any employee or officer discovering or suspecting a loss, which is not fraud must either immediately inform their head of department, who must immediately inform the

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Managing Director and the Director of Resources or inform an officer charged with responsibility for responding to concerns involving loss confidentially. This officer will then appropriately inform the Resources Director and/or Managing Director. Where a criminal offence is suspected, the Director of Resource and Local Security Management Specialist must immediately inform the police if theft or arson is involved.

~~8.5.2~~ 12.2.3When an employee discovers or suspects fraud or corruption it must be immediately reported to the Trust's Local Counter Fraud Specialist or Director of Resources .

12.2.4Alternatively, employees can contact the NHS Fraud and Corruption Reporting Line – 0800 028 40 60. In cases of fraud and corruption or of anomalies that may indicate fraud or corruption, the Local Counter Fraud Specialist will inform the NHS Counter Fraud Authority.

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~~8.5.3~~ 12.2.5The Director of Resources or Local Counter Fraud Specialist must notifyNHS Counter Fraud Authority and both the Internal and External Auditorof all frauds.

~~8.5.4~~ 12.2.6For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Resources must immediately notify:

~~(a)~~ 1.the Management Group

~~(b)~~ 2.Board of Directors,

~~(b)~~ 3.the External Auditor, and

~~(c)~~ 4.the Head of Internal Audit.

~~8.5.5~~ 12.2.7The 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.

~~8.5.6~~ 12.2.8For any loss, the Director of Resources should consider whether any insurance claim could be made.

~~12.2.8~~ 12.2.9The Director of Resources shall maintain a Losses and Special Payments Register in which write-off action is recorded. This register willbe reviewed by the Audit Committee on an annual basis.

~~12.2.9~~ 12.2.10No special payments exceeding delegated limits shall be made without the prior approval of the Treasury.

~~86~~ 12.3Bankruptcies, Liquidation and Receiverships

~~8.6.2~~ 12.3.1The Director of Resources shall be authorised to take any necessary steps to safeguard the YTHFM's interests in bankruptcies and company liquidations.

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~~8.6.3~~ 12.3.2When 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 YTHFM.

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9 13.COMPUTERISED FINANCIAL SYSTEMS

~~9.4~~ 13.1 The Director of Resources, who is responsible for the accuracy and security of the computerised financial data of the YTHFM, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the YTHFM's financial data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

(b) ensure that adequate (reasonable) controls exist over financial data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the financial computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the financial computerised system and that such computer audit reviews as he/she may consider necessary are being carried out.

~~9.5~~ (e) The Director of Resources shall satisfy themselves 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.

~~9.6~~ (f) 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:

~~(a)~~ (g) details of the outline design of the system;

~~(b)~~ (h) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

~~9.7~~ (i) The Director of Resources 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.

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~~98~~ (j)Where another health organisation or any other agency provides a computer service for financial applications, the Director of Resources shall periodically seek assurances that adequate controls are in operation.

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~~99~~ (k)Where computer systems have an impact on corporate financial systemsthe Director of Resources shall satisfy themselves that:

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(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 staff have access to such data; and

(d) such computer audit reviews are being carried out as are considered necessary.

10 14.ACCEPTANCE OF GIFTS BY STAFF

~~10~~4 14.1The Director of Resources shall ensure that all staff are made aware of YTHFM 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.

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11 15.RETENTION OF DOCUMENTS

~~14~~ 15.1The 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~~ 15.2The documents held in archives shall be capable of retrieval by authorised persons.

~~16~~ 15.3Documents 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 YTHFM policy for document management and retention.

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12 16.RISK MANAGEMENT

~~12~~4a. 16.1~~T~~he Managing Director shall ensure that YTHFM has a programme of risk management, in accordance with the terms of the license issued to the Trust by NHS England and Improvement. This programme will be approved and monitored by the Management Group.

~~125~~ 16.2The 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 YTHFM 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.

16.3The 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.

~~126~~ 16.4The Management Group shall review insurance arrangements for YTHFM.

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Appendix 1

The Public Procurement (Agreement on Government Procurement) (Thresholds) (Amendment) Regulations 2021

Note a change under the Regulations, whereby the estimated value of procurements (under all the above-mentioned regulations) will be calculated on the total amount of the procurement **inclusive of VAT** rather than net of VAT.

~~Staff will need to consider whether or not VAT will apply to relevant contracts and the relevant rate which might be applicable. If VAT does apply, this must be included in the assessment of the contract value in order to determine whether or not the contract will exceed the relevant thresholds.~~

These thresholds apply from **1 January 2022**.

Contract type	**Current threshold**	**New threshold**
	Net of VAT	**Inclusive of VAT**
Public works	£4,733,252	£5,336,937
Public service and supply awarded by central government authorities, and their design contests	£122,976	£138,760
Public service and supply awarded by sub-central contracting authorities, and their design contests	£189,330	£213,477

UK 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.

Draft Risk Management Strategy and Policy 2023-2025

Summary	The Risk Management Strategy and Policy describes what the Trust aims to deliver in its management of risk and how this is implemented.	
Keywords	Risk Management, Trust Strategy, Corporate Strategies, Care Group Strategies, KPIs	
Target audience	All staff employed by the Trust	
Date issued	March 2023	
Approved & Ratified by	Board of Directors	**Date of meeting:** March 2023
Next review date	February 2025	
Author	Associate Director of Corporate Governance	
Executive Director	Chief Executive	

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 only valid for 24 hours.**

Version Control

Change Record

Date	Author	Version	Page	Reason for Change
February 2023		1		New Version

Reviewers/contributors

Name	Position	Version Reviewed & Date
Mike Taylor	Associate Director of Corporate Governance	V0.1-0.2 – February 2023

Glossary of Definitions

Action Plan	Sets out the activities that will address the identified gap and reduce, eliminate, or minimise the risk.
Action Owner	The individual responsible for concluding mitigating actions in the management of risks.
Assurance	Evidence that control measures are working effectively to manage risk.
Board Assurance Framework (BAF)	The Board Assurance Framework defines and assesses the principal strategic risks to the Trust's objectives and sets out the controls and assurances in place to mitigate these.
Control	Process/plan/measure in place to assist in the prevention of risk occurring.
Impact	Result of a particular threat or opportunity should it occur
Issue	A risk that has already happened.
Likelihood	Measure of probability that the threat will happen including a consideration of frequency with which it may arise.
Operational risk	A risk that has the potential to impact on the delivery of business, project or programme objectives.
Risk	The combination of the probability (likelihood) of an event and its consequences (impact/severity) to achieve objectives.
Risk appetite	The level of risk that the Trust is prepared to accept.
Risk assessment	The process used to evaluate the risk and to determine. whether controls are adequate or more should be done to mitigate the risk.
Risk Lead	Nominated lead for managing the review and update of either an individual risk or risk register.
Risk management	The culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse threats.
Risk owner	The member of staff responsible for managing the risk.
Risk register	A record of all risks that may threaten the achievement of objectives. It is a living document on Datix which is populated through the Trust's risk assessment process.
Risk type	A risk may impact on several areas of business, for example finance or health and safety. The risk type reflects the main impact of the risk and the area that planned actions will be based on.
Strategic risk	A risk that has the potential to impact on the delivery of the Strategic objectives.

Contents

1 Introduction

York and Scarborough Teaching Hospitals NHS Foundation Trust (The Trust) acknowledges that the services it provides carry risks. The business of healthcare can by its nature be a high-risk activity and the process of risk management is an essential control mechanism.

Effective risk management processes are central to providing the Trust's Board of Directors with assurance that services are delivered safely, effectively and in line with corporate strategic objectives. The Trust's aim, therefore, is to promote a risk awareness culture in which all risks are identified, assessed, understood, proactively managed and regularly reviewed. The identification and recognition of these risks together with proactive management and mitigation, is essential for the efficient and effective delivery of safe and high quality of care for patients and staff.

This will promote a way of working that ensures risk management is embedded in the Trust's culture and becomes an integral part of the Trust's objectives, plans, practices, and management systems.

The benefits of managing risk include:

- Supporting the safe delivery of care to our patients
- Supporting the achievement of Trust objectives
- Avoiding or mitigating the impact of failure
- Supporting the cost efficiency and value for money
- Compliance with legal and regulatory frameworks
- Management of external impacts and changes
- Exploiting opportunities encouraging innovation.

This Policy applies to all Trust Staff, agency staff and contractors, engaged on Trust business in respect of any aspect of work.

2 Policy Aim & Objectives

The aim of this strategy and policy is to strengthen the existing risk management framework, further embed risk management at a Care Group and Corporate level and ensure appropriate escalation of the risks throughout the organisation to the Board.

In addition, the greater local level ownership of risk, enhanced clarity regarding roles and responsibilities for risk management and strengthened governance arrangements will support the delivery of improved risk management. The strategy and policy is aided with objectives to support the achievement of the aims, as outlined below. The strategy and policy aims and objectives will be monitored by the Group Audit Committee.

The key objectives of this Risk Management Strategy and Policy are to:

I. Embed risk management at all levels of the organisation
II. Create a culture which supports risk management
III. Provide the tools and training to support risk management

IV. Embed the Trust's risk appetite in decision making
V. Measure the impact of implementation

3 Embedding Risk Management at all levels of the organisation

One of the key aims of this strategy and policy is to ensure greater local ownership of risks. To achieve this,Corporate Governance will aim to strengthen risk registers at Corporate, Care Group and Department/Specialty level, supported by clear criteria and timeframes for escalation of risks. This is across the following key areas of operational services to the Trust Board of Directors – Ward to Board.

3.1 Wards and Clinical Departments reviewed at team meetings will be required to identify, assess, and monitor risks as they arise or are anticipated. Risks can be identified as a result of:

- Staff raising and/or reporting risks
- Risk Assessments
- Incidents
- Issues
- Complaints
- Claims
- Serious Incidents Requiring Investigation and Never Events
- External and internal reviews, inspections and assessments
- External and internal audit activity

All such risks will be referred to and recorded on Care Group/Specialty Risk Registers and Issue logs on Datix which will then be used to ensure the effective management of those risks and issues.

3.2 Care Groups at their Board meetings will be required to maintain Risk Registers, comprised of all risks escalated from the Specialty Risk Registers in that Care Group or service, plus such other risks as have been identified as relevant to the Care Group or service as a whole. Specialty Risk Register risks managed originally at specialty/department team meetings may be amalgamated on the Care Group Risk Register if their management will be more effective when addressed at Care Group level rather than Specialty/Department level. Care Group Risk Registers will be owned by the appropriate Care Group owner and reviewed at Care Group Board meetings.

3.3 Corporate services (including Human Resources, Finance, DIS, Integrated Governance, Corporate Nursing and Medical Director) will also be required to develop and maintain Risk Registers which reflect the risks relevant to their services which are not incorporated into any of the other Risk Registers identified above. The Corporate Services Risk Registers will be owned by the individual Service Management teams and reviewed at team meetings.

3.4 The Corporate Risk Register will be comprised of all risks on the Care Group and Corporate Services Risk Registers which are identified as likely to affect the organisation as a whole or as best managed at an Executive level (15 or above) owned by Executive leads. Care Group and Corporate Services Risk Register risks may be aggregated onto the Board Corporate Risk Register where appropriate for effective oversight and/or management.

4 The Role of Risk Management

The role of risk management at the Trust involves the managing of strategic risks as threats and opportunities to the Trust strategy and priorities linked to the top operational risks on the Corporate Risk Register and that throughout the organisation on Care Group, Specialty/Department and Ward level risk registers.

4.1 The achievement of the Trust's strategic objectives is subject to uncertainty, which gives rise to both opportunities (desirable risk) and threats (undesirable risk). Uncertainty of outcome helps to define risk. Risk management includes identifying and assessing risks and responding to them in an effective and resilient manner.

4.2 The Trust's Board Assurance Framework (BAF) is a key mechanism which boards should be using to reinforce strategic focus and effective management of risk.

4.3 The risks to the achievement of the strategic objectives are identified by the Board each year and are recorded in the Board Assurance Framework (BAF). The BAF is the key mechanism that the Board uses to gain assurance around the management of the identified risks to the corporate objectives and to determine whether the risk is sufficiently controlled and mitigated.

4.4 The Trust's governance framework shall be supported by an effective risk management system that delivers continuous improvements in safety and quality and maximises opportunity for growth and development.

5 Defining Risk Appetite

Risk appetite is described as the level of risk that an organisation is willing to accept in pursuit of its strategic objectives before action is required to mitigate the risk. It provides a balance between the potential benefits of innovation and the threats that change inevitably brings. Different levels of appetite may be set for different risks which may also vary over time.

Risk appetite is usually designed to:

a) clearly express the extent to which an organisation's willingness to take risk in order to meet their strategic objectives i.e., define a firm's 'fight or flight' response to risk

b) discharge the organisation's corporate governance responsibilities more effectively

c) understand an organisation's propensity to take risk compared to exercise control

The Risk Appetite is owned and approved by the Trust Board. Once approved, it is built into the processes and culture of the Trust. Target risk scores should be determined to reflect the risk appetite of the Trust and recorded in the organisation's risk registers. Risk appetite metrics are used to monitor adherence to risk appetite.

Actions should be taken where risks are outside appetite to bring them back within agreed levels. Monitoring adherence to risk appetite will be tracked and reported through the governance structure. Risk appetite helps to inform and direct decision-making. Once determined, the risk appetite should be reviewed on an annual basis.

Risk appetite therefore goes to the heart of how the Trust operates and how it wishes to be perceived by key stakeholders including employees, regulators, ratingagencies and the public.

Risk appetite, tolerance and capacity is illustrated in diagram 1. The appetite for each area of risk at the Trust is as follows in table 1:

Category (TBC)	**Board Defined Appetite (TBC)**	**Executive Lead (at an operational level)**
TBC	*TBC*	*TBC*

The Trust Risk Appetite Statement by each of these categories can be found at Appendix B.

5.1 Risk Tolerance

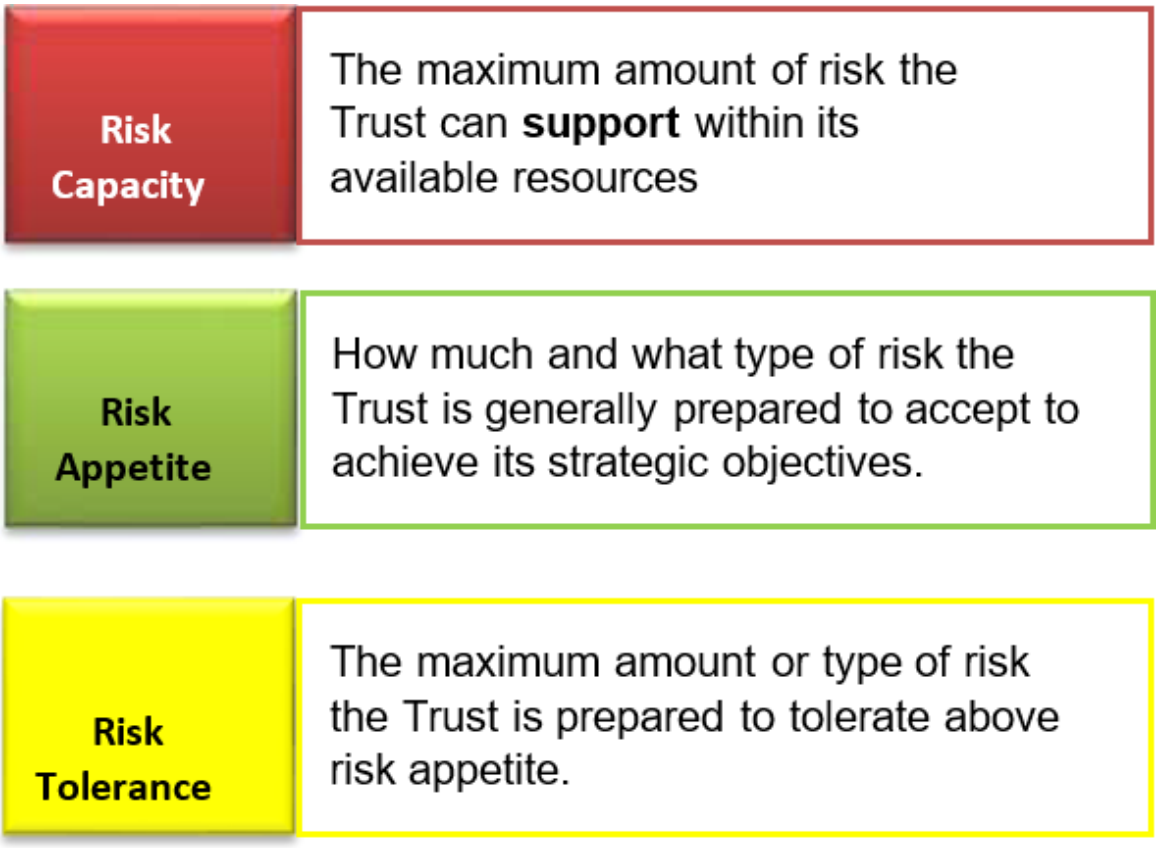
Whilst risk appetite is about the pursuit of risk to achieve objectives, risk tolerance is about what an organisation can cope with and thresholds at which it is willing to 'accept' a specific risk. Risk appetite and tolerance both need to be considered in the context of risk capacity.

5.2 Risk Capacity

This is the amount of risk the Trust can bear. The Trust's Board may have a

high-risk appetite but not have enough capacity to handle a risk's potential volatility or impact beyond it. Conversely, the risk capacity may be high, but the Trust may decide based on strategy and objectives to adopt a lower risk appetite.

Diagram 1



6 Strategic and Operational Risks

At the Trust there are two categories of risk:

- Strategic Risks - Each year a Board Assurance Framework is developed to identify and record the key strategic risks for the Trust that may impact on the achievement of its strategic priorities. Further detail regarding the Board Assurance Framework is outlined in Appendix A.
- Operational Risk - These are the identified risks that have the potential to impact on the delivery of day-to-day operational activity, projects or programme objectives. Operational risks are recorded on the Corporate Risk Register and Care Group, Specialty/Department and Ward risk registers on the Datix system. The Datix system is the only place where operational risks should be captured so the corporate governance team can identify Trust wide themes for effective Trust risk mitigation.

The Risk Management Strategy and Policy is supported by the Trust's suite of policies as listed on the Y&STHNHSFT website. There is a strong link to a range of policies including:

- Incident Reporting Policy
- Serious Incident Management Policy
- The Complaints Policy
- Suite of Health & Safety policies
- Claims Management policy
- Standing Financial Instructions

7 Roles and Responsibilities

7.1 Chief Executive

The Chief Executive is the Accountable Officer for effective risk management and the system of internal control with the organisation. The Chief Executive is also responsible for meeting all statutory requirements including health and safety and ensuring risk management systems are established, implemented and maintained.

7.2 Board of Directors

The Board of Directors has responsibility for ensuring that a framework of systems and processes for effective risk management are in place and that they are functioning appropriately. It is responsible for assuring itself that the Trust identifies and effectively manages any risks that could affect the achievement of the Strategic Goals.

7.3 Risk Committee

The Risk Committee will be Executive-led and have oversight of the Corporate Risk Register and the Board Assurance Framework. The Committee will approve any new additions and removals to and from the Corporate Register as well as being the main governance forum where risks are presented for either escalation or de-escalation.

All risks scored as 15 or above must be escalated to the Risk Committee via their Risk Committee representative for consideration and possible inclusion in the Corporate Risk Register (CRR). The Risk Committee will discuss the risk that has been escalated and the rationale for why it should be considered in either being a trust wide risk or requiring direct Executive intervention and oversight, and therefore included in the CRR.

If the Risk Committee agrees, the decision will be documented and the risk added to the CRR. If the risk is rejected for inclusion on the CRR by the Risk Committee, it will be de- escalated to its point of origin along with the rationale

for why it is being de-escalate.The de-escalation will be done via the relevant Risk Committee representative. The Committee will also provide assurance that the Board of Directors is sighted on all strategic risks.

7.4 Audit Committee

The Audit Committee has responsibility to ensure that risk management systems are in place, up to date and has assurance that risk management processes are embedded throughout the Trust. It will provide assurance to the Board of Directors on the adequacy, efficiency and effectiveness of the Trust's Corporate Governance, Risk Management and Internal Control systems.

7.5 Board Assurance Sub-Committees

The Sub-Committees of the Board of Directors are responsible for providing assurance in relation to the relevant risks on the Corporate Risk Register (CRR) andthe Board Assurance Framework and receiving, managing and monitoring relevant risks within the scope of their Terms of Reference as illustrated below in table 2:

Board Sub-Committee	**Type of Risk under terms of reference**
Quality and Safety Assurance Committee	Safety Quality Statutory (CQC)
Digital, Performance and Finance Assurance Committee	Digital Performance Finance
People and Culture Assurance Committee	Workforce

7.6 Care Group Management (Board) Team Meetings

Care Group Management (Board) Team Meetings are responsible for identifying, receiving, managing, monitoring and reviewing relevant risks within the scope of their terms of reference. This will be facilitated by the Clinical Governance Facilitators/Clinical Governance Coordinators who will be responsible for managing the risk process at Care Group level.

7.7 Specialty/Department Management Teams

The Care Group Specialty/Department Management Teams are responsible for identifying, receiving, managing, monitoring, reviewing, escalating relevant risks within the scope of their Care Group.

7.8 Executive Directors

The Executive Directors are responsible for the implementation of risk management and its assurance mechanisms bringing together the corporate, financial, workforce,clinical, information, research and governance risk agendas and escalating where required risks to the Corporate Risk Register.

7.9 Non-Executive Directors

The Non–Executive Directors are responsible for providing independent/ objective scrutiny of the risk management structure and processes in a custodian role and for ownership with all Board of Directors members of the Board Assurance Framework.

7.10 Associate Director of Corporate Governance

The Associate Director of Corporate Governance is responsible for ensuring that all risk and assurance processes are identified and reported. The role also has responsibility for coordinating the review, update and reporting of the BAF.

7.11 Head of Risk

The Head of Risk is responsible for the development of the Risk Management Strategy and Policy and associated policies, guidance, standards and training to facilitate the effective management and oversight of risk across the trust.

7.12 Managers

Managers are responsible for the identification of risks and for implementing and monitoring any identified risk management control or assurance measures within their designated area and scope of responsibility. Managers should also ensure that all staff are aware of risks within their workplace and provide adequate information, instruction and training to enable them to work safely.

Managers should seek advice on risk management issues, as required, and liaising with relevant specialist advisors where necessary.

7.13 Staff

All staff are responsible for having a sense of ownership and commitment to:

- identifying and minimizing risk
- reporting and responding to risk
- participate in training sessions
- carry out any agreed control measures and duties as instructed.

8 Training

In addition to the mandatory training delivered and coordinated by learning and development, a programme of risk training is provided for all employees, as outlined below in table 3:

Level of Training	Staff Group	Frequency	Timeframe of training	Delivery method	Delivered by
General Risk Awareness	All staff	5 Yearly	N/A	Learning Module	Learning Hub
Management of risks	Senior Management and Non-Executive Directors	As required	As required	Face to face / Teams	Head of Risk
'Risk Module' Datix	Identified Risk Leads	Once	1 hour	Face to Face/ Teams	Head of Risk

9 Risk Management Process

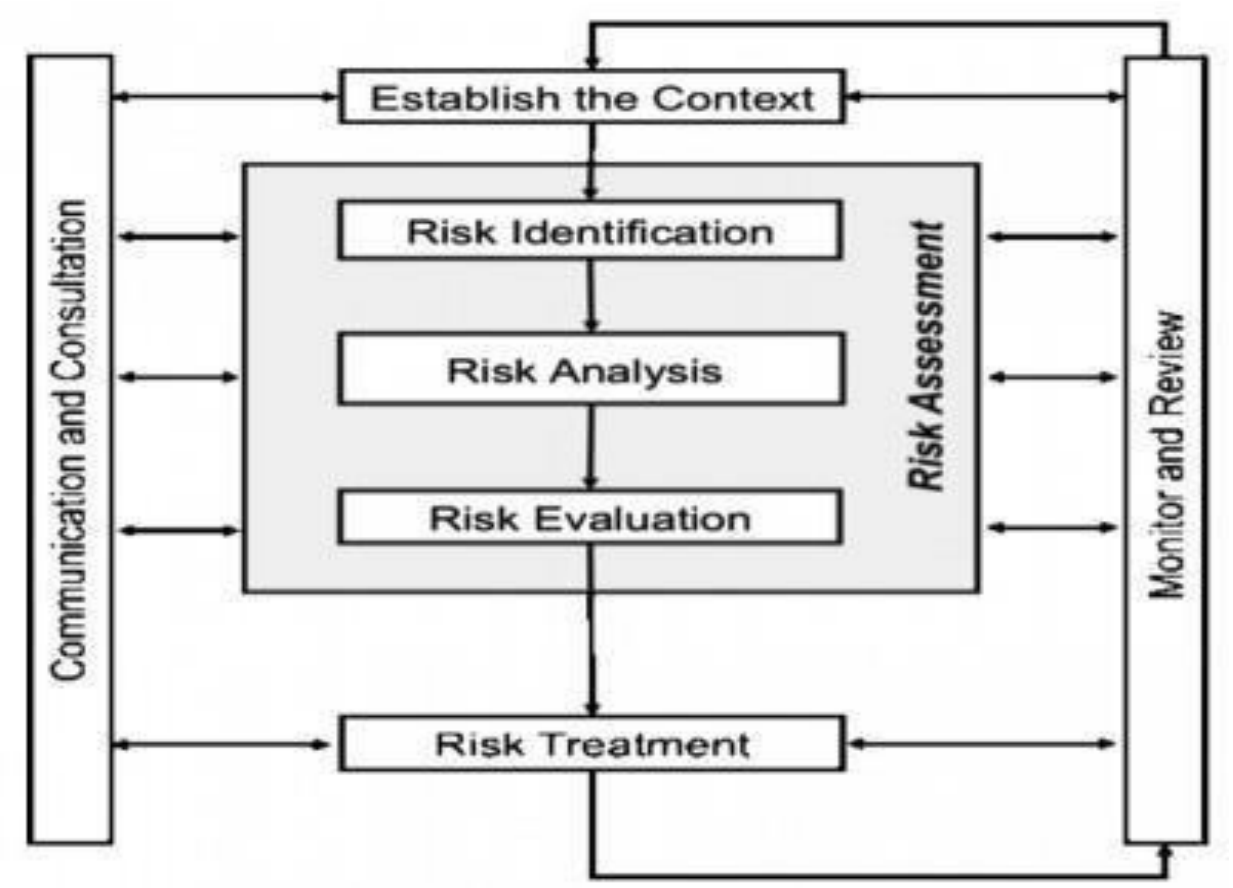
9.1 Overview

At the Trust, both a 'top-down' enterprise-level approach and a 'bottom-up' approach to risk management is in place. The top-down approach identifies and reports on Trust-wide risks – the "top risks" to the achievement of the Trust's objectives. These are captured within the Board Assurance Framework (BAF) and the Corporate Risk Register (CRR). This includes the production and reporting of risk reporting dashboards, risk heat maps and performance against agreed appetite levels to the Trust Board of Directors and Assurance Committees.

The bottom-up approach consists of business-specific risks that are unique to a particular Care Group, specialty, or corporate function (e.g., Finance, Procurement). These risks are identified and reported through localised governance structures such as business management committees or Care Group Governance meetings.

A Risk Management Process is a methodical approach to address risks to an organisation's activities. Diagram 2 below illustrates the stages of the Risk Management Process as defined by the ISO 31000 standard on Risk Management. This is a continuous and repeatable process which starts by establishing the context.

Diagram 2



a) **Establishing the context** – During this initial stage, objectives of the risk assessment should be established so that it is clear at the outset and throughout the entire process, that only risks relating to these objectives are identified. Objectives may be at a process, specialty, Care Group, functional, project, enterprise or strategic level. These considerations all help to determine the context for undertaking a risk assessment and ensuring conversations around the risk assessment process remain relevant.

b) **Risk Assessment** – Once the correct context has been established, a risk assessment process is initiated. This consists of three stages to ***identify, analyse*** *and* ***evaluate*** risks to the context. This stage establishes the exposure of the Trust to risk and uncertainty which requires an intimate knowledge of the organisation and sector within which the Trust operates (the context). It highlights where, when and how events could prevent, obstruct or augment the achievement of objectives. To facilitate **risk identification**, considerations should remain focused on the context: that is, keeping the objectives established earlier in mind and identifying risks that threaten the achievement of those objectives. Risk identification should take place on a continual basis, but particularly where new activities are planned, new legislation or policy requirements have been identified, at the initiation of projects or when incidents

or near misses have taken place. It is vital that all risks are assessed in an objective and consistent manner if they are to be managed effectively. The **analysis** of the risks consists of the identification and evaluation of existing controls. The **evaluation** of the risk includes an assessment of the gross risk (before controls) and the net risk (after controls), an assessment against risk appetite and an assessment on the effectiveness of controls in terms of control design and control operation.

c) **Risk Treatment** – As the risk assessment stage completes and all potential sources of information have been explored to perform the assessment, the appropriate risk response or risk treatment should be applied. Risk treatment is presented within ISO 31000 as, 'the activity of selecting and implementing appropriate control measures to modify the risk'. Therefore, control measures are central to risk treatment. However, there are a number of other risk response options available. These have been highlighted below:

Treat – To mitigate the risk through controls.

Tolerate – To accept the risk as the cost of mitigation may outweigh the benefits of introducing controls. The risk may also be accepted if it is deemed to be within risk appetite.

Transfer – To transfer the risk for example through insurance or outsourcing arrangements.

Terminate – To stop or avoid the activity that gives risk to the risk.

Where the risk response option to treat a risk has been selected, controls may be deemed to be ineffective, missing or newly introduced. In this case, action plans may be developed to strengthen the control environment. The action plans should clearly state the activity required to address any control deficiencies, the person responsible for delivering the action and a date when the action is expected to be completed by. Details of the actions should be recorded in the 'Next Steps' field within the risk register module of Datix. For further guidance on how to complete the risk register fields on Datix, users should refer to the 'Datix Risk Register Procedural Guide'.

d) **Monitoring and Review** – This is a continuous process to provide constructive review, challenge and oversight over the Risk Management Process. It is exercised all the way from establishing the context through to risk treatment and provides an opportunity to provide feedback on the process, the decisionsand the data. Any action plans should be monitored to ensure they are completed within the target dates that have been set. The risks should also beregularly monitored, reviewed and re-scored in light of any actions that are completed as these will contribute to strengthening the control environment.

e) **Communication and Consultation** – Similar to the monitoring and review

stage, communication and consultation occurs throughout the process to ensure that stakeholder expectations continue to be met, there is regular engagement from all necessary parties within the process and there are open channels of communication on all risk management issues identified and any lessons learnt.

It also provides transparency and the opportunity to make any refinements throughout the end-to-end Risk Management Process.

9.2 Measuring and Calculating Risk

Scoring risks is achieved by estimating severity of impact and likelihood of occurrence using a standard 5x5 matrix. Each risk can be measured by multiplying the likelihood of that harm occurring with its severity should it occur.

Likelihood score (L)

What is the likelihood of the consequence occurring?

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.

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever possible to identify a frequency.

Consider how likely it is that the risk will occur using the following descriptors:

	1	2	3	4	5
Descriptor	**Extremely Unlikely**	**Unlikely**	**Possible**	**Somewhat Likely**	**Very Likely**
Frequency (general) How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Frequency (timeframe)	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability Will it happen or not	<5 per cent	6-25 per cent	26-50 per cent	51-75 per cent	76-100 per cent

Severity score (S)

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.

Severity score (severity levels) and examples of descriptors - this is not an exhaustive list					
Domains	**1 No Harm**	**2 Minor Harm**	**3 Moderate Harm**	**4 Severe Harm**	**5 Catastrophic Harm**
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days. Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death(s) Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality / complaints / audit	Peripheral element of treatment or service suboptimal Informal complaint /inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources / organisational development / staffing / competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff On-going unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an on-going basis
Statutory duty / inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating, critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity / reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives / projects	Cost increase /schedule slippage <1% over project budget /plan	Cost increase /schedule slippage >1<5% over project budget /plan	Cost increase/schedule slippage >5<10 % over project budget /plan	Cost increase/schedule slippage >10<25 % over project budget /plan Key objectives not met	Cost increase /schedule slippage >25% over project budget /plan Key objectives not met

Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective /Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results , Claim(s) >£1 million
Service / business interruption Environmental impact	Loss or interruption of >1 hour Minimal or no impact on the environment	Loss or interruption of >4 hours Minor impact on environment	Loss or interruption of >1 day Moderate impact on environment	Loss or interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

*Use of relative frequency can be helpful in quantifying risk, but a judgment may be needed in circumstances where relative frequency measurement is not appropriateor limited by data.

Risk Scoring: Likelihood x Severity (L x S)

Then **multiply** the two scores together from the table below.

L↓ S→	No Harm	Minor Harm	Moderate Harm	Severe Harm	Catastrophic Harm
Very Likely	**5**	**10**	**15**	**20**	**25**
Somewhat Likely	**4**	**8**	**12**	**16**	**20**
Possible	**3**	**6**	**9**	**12**	**15**
Unlikely	**2**	**4**	**6**	**8**	**10**
Extremely Unlikely	**1**	**2**	**3**	**4**	**5**

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 risk score that must be referred toon the risk register.

9.3 Risk Grading, Review and Reporting

The process of risk assessment at the Trust is designed to define the grade of risk to subsequently be managed and/or escalated based on the risk criteria (likelihood x severity) with owners including whom to inform, the required forum and frequency of review as follows:

Risk Rating (5x5)	Risk Grade	Level	Owner and to inform	Forum for review	Frequency of Risk Review

Likelihood x Severity					
1-3	Very Low	Ward	Ward/ Departmental Management	Team Meetings	At least quarterly
4-6	Low	Ward	Inform Ward/ Departmental Manager Oversee at Ward/ Departmental Level	Team Meetings	At least quarterly
8-10	Medium	Specialty/ Department	Inform Deputy Care Group Manager and Governance Facilitator	Team Meetings Quality & Safety Meetings Workforce Meetings Finance Meetings (dependent upon risk type)	At least bi-monthly
12	High	Care Group, Corporate Team	Alert appropriate Clinical Director, Care Group Manager and Governance Facilitator	Care Group Boards	At least monthly
15-25	Extreme	Care Group, Corporate Team	Alert appropriate Clinical Director, Care Group Manager and Governance Facilitator	Care Group Boards	At least monthly
15-25 (if considered for CRR)	Extreme	Corporate Risk Register	Alert Care Group Director, Care Group Manager and Deputy Director of Healthcare Governance. Overseen by relevant Executive Lead	Risk Committee	At least monthly

9.4 Datix Risk Documenting

All risk assessment should be captured in Datix with no exception. This allows analysis across the Trust by the Corporate Governance team to identify risk themes and how risks can be managed most effectively considering risk aggregation to within the Trust's risk appetite. Click here for a step-by-step guide to documenting risks on Datix.

10 Monitoring and Reporting Arrangements

All risks are subject to continual review and monitoring by the relevant meeting:

- Board of Directors,
- Board Assurance Sub-Committees:
    - Quality and Safety Assurance Committee
    - Digital, Performance and Finance Assurance Committee
    - People and Culture Assurance Committee
    - Group Audit Committee
- Risk Committee
- Ward/Specialty/Department
- Care Group Board
- Executive Committee

Board of Directors

The Board of Directors will:

- Receive and overview the strategic risks (Board Assurance Framework) quarterly to drive meeting agendas
- Receive an overview of all corporate risks on a monthly basis
- Receive assurance of risk management on an annual basis via the Audit Committee

Audit Committee

The Audit Committee will review the Board Assurance Framework and Corporate Risk Register at each meeting in review of the risk management process and assurance that risks are being managed effectively.

Quality and Safety Assurance, Digital, Performance and Finance Assurance and People and Culture Assurance Committees

The Committees will (relevant to the scope of the Terms of Reference):

- Review all Strategic Risks (Board Assurance Framework) on a quarterly basis
- Review all the Extreme Operational Risks scoring 15 or above at each meeting

Risk Committee

The Risk Committee will:

- Consider risks for escalation from the Care Groups and Corporate Areas for those risks rated at 15 and above
- Support the Care Groups and Corporate Areas to describe, categorise and mitigate risks
- Provide assurance when required to the Board of Directors and Audit Committee that a robust risk management process is in place

Care Group Board, Corporate Team Meetings

Care Group Board Meetings will (relevant to the scope of the Terms of Reference):

- Review all risks scoring 8-10 and over (extreme) on monthly basis and consider those risks high risks scoring 12-25
- Review all risks on a quarterly basis
- Highlight to the Risk Committee risks 15 and above requiring escalation, risks as part of regular reporting to assurance committees and ad hoc reporting as and when required across the Trust

Specialty/Department Teams

The Specialty/Department Teams will (relevant to the Care Group):

- Review all risks scoring on at least a bi-monthly basis and consider those risks higher escalating to the care group boards
- Review all risks on at least a quarterly basis
- Ensure the reporting of risks at Ward and Specialty/Department level

Ward Teams

Ward teams will:

- Review all risks scoring 1-6 on at least a quarterly basis
- Review all risks on at least quarterly basis
- Highlight to Specialty/Department level those risks above 1-6

Appendix A: Board Assurance Framework

The Board Assurance Framework (BAF) defines and assesses the principal strategic risks to the Trust's objectives and sets out the controls and assurances in place to mitigate these.

Each of the strategic risks in the BAF have been aligned to the objectives within the Trust Strategy, have their original, current and target risk scores reported, and information showing the anticipated changes in scoring over time. Gaps or areas where controls can be improved are identified which are translated into actions.

The BAF is reviewed by the Board in an ongoing quarterly cycle with key risk changes highlighted, and updates provided on any ongoing actions to improve risk control and mitigation. The BAF is also used to inform the Internal Audit work programme, and audit outcomes are used to inform further actions, or are used by the Board as part of its assurance process that the risk is adequately controlled. The risks are also used to inform the Board's committees' work programmes to ensure they are focusing on the key risks to the delivery of the Trust's Strategy.

In accordance with the Annual Reporting Manual issued by NHS England, all Foundation Trusts are required to present in the Annual Report an annual governance statement signed by the Chief Executive and underpinned by a supporting Board Assurance Framework (BAF). This aims to provide the Board of Directors with assurance that systems are safe and subject to appropriate scrutiny and that the Board of Directors are able to demonstrate that they are informed of key strategic risks. The BAF contains all the strategic risks that have the ability to undermine the Trust's Strategic Priorities:

- Our People
- Quality and Safety
- Elective Recovery
- Acute Flow

The framework is built up of the strategic risks and includes:

- Current and Target Risk scores
- Lead Assurance Committee
- Lead Director
- Key Controls intended to manage the risk
- Sources of Assurance
- Gaps in either control or assurance
- Action plan to address the gaps
- Risk Appetite

Key Controls

The key controls are the processes/procedures/delivered actions that are in place to assist in the prevention or limiting the risk occurring include:

- Operational delivered plans
- Statutory frameworks, for instance standing orders, standing financial instructions and associated scheme of delegation
- Actions in response to audits, assessments, and reviews
- Workforce training and education
- Clinical governance processes
- Claims outcomes to change processes
- Incident reporting and risk management processes
- Complaints and other patient and public feedback procedures
- Performance management systems
- Strategies/Policies/Procedures/Guidance
- Robust systems/programmes in place
- Objectives set and agreed at the appropriate level
- Frameworks in place to provide delivery
- SLA/Contracts/Agreements in place
- External Scrutiny

Sources of Assurance
Source of assurance refers where evidence can be acquired that describes how well the controls are operating and positive assurance the actual evidence. Assurance can be categorised using a 'three lines of defence' model:

- First line – operated by managers and staff across the Trust
- Second line – corporate oversight functions/governance and challenge
- Third line – independent assurance

First Line of Defence – operational management, examples include:

- Processes and procedures
- Budgets
- Risk assessments
- Work programmes of groups / committees
- Planning exercise outcomes
- Training needs assessments outcomes

Second Line of Defence – Corporate oversight, examples include:

- Performance/Quality monitoring in place and at what level, how and when
- Action monitoring reports
- Complaints and Compliments / Incident monitoring
- National returns
- Training compliance monitoring
- Routine reporting of key targets together with any necessary contingency plans.

Third Line of Defence - Independence assurances example include:

- Internal audit
- External audit

Appendix B: Risk Appetite Statement

The Trust recognises the complex nature of health care provision is an inherently risky activity. Whilst acknowledging the skills and dedication of all the team, accidents, incidents and mistakes can potentially happen.

York and Scarborough Hospitals NHS Foundation Trust makes every effort to ensure that there is a systematic approach to the identification, evaluation and control of risk and, wherever possible, risks are designed out of procedures and practice, to reduce it to the lowest possible level through the introduction of control and mitigation measures.

Risk Appetite Category Statements

(TBC)

York Teaching Hospital Facilities Management

Reference:

Health and Safety Policy

Version: 2

Summary	This policy sets out the health and safety responsibilities and arrangements for York Teaching Hospital Facilities Management LLP	
Keywords	Policy, Health & Safety	
Target audience	All YTHFM staff, contractors, sub-contractors, visitors, volunteers, and others employed in delivering a service to YTHFM. (This includes contractors/suppliers providing demonstrations and trials)	
Date issued	April 2023	
Approved & Ratified by	YTHFM Management Group Y&STHNHSFT Board of Directors	**Date of meeting:** **28th February 2023** **29th March 2023**
Next review date	March 2024	
Author	Norman Elliott (Health & Safety Manager and Training Lead) Penny Gilyard (Director of Resources)	
Executive Director	Heather McNair, Chief Nurse	

Version Control

Change Record

Date	Author	Version	Page	Reason for Change
1st Sep 2018	Brian Golding	1.0	All	Development and update of policy
1st Apr 2022	Penny Gilyard & Norman Elliott	1.4	All	Updated to current arrangements
10th Jan 2023	Norman Elliott & Penny Gilyard	2.0	All	Policy transferred to new policy format including new sections 10 & 13 along with some minor grammatical changes, a new acting chair, and an update to the responsibilities of the Director of Property and Asset Management.

Reviewers/Contributors

Name	Position	Version Reviewed & Date
Brian Golding	Director of Estates	1.1 22nd Aug 2019
John Dickinson	Assistant Head of Estates Operations	1.2 17th Nov 2020
Penny Gilyard	Director of Resources	1.3 22nd Feb 2021
Penny Gilyard	Director of Resources	1.4 1st Apr 2022
Norman Elliott & Penny Gilyard	Health and Safety manager Director of Resources	2.0 10th Jan 2023

Contents

1. Policy Statement

1.1 York Teaching Hospital Facilities Management LLP[1] (YTHFM) recognises its responsibilities in ensuring the health, safety, and wellbeing of all our employees, customers[2], contractors, volunteers and visitors and is committed to ensuring the highest standards of health, safety and welfare in all aspects of the business.

1.2 YTHFM accepts responsibility as an employer, for the duties placed upon it by the Health and Safety at Work etc. Act 1974 and other related legislation. YTHFM recognises by doing so it provides, not just legal and financial assurance, but a moral obligation as the right thing to do which is viewed as critical to our continued success.

1.3 YTHFM operates a systematic approach to the identification of hazards and the management of risk within its operations, in line with York and Scarborough Teaching Hospitals NHS Foundation Trust Policy (Y&STHNHSFT), in supporting wider Trust and NHS overall strategy.

1.4 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 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.
- Follow appropriate procurement policies to ensure that only competent contractors and suppliers are engaged by YTHFM.
- 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.
- Monitor, audit and review YTHFM safety policy and procedures at regular and prescribed intervals.

1.5 This policy statement will be reviewed annually as part of the management review process and communicated to all employees.

Penny Gilyard

Director of Resources
York Teaching Hospital
Facilities Management LLP

Date:

Graham Lamb

Acting Chair- Management Group
York Teaching Hospital
Facilities Management LLP

Date:

[1] A Limited Liability Partnership and wholly owned subsidiary of York and Scarborough Teaching Hospital NHS Foundation Trust.
[2] Customers include patients and service users in healthcare settings.

2. Introduction

2.1 YTHFM provides high quality Estates and Facilities Management (including but not limited to maintenance, Capital planning, engineering, security, cleaning, grounds, catering, and energy) services, primarily to Y&STHNHSFT 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 and provide 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. This includes those who carry out product/service/equipment demonstrations and trials on site.

4. Accountabilities and Responsibilities

4.1 The Management Group (YTHFM)

The Management Group are responsible for setting the strategic direction, policies, and objectives for health & safety. The Management Group 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.

4.2 Managing Director YTHFM

The Managing Director holds ultimate responsibility for the adherence to health and safety legislation within YTHFM and is accountable for the establishment and adherence of health and safety policies and procedures within the organisation. In the event of the Managing Director's absence, a Management Group nominated Director will take up these responsibilities.

4.3 Directors and Heads of Service YTHFM

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, the activities in their charge and provide leadership by example by proactively promoting a positive attitude and safety culture. The Director of Property & Asset Management has responsibility for ensuring the Control of Contractors Policy and Procedure and safe systems of work are in place and being adhered to within YTHFM in compliance with current legislation, regulations, and good practice.

4.4 Managers and Supervisors YTHFM

Managers and Supervisors are responsible for the impact of the overall health, safety and risk in their departments relating to staff, patients, contractors, and visitors. It is their responsibility to ensure health, safety and risk is effectively managed in their areas of control. They are expected to promote a high degree of health and safety awareness amongst all their teams and work in collaboration with, Heads of Service and Directors in the development of health & safety policies and procedures.

4.5 Head of Safety & Security (Y&STHNHSFT)

The Trust's Head of Safety and Security oversees the provision of competent advice as required to assist in developing, implementing, and maintaining measures to comply with relevant statute, YTHFM policy, Y&STHNHSFT and NHS policy and strategy. Y&STHNHSFT will ensure that the appropriate support and resource is allocated to YTHFM for relevant

health and safety management.

4.6 **Y&STHNHSFT Health and Safety Manager**

The Health and Safety Manager is appointed to provide competent advice and, as required, to assist in developing, implementing, and maintaining measures to comply with relevant statute, YTHFM and wider Y&STHNHSFT and NHS policy and strategy.

4.7 **YTHFM Assistant Head of Estates and Health & Safety Compliance**

Is to provide support and operational information to ensure compliance with YTHFM policy and procedures, by ensuring relevant inspections and audits are undertaken across YTHFM LLP as prescribed by company policy and procedures.

4.8 **Specialist / Competent Advisors YTHFM**

YTHFM has in place, appointed / responsible specific topic experts. This expertise will be supported 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 consider 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.

4.9 **Employee Safety Representatives**

YTHFM promotes active involvement and encourages appointed Trade Union employee safety representatives 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 as required by statute.

4.10 **All YTHFM Employees[3]**

All employees, including work experience, agency, and temporary staff within 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 the Health and Safety at Work etc. Act 1974 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 organisation 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.

4.11 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.

4.12 **Contractors, Consultants and Visitors Responsibilities**

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 to observe YTHFM health and safety policy and procedures. No contractor (this includes product/service/equipment demonstrations and trials) is to work on the client's premises unless they follow the Control of Contractors policy, and the correct type of method statement and/or risk assessment has been completed and agreed by the relevant manager as per the Control of Contractors policy. If work to be undertaken is particularly hazardous, this must not commence until the appropriate permit to work is obtained from the appropriate relevant source/manager.

[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. Policy Arrangements

5.1 This policy will be delivered by:

- Ensuring as a minimum, the requirements defined in this policy are met, and as a wholly owned subsidiary of Y&STHNHSFT following and complying with wider corporate Trust policy, procedures, and arrangements in place to ensure work activities are carried out safely.
- Ensuring compliance with all service level agreements with the Trust and meeting agreed key performance indicators.
- YTHFM has in place robust governance arrangements and structures to effectively manage business process including safety.
- Ensuring competent advice on related estates and facilities topics, appropriate arrangements are developed as required and are in place to fulfil YTHFM and Trust statutory duties and associated NHS guidance.
- Where YTHFM is required to carry out work activity, for customers other 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
- Notice boards
- 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)4 .
- The Construction (Design Management) Regulations 2015

8. Training

8.1 The contents of this policy form part of the mandatory health & safety training delivered at induction and in refresher courses.

9. Equality Impact Assessment

9.1 A copy of the Equality Impact Assessment for this policy is at Appendix A.

10. Definitions

Term	Definition
Y&STHNHSFT	York and Scarborough Teaching Hospitals NHS Foundation Trust
YTHFM (LLP)	York Teaching Hospital Facilities Management LLP
EPAM	Executive Performance Assurance Meeting

11. Consultation and Approval Process

11.1 The list below details the consultation, and approval process. The Y&STHNHSFT Board of Directors is to finally approve this Policy as a reserved matter.

Group	Consultation, information, or approval
Y&STHNHSFT Board of Directors	Approval
YTHFM Management Group	Approval
YTHFM Senior Leadership team	Consultation
YTHFM Operational Management Group	Consultation
YTHFM Staff Side Safety representatives	Consultation
Group Health & Safety Committee	Information
Group JNCC	Information

12. Document Control including Archiving

12.1 The register and archiving arrangements for policies will be managed by the YTHFM.

13. Monitoring Compliance

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements
Key performance Indicators	YTHFM Operational Management Meeting	In line with the Master Service Agreement	Monthly	Via reporting on compliance and safety performance

14. Document review

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 Staff Room).

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: Penny Gilyard (Director Resources)	
	Date Assessment Completed 10/01/2023	
	Name of responsible Director (YTHFM) Penny Gilyard, Director of Resources.	

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.

Minutes
Executive Committee
01 February 2023

Members in attendance: Simon Morritt (SM) (Chair), Karen Stone (KS), Melanie Liley (ML), Polly McMeekin (PM), Lucy Brown (LB), Heather McNair (HM), James Hawkins (JH), Gary Kitching (GK), Amanda Vipond (AV), Jo Mannion (JM), Mark Quinn (MQ), Donald Richardson (DR), Stuart Parkes (SP), Mike Taylor (MT)

Attendees: Lisa Gray (LG) (minute taker), Jamie Todd (JT), David Thomas (DT), Damian Mawer (DM) (161-22/23 item only), Sue Peckitt (SPe) (161-22/23 item only), Edd James (EJ) (162-22/23 item only)

154-22/23 / Apologies for Absence: Andrew Bertram (AB), Gerry Robins (GR), Srinivas Chintapatla (SC), Ed Smith (ES)

SM welcomed GK to his first meeting of the committee following GK being appointed to interim Care Group Director for Care Group 1.

155-22/23 / Declarations of Interest

No declarations of interest were declared.

156-22/23 / Minutes of the meetings held on 18 January 2023

The minutes of the meeting held on 18 January 2023 were agreed as an accurate record.

The committee:

- **Agreed the minutes of the meeting held on 18 January 2023 were an accurate record.**

157-22/23 / Matters arising from the minutes and any outstanding actions

Action 20 – the committee agreed this action could close as it will be picked up as part of the York ED Clinical Model which is currently being worked up.

Action 21 – the committee agreed to remove this action, as there is more detailed work required which KS would pick up with care group directors outside of the meeting.

Action 28 – KS noted she has made enquiries in relation to the POTS service and confirmed that it does not need to come back to the committee. It will go through to Quality and Patient Safety Group (QPAS) therefore the action can be closed.

Action 31 – is part of the UEC discussions and SM will ensure the current contract is not rolled over during conversations at PLACE. The maternity meeting has taken place, action to be closed.

Action 32 – action is ongoing.

Action 34 – action to be closed as regular updates received from IPC.

Action 35 – action is ongoing, with a meeting to take place in February 2023.

Action 36 – action is ongoing.

Action:

- **LG to update the action log.**

158-22/23 / Items an escalation from Board and other committees

No matters of escalation received.

159-22/23 / Chief Executives Update

SM highlighted to the committee that the Trust was under intense pressure nationally to do everything that is feasibly possible to clear the 78 week waits by the end of March. Tier one meetings are taking place weekly, and the Trust is receiving support from the Intensive Support Team and Ernst & Young. ML added that this is the main external focus currently and that there is a need to make consistent improvements and to be sighted on the quality and safety of patients who are waiting.

SM noted that it has been flagged with the national team that the Trust will need financial support to be able to do this as there is not enough capacity within the NHS so there will be a need to use insourcing. Care Groups are however asked to discuss with specialty teams as to whether they can do any additional incentivised work between now and the end of March and feed this back to the Corporate Operations team, highlighting what positive impact this would have on numbers. ML flagged this is a short-term measure until the end of March for 78 week waits before the cycle for 65 week waits commences in the new financial year. Stressing it is important that all options are explored so the Trust can demonstrate it has tried everything it can to clear the 78 week waits.

KS added that any changes made should be reviewed to see whether they are sustainable moving forwards to keep the movement especially when moving to Patient Initiated Follow Ups, as there needs to be a reduction in follow ups.

SM & ML thanked the Care Groups and Corporate Services for their continued hard work in relation to the 78 week waits in addition to dealing with all the other operational issues currently being seen.

The committee:

- **Noted the update.**

Action:

- **Care Groups to discuss with specialty teams as to whether they can do any additional incentivised worked between now and the end of March to decrease the 78 week waits and feed this back to the Corporate Operations team.**

160-22/23 / Care Group Escalation Reports

Combined report
MQ highlighted the risks for escalation from the report which includes the uncertainty of care group structure, medical and dental local pay, lessons learnt from bank holiday planning, and the lack of capacity and capability within capital planning, estates, and facilities services.

SM proposed a time out session for the committee is held in April to discuss the care group structure, looking at what works well and what may need to be done differently. This will allow those changes to be put in place before the summer. SM asked the care group directors to share with their teams that the committee will be having this conversation.

PM provided an update regarding medical and dental local pay and noted further progress on this would now be made with KS now that she is in post, a paper with recommendations will be shared with the committee when ready. It was agreed an email would be sent out to all consultants to clarify those rates that the committee did agree in late 2022.

ML confirmed the lessons learnt report regarding bank holiday planning would be presented to the committee in March in advance of the next bank holiday dates.

SM noted he would pick up with AB regarding YTHFM, adding they are working on getting some interim support in to strengthen the management in the absence of a managing director. LB confirmed charitable funds through the Trust charity would not be lost if the works fall into next year, it would be any external charities that would be problematic.

Care Group 1
JT highlighted the risks for escalation from the report which included the issues emerging in gastroenterology. Care groups 1 & 2 are meeting next week to discuss short and long-term actions required, and this will be presented to the committee next month.

The committee were asked to support a reduction of 5 beds on the acute site and opening of 3 beds at White Cross Court in support of creating an appropriate therapy environment on the ASU (ward 23). The committee discussed and supported the request asking if more beds could be opened at White Cross Court following minor works this should be undertaken.

Care Group 2
DT highlighted the risks for escalation from the report which included the gastroenterology issue with JT had flagged to the committee.

The care group are struggling to get job plans on Prep currently, with it being flagged at the oversight and assurance meeting a few months ago. It was agreed the care group might be able to get some administration support to do this so DT will pick this up with ML and PM to see whether this can be supported.

DT flagged he wanted to discuss the management of complainants with HM as the senior team are spending a lot of time managing these, so would like to explore how this could be dealt with differently to release their time. Care group directors flagged this was happening within their care groups too. HM agreed to pick this up outside of the meeting.

A rapid improvement piece of work is due to be undertaken w/c 27 February, which will jointly be delivered with Yorkshire Ambulance Service to look at ambulance handovers,

with the Trust also focusing on the first assessment process. Details and learning from this will be shared with the committee.

Progress to deliver the frailty virtual wards with Humber continues.

Care Group 3
AV highlighted the risks for escalation from the report, asking the committee to note the critical risk around maternity theatre staffing and the difficulty in securing agency staffing to mitigate the risk in the short-term. SM noted there was a need to ensure there was evidence to provide the CQC that the Trust was actively trying to recruit.

Requested the committee escalate the significant risk around Critical Care GPIC Standard to the ICB and request a decision on funding for the business case and to support care group 6 to increase capacity within the Patient Access team (agency and bank staff) to reduce the number of vacant slots in clinics.

The committee discussed this in detail with ML noting it is being seen across the trust that the recruitment and retention of administration staff is proving difficult, the national team have been asked whether there is any support for this. Amber Lee in her new role as Lead for Patient Pathways will be looking to work with DIS to bring in standardised and efficient processes across the Trust as each area works differently. In the short-term ML noted the team were going to go out to see if there is any admin support throughout the Trust that could be released to support this work.

Care Group 4
SP highlighted the risks for escalation from the report include the management capacity across CG4 as a result of turnover which will reduce oversight of key issues in the care group. Interim arrangement is in place with Karen Priestman from care group 6.

Gastroenterology issues are impacting on endoscopy, it is expected this will be picked up as part of the conversations next week between care groups 1 & 2.

An update on the LIMS project will be coming to the next meeting to highlight the project delays and increase in costs.

Care Group 5
JM highlighted the risks for escalation from the report which included the concerns around YTHFM, as there is a high level of concern around ability to deliver immediate, urgent and critical estates work that are in response to CQC requirements. There is a risk to continuity for the maternity transformation programme as consultant (interim) programme manager ends his contract as the programme moves to establishing a robust PMO and Programme Board. ML confirmed two programme managers were appointed yesterday, subject to pre-employment checks, and one will be focussed on this programme until they are no longer required.

The Scarborough paediatric medical workforce reached a critical point on Sunday, with issues in both consultant and middle grades, causing a lot of issues for the clinical director.

There has been a Birth rate Plus audit request to repeat the audit with refreshed 2022 data to ensure workforce planning for midwifery for 2023-24 is informed by robust analysis and modelling. Director of Midwifery to approach the LMNS to request funding support.

Care Group 6
MQ highlighted the risks for escalation from the report which includes staffing issues within Dermatology. REI is ready to be released and MQ talked the committee through the detail, with the committee confirming they were happy for this to be released mid-February noting there was a need to send out some directive communication in regard to it.

The committee:

- **Noted the Care Group escalation reports.**
- **Supported the request for a reduction of 5 beds on the acute site and opening of 3 beds at White Cross Court in support of creating an appropriate therapy environment on the ASU (ward 23).**

Action:

- **PM and KS to submit a medical and dental local pay update once the detail has been worked through.**
- **Lessons learnt report regarding bank holiday planning to be added to a March agenda.**
- **SM to organise a time out session in April to discuss the care group structure.**

161-22/23 / Infection Prevention & Control Update

SM welcomed DM and SPe to the meeting.

IPC Update and Improvement Plan
DM flagged to the committee the performance data shows the trajectory remains the same with no signs of improvement yet. Quarterly infection rates for Care Groups 1-3 are highlighted in the report which show Care Group 1 is performing well, Care Group 3 is better with some than others however the real challenges are within Care Group 2 despite all the good work that they are undertaking. C.Diff cases throughout the Trust are mainly driven by Care Group 2 therefore there is more work to be undertaken.

DM presented an update on progress against the IPC improvement plan, highlighting Scarborough have completed the pro-active HPV cleaning of all areas including ED on a bay-by-bay basis given there is no decant space to complete a full ward at a time. DT added Endoscopy was also included and it is hoped this will be of benefit. DM added a productive reduction group meeting in relation to staphorsius bacteraemia has taken place and there are now plans for Quality Improvement based work in several areas which have been identified as route causes.

Infection Prevention & Control Board Assurance Framework and Code of Practice compliance
SPe noted a report is included in today's meeting pack to update the committee of the self-assessment outcome of the Infection Prevention and Control Code of Practice (COP) and the Board Assurance Framework which SPe was asked to undertake on behalf of the Trust. The tool enables a self-assessment of the Trust's compliance against the ten criteria contained within the Health and Social Care Act 2008.

The revised IPC BAF was published in September 2022 and contains 15 sections and 128 key lines of enquiry. The report outlines the full review of the IPC BAF which is a dynamic document and an IPC improvement plan with RAG ratings has been developed based on the evidence and assurance received and the gaps identified at the point of SPe writing the report.

The Action Plan contains 8 actions rated red, 18 actions rated amber and one action

rated green.

The committee discussed the self-assessment and the work that needs to be undertaken to improve, noting specific issues are getting the basics right, having decant space and being assured around the cleaning measures in place within YTHFM.

The committee confirmed support of the delivery of the work plan to facilitate the necessary improvements. It was agreed updates on this would be included in the monthly IPC standing agenda item.

The committee:

- **Noted the IPC update, COP self-assessment and the IPC improvement plan.**
- **Confirmed support of the delivery of the work plan to facilitate the necessary improvements.**
- **Agreed updates on the COP self-assessment and improvement plan would be included in the monthly IPC standing agenda item.**

162-22/23 / Business Cases

SM welcomed EJ to the meeting.

H&NY Procurement Collaborative – Business Case for the establishment of a shared procurement collaborative
EJ highlighted the case is looking to bring together the three procurement teams across H&NY into a single management function. There is a level of investment required to increase the seniority of the procurement function across the three trusts and for moving onto one single IT platform.

The investment is looking to:

- Provide procurement business partners who link to each of the care groups
- Provide dedicated clinical procurement specialists that allows challenge of clinical standardisation and enable informed discussions with the clinical community
- Implement dedicated resource for contract management and supplier relation management
- Start to use procurement data captured to inform future procurement decisions
- Extend the material management offering to avoid nursing and clinical staff spending time ordering stock and packing it away
- Implement a single inventory management system, bringing better visibility of stock held, linking it to the scan for safety programme
- Implement a single ordering system which will deliver cost savings given the three trusts together will take a larger volume to market. NHS supply chain alone would see a saving of approximately £300k each year.
- Cover procurements costs and return a benefit to all three trusts year on year.

The committee discussed the case in detail and approved for the case to progress to the Digital, Finance and Performance Assurance Committee and Board of Directors later in the month for final approval.

The committee:

- **Approved for the case to progress to the Digital, Finance and Performance Assurance Committee and Board of Directors later in the month for final approval.**

Action:

- **LG to flag with the relevant administration support that this is to be submitted to the Digital, Finance and Performance Assurance Committee and Board of Directors meeting later in the month.**

163-22/23 / CQC Update

HM provided an update to the committee noting a detailed report was included within the meeting pack for information.

HM flagged it was important to get the final must-do and should-do actions closed off in advance of the CQC report being received as this will bring more with it.

The Trust is going to request the warning notice in relation to the PEM consultant is lifted. It is anticipated the trust will be able to request for the remaining section 29a's to be lifted over the next few months. The Section 31 in relation to mental health risk assessments remains open, work on this is ongoing, in addition to the new maternity section 31 warning notice.

The committee:

- **Noted the update.**

164-22/23 / Trust Priorities Report

SM highlighted the report is for information and to allow directors raise any specific issues not already highlighted. Adding there will be further discussions at the Board as to whether the new style report meets all the trust's needs. SM asked for any comments on this to be sent to MT so these can be taken into consideration during the Board conversation.

The committee:

- **Noted the update.**

165-22/23 / Industrial Action

PM presented an update to the committee on industrial action noting the Trust was continuing to work closely with the RCN and to put in place arrangements for days of industrial action.

Ballots are currently being undertaken by Junior Doctors and the BMA and Unite are currently preparing to ballot their members.

The committee discussed and noted the update.

The committee:

- **Noted the update.**

166-22/23 / UEC Programme Update

ML noted a highlight report had been shared within the committee pack, providing an overview of the key points to note in relation to the work ongoing under the seven work streams previously agreed which have an overarching theme of health inequalities.

ML confirmed Gemma Ellison (GE) has been successfully appointed into a substantive post following her secondment to lead on the Urgent & Emergency Care (UEC) Programme. If there are any comments on the highlight report, these should be sent to GE as she is keen to improve this and present it slightly differently in future. Reports will be submitted to future meetings on both the UEC and elective recovery programmes.

The committee:

- **Noted the update.**

167-22/23 / Referral to Treatment (RTT) Staff Training Programme

ML noted that in the feedback received following the IST visit on 6th and 7th of December several recommendations were made that require urgent addressing, many of which have a significant potential impact on the workload of the RTT Tracking Team as well as others involved in the monitoring of RTT pathways. To implement some of these recommendations it is vital that all staff members involved have a current and comprehensive understanding of RTT rules.

In December 2022 the trust entered into a contract with Source Group, an external RTT online training provider, to purchase 330 Introduction level and 50 Advanced level licenses for a period of 12 months, and the trust began working with Care Groups to establish appropriate users for these licenses including administrative staff, medical secretaries and operational managers.

With the feedback from the IST received shortly after the licenses were purchased, it was agreed to pause the rollout of the project and consider whether to extend the training to additional staff members including clinical staff and the Executive Team. With the clear feedback from the IST that RTT is of key importance to the Trust's overall elective recovery, extending the training to additional staff members would allow a better understanding throughout the organisation of RTT and potentially alleviate some of the pressure on the RTT Tracking Team. Therefore, the committee are being asked to approve the below recommendations:

- RTT Training is rolled out to any staff member whose role involves any monitoring or updating of patient RTT pathways, including clinical and administrative teams. It is also recommended that the training is completed by the full Executive Team to promote better understanding of RTT and the impact it has on elective recovery. This would require the purchasing of approximately 1,000 additional licenses over and above those already agreed with Source Group, at a cost of circa £9,000.
- To add 2 yearly RTT and Cancer training to statutory and mandatory training for all relevant staff roles.

The committee discussed the recommendations and agreed they needed to be discussed and approved at the QPAS, noting the committee agreed the training should be required learning, rather than statutory and mandatory, for defined groups of staff only.

The committee:

- **Discussed the recommendations and agreed they needed to be discussed and approved at the QPAS, noting the committee agreed the training should be required learning, rather than statutory and mandatory, for defined groups of staff only.**

168-22/23 / Items to note

NHSEI Agency Report
The committee noted the report.

Board Assurance Framework and Corporate Risk Register
The committee noted the Board Assurance Framework and Corporate Risk Register.

Business cases approved outside the meeting:
The committee noted the below business case was approved outside of the meeting:

- 2022/23-104 NHSE Pulmonary Rehabilitation Service Improvement was approved outside of the committee.

The committee:

- **Noted the NHSEI Agency Report.**
- **Noted the Board Assurance Framework and Corporate Risk Register**
- **Noted business case 2022/23-104 NHSE Pulmonary Rehabilitation Service Improvement was approved outside of the committee**

169-22/23 / Issues to escalate to Board and other committees

SM noted there were no issues to escalate to Board and other committees but noted the H&NY Procurement Collaborative – Business Case for the establishment of a shared procurement collaborative would progress to February's Digital, Performance & Finance Committee and Board of Directors for approval.

The committee:

- **Noted the update.**

Action:

- **LG to inform administration support the H&NY Procurement Collaborative – Business Case for the establishment of a shared procurement collaborative needs to be added to February's Digital, Performance & Finance Committee and Board of Directors for approval.**

170-22/23 / Issues to escalate for BAF & CRR consideration

No issues to escalate to BAF & CRR. MT is currently having conversations with the Executives.

171-22/23 / Any other business

No other business was discussed.

172-22/23 / Time and Date of next meeting

The next meeting will be held on 15 February 2023, 8.30am-12pm in the Trust Headquarters Boardroom.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Action Notes

Executive Committee
15 February 2023

Members in attendance: Andrew Bertram (AB) (Chair), Karen Stone (KS), Melanie Liley (ML), Polly McMeekin (PM), Lucy Brown (LB), Heather McNair (HM), Gary Kitching (GK), Amanda Vipond (AV), Jo Mannion (JM), Mark Quinn (MQ), Donald Richardson (DR)

Attendees: Lisa Gray (LG) (minute taker), David Thomas (DT), Luke Stockdale (LS), Neil Todd (NT), Mark Steed (MS) (item 178-22/23 only), Kevin Richardson (KR) (item 179-22/23 only), Penny Gilyard (PG) (item 179-22/23 only), Jenny Flinton (JF) (item 183-22/23 only), Gail Dunning (GD) (item 183-22/23 only), Vicky Mulvana-Tuohy (VMT) (item 184-22/23 only)

173-22/23 / Apologies for Absence and Quorum	
Summary	Apologies received from: Simon Morritt (SM), James Hawkins (JH), Gerry Robins (GR), Srinivas Chintapatla (SC), Ed Smith (ES), Stuart Parkes (SP), Mike Taylor (MT)
Decision/s	• The meeting was declared quorate.
Action/s	• Nil.
174-22/23 / Declaration of Interest	
Summary	No declarations of interest were declared.
Decision/s	• Nil.
Action/s	• Nil.
175-22/23 / Minutes of the meeting held on 01 February 2023	
Summary	LG apologised noting that due to unforeseen circumstances the minutes were not yet available and would be shared at the next meeting.
Decision/s	• Nil.
Action/s	• LG to share minutes at the next meeting.

176-22/23 / Matters arising from the minutes and any outstanding actions	
Summary	LG noted an updated action log would be shared at the next meeting.
Decision/s	• Nil.
Action/s	• LG to share action log at the next meeting.
177-22/23 / Items and escalations from Board and other committees	
Summary	No matters of escalation received.
Decision/s	• Nil.
Action/s	• Nil.
178-22/23 / Capital Programme Update	
Summary	AB welcomed MS to the meeting, noting the capital programme was not listed on the agenda however as MS was present, MS would provide the committee with an update on the capital programme. MS provided the committee with an update on the key projects currently ongoing noting it remains a challenging environment for construction. It was highlighted one of the sub-contractors for the Scarborough UEC build is likely to go into administration. This may cause some disruption to the build however IHP who are the main contractors are looking to resolve this quickly.
Decision/s	• Nil.
Action/s	• LB to discuss with Andrew Bennett how the Capital Programme Newsletter can be shared more widely to give staff a better oversight.
179-22/23 / Car Parking & Sustainability Report	
Summary	AB welcomed KR and PG to the meeting. A full review of car parking and sustainable travel options has been successfully undertaken last year as part of an overall strategy to improve accessibility to the York, Scarborough & Bridlington Hospital Trust sites. Extensive work has been completed across several schemes which includes, the requirement to change out the failing 'end of life' car parking control equipment, updated app-based permit application systems, car parking spaces, sustainable travel options (review of hospital bus service, free/subsidised bus travel) and additional cycle storage. The report presents the remaining schemes/actions with timescales for implementation where approval is required from the committee prior to the

	presentation for final approval from the Board of Directors (BoD) at their meeting on 22 February 2023. This is to support a combined communication package of all elements of car parking and sustainable travel to the wider organisation by the end of February 2023. The Executive Committee is asked to discuss and approve: • The cancelation of all current car parking permits from March 2023, with all staff required to re-apply by June 2023, through the NEW Glide App-based service in accordance with the NEW approved permit criteria. • To re-implement staff car parking charges from June 2023, after the 3 months' notice period for permit applications and go-live for the ANPR system to be turned on. • To commence the 3-month free bus trial through First York & East Coast Travel from the date of reintroducing staff car parking charges (June 2023). • To endorse the paper going forward to the BoD for approval on 22 February 2023.
Decision/s	• The committee supported the recommendations to go to BoD for approval.
Action/s	• Nil.
180-22/23 / Business Cases	
Summary	**2022/23-114 Waiting List Validation** LS presented the business case to the committee outlining the Trust has been given £150k over two years to support waiting list validation. Full details are supplied within the business case paperwork.
Decision/s	• The committee approved the case.
Action/s	• Nil.
181-22/23 / CQC Update	
Summary	HM noted an updated position was included in the meeting pack in relation to the action being taken to address the CQC regulatory conditions. On the 23 January 2023 the maternity action plan in response to the section 31 was submitted in line with CQC requirements. Progress continues with the delivery of the actions from the section 29A for medicine. However, the dashboards to monitor risk assessment compliance require further development work to ensure that assurance can be provided via the dashboards. The CQC are continuing to undertake further interviews, focus groups and questionnaires but no formal feedback has been received. The CQC expect to share their report with the Trust at some point in March 2023.

	Ellen Armistead is starting a 6-month contract on 16 February with the Trust as a Quality Improvement Director.
Decision/s	• Nil.
Action/s	• Nil.
182-22/23 / Industrial Action	
Summary	**Lessons Learnt from Royal College of Nursing (RCN) Industrial Action 18-19 Jan 2023** The RCN declared that 55 Trusts would take IA on 18 and 19 Jan 2023. The Senior RCN Officer wrote to the Chief Executive on 06 Jan 2023 out lining the requirements of the local strike committee and how they would coordinate the industrial action and specifically how the derogation request process would be implemented. The Trust implemented planning in accordance with a pre agreed SOP 14 days prior to the IA and then established an Incident Coordination Centre (ICC) at each site to coordinate the response. Pre-derogated services and services where the Trust had requested derogation were operated on both days. Matrons and Heads of Nursing monitored nursing attendance and through a series of meetings staff from services that had been stood down were redeployed as required. The ICCs had a close working relationship with the RCN Officers at each site which enabled the processing of short notice derogation requests on each day. The response was deemed successful as appropriate safe care was delivered on all inpatient wards and all services that had been derogated. The committee are asked to note the content of the lesson learnt report and accept the recommendations outlined in the report. **Industrial action update** Junior doctors are currently being balloted with the outcome due on 20 February. Teams are reviewing how services could be delivered if they go ahead with IA in March. The RCN have announced further strikes for 48hrs between 1-3 March. The committee wished to formally note their thanks and appreciation for the exemplary way the Trust's workforce conducted themselves throughout the previous IA days.
Decision/s	• The committee noted the lessons learnt report and accepted the recommendations outlined in the report.
Action/s	• Nil.

183-22/23 / Proposal to join NHSE Culture & Leadership Programme	
Summary	AB welcomed JF & GD to the meeting. The initial results from the 2022 NHS Staff Survey were shared in January 2023 highlighting low levels of engagement within the Trust and YTHFM and the need for cultural change. The report in the meeting pack outlines the proposal that the NHSE Culture & Leadership Programme (CLP) is used as a framework to re-engage with the workforce across all sites, and to expand upon and continue the cultural change work that commenced during 2022. It outlines how the CLP would fit with other programmes of work in the Trust focused on meeting the 'Our People' and 'Quality and Safety' priorities; why the CLP has been chosen (evidence-based, measurable); the anticipated impact if the CLP has active participation from across the organisation; and the resource needed to support the transformation. The committee are asked to: • support the use of this culture change programme • commit to active participation in developing a collective, compassionate, and inclusive culture of leadership • approve the funding of the Deputy Head of Engagement post on a substantive basis, and the temporary resources (including releasing staff) needed to support the discovery phase of this programme.
Decision/s	• The committee confirmed full support of the programme noting this has got to be the Trust's number one narrative. There needs to be a refocus of all energy on this, with a need to look at how staff are released to do this and ensure this is what they are focusing on. There is no money to invest in the posts requested so it was agreed AB and PM would discuss this with SM on his return from leave as to how this can be funded as it cannot be incremental.
Action/s	• AB and PM to agree with SM how the posts for the NHSE Culture & Leadership Programme can be funded.
184-22/23 / Right to Rehabilitation	
Summary	AB welcomed VMT to the meeting. VMT delivered a Right to Rehabilitation presentation to the committee which has already been delivered to many different forums externally and to the ICB. A report is included in the meeting pack which provides the committee with an overview of the current demand of Complex Rehabilitation within the organisation and the existing workforce capacity available. The report identifies gaps within the current model and associated risks to patient care and provides an optional appraisal for a workforce model with the capacity to meet rehabilitation requirements for complex rehab patients.

	In summary: • Current services are not meeting national guidelines • Significant gaps have been identified in service provision between SGH and YDH • Regular rehabilitation not occurring consistently across specialties in the acute inpatient setting • There is no dedicated MDT workforce for complex rehab • The review found that 13 patients that had specialist rehabilitation prescriptions (SRP's) had no input from AHP (OT/PT) based on the data we were able to collect and whilst SRP's are sent by tertiary centres; they are rarely were they seen by therapists on the wards or the actions specified were not taken on repatriation • There is therefore a significant risk to patient safety as evidenced by recent serious incident reports • A review of rehab space is needed. Gym space has been converted to storage space due to ward moves during the COVID-19 pandemic, therapy kitchens & quiet rooms have been repurposed which is impacting on the quality of provision. The committee is asked to: • consider the priority of rehabilitation and how this can be delivered in a consistent way in line with national guidelines • review/identify rehabilitation areas within care groups to enable effective undertaking of rehab activities.
Decision/s	• The committee acknowledged the work been done so far on the gaps in service agreeing that this needs to feed into the wider AHP review due to be undertaken. • The committee agreed to reinforce the message with ICB partners and other organisations. • VMT to deliver the message to individual care groups to get this message out wider and discuss with them about regaining the space required to enable effective undertaking of rehab activities with the full support of the committee.
Action/s	• LG to flag to MT Right to Rehabilitation requires a slot at a future BoD meeting.
185-22/23 / Excess Treatment Policy	
Summary	AB outlined the policy detail and asked for the committee's approval.
Decision/s	• The committee approved the policy.
Action/s	• Nil.
186-22/23 / Overseas Visitor Policy	
Summary	AB outlined the updated policy detail and asked for the committee's approval.

Decision/s	• The committee approved the policy.
Action/s	• Nil.
187-22/23 / Identification of Patients Policy	
Summary	AB outlined the policy detail and asked for the committee's approval.
Decision/s	• The committee approved the policy.
Action/s	• LB to look to add a summary of the updated policies to the staff brief/bulletin/screensavers. • KS & HM to circulate a letter to the senior clinical leaders requesting they lead by example to ensure this gets embedded, outlining the risks people are exposing themselves too if they don't do it.
188-22/23 / Items to note	
Summary	**Business cases approved outside the meeting:** The committee noted the below business cases were approved outside of the meeting: • 2022/23-112 SHYPS Digital Diagnostic Capabilities Fund Spend • 2021/22-35 Theatres, anaesthetics, and critical care haemodynamic monitor replacement • 2021/22-38 Replacement and upgrade of laparoscopic stacks • 2022/23-85 Replacement Auricals • 2022/23-82 Replacement of ICU beds and air mattresses in Scarborough York hospitals • 2021/22-46 Replacement Autoclaves in Scarborough SSD
Decision/s	• Nil.
Action/s	• Nil.
189-22/23 / Items to escalate to Board and other committees	
Summary	PM to provide an update on the issues with Learning Hub.
Decision/s	• Nil.
Action/s	• PM to provide an update at the BoD.
190-22/23 / Items to escalate for BAF & CRR consideration	
Summary	No items to escalate.
Decision/s	• Nil.

Action/s	• Nil.
191-22/23 / Any other business	
Summary	**Learning Hub** PM updated the committee on the work being undertaken to restore Learning Hub. An information request has been sent to ESR to retrieve core statutory and mandatory records which is fed from Learning Hub to ESR at midnight every day therefore the data will be up to date once is has been restored on Learning Hub. Discussions are taking place with the software provider to see what support they can provide to upload data in relation to appraisals, required learning, clinical skills and anything required for revalidation from reports which has been run off Learning Hub recently. Work is ongoing and updates will be provided with the workforce to keep them informed of progress. The Digital, Finance and Performance Committee are fully sighted on the situation and an update will be provided at BoD. It was felt at this stage there was not a need to flag this wider.
Decision/s	• Nil.
Action/s	• PM to provide an update at the BoD.
192-22/23 / Time and date of the next meeting	
The next meeting will be held on 01 March 2023 in the Trust Headquarters Boardroom.	

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

April 2023

Waiting List teams – Scarborough and York	**Scarborough and York**	**Nominated by Sarah Crossland, colleague**

I would like to nominate the whole waiting list team across all sites for the way they have embraced the challenges and constant changes in demands on them as a team to support the various work the Trust is doing to enact the elective recovery. The team always rise to the challenge and deliver what is needed despite the conflicting demands. They are a real credit to the Trust.

Miss L Fahel, Consultant	**York**	**Nominated by Stephanie Knowles, patient**

I would like to give thanks to Miss Fahel who was there for me throughout my pregnancy which wasn't easy. I'm a type one diabetic and I was seen at least every two weeks if not more frequently. Miss Fahel made time for me; I know that on at least two of the days I went to see her she saw me on her lunch break when she was on training days. Miss Fahel provided a consistent approach making me feel listened to.

Towards the end of my pregnancy I became very unwell and Miss Fahel was able to see the difference in me physically as we had met several times, so was able to act quickly with care and compassion to ensure my baby was born safely. Throughout the day he was born I was in the antenatal day unit and Miss Fahel was in clinic but allowed the midwives to interrupt her clinic so she could continue caring for me. I felt like I was important to her. Miss Fahel came to see me on the delivery ward a few days after his birth and invited me back for a debrief as I was struggling to come to terms with the birth trauma I experienced. Miss Fahel is one of a kind and deserves a star award.

Michelle Boughton-Bond, Specialist Biomedical Scientist	**Scarborough**	**Nominated by Jennie Raven, colleague**

We had a major analyser breakdown in the laboratory which led to a significant backlog of work and a thorough investigation of previously released results.

Michelle volunteered to stay behind for several hours after her shift and took on the ownership of re-running samples and checking the validity of thousands of test results, a huge undertaking. She came in the following morning and continued this challenging work all day until she was satisfied that all the patient results were correct.

Michelle showed incredible resilience and dedication in a highly pressured situation, aware of the need to complete this task quickly yet carefully. She embraced the Trust values in this task, showing kindness in her care for the patients behind the samples and excellence in her meticulous approach to ensuring all results were correct.

All the laboratory team felt she went above and beyond and is very deserving of the star award.

Lynne Ward and Luisa Certo, Healthcare Assistants	**York**	**Nominated by a colleague**

Lynne had noticed a patient in the dermatology waiting area looking pale and clammy. She immediately jumped into action with the patient and recognized his symptoms to be potentially of cardiac involvement.
Both Lynne and Luisa then took the patient straight to the emergency department on a wheelchair and got him straight to the correct team before any further deterioration. Their quick thinking has potentially saved this man's life.

Adrian Gray, Dispatcher **York** **Nominated by Emily Keeley and Ian Barnett, colleagues**

A patient came to the main desk with mental health issues, reporting they were going to commit suicide upon leaving the hospital. Adrian spoke to the individual, assisted them to the emergency department and gave them additional crisis and mental health information to help them.

He stayed with the individual for some time, even after the end of his shift, ensuring he was in the right hands and taken care of before leaving to go home.

Others on shift were not confident in how to help the man and Adrian took control of the situation admirably, for which the patient was very grateful.

Alex Winfield, Midwife **Scarborough** **Nominated by Ella Perry, patient**

Alex was my midwife back in November and I couldn't have asked for anything more from her.

From breaking my waters to being with me during my emergency c section she did everything she could in her role to support me and make me feel at ease. Unfortunately, I was readmitted due to a scar infection and Alex was one of the staff members caring for me. Once again, she went out of her way to ensure I had the best care and I felt she was a member of staff that listened to me and didn't just treat me like another patient. She had a lot of empathy and it was clear how hard she works.

Any woman would be lucky to have her as a midwife.

Becky Coates, Apprentice Assistant Audiology Practitioner | **Scarborough** | **Nominated by a colleague**

Since Becky started working as an apprentice in our department, she has excelled in everything thrown at her. Unfortunately, we have had a loss in staff in our department and Becky has been a great asset and addition to our team. She has fitted into our department perfectly, picking up the methods in which we all work with a positive attitude. She regularly takes her role further by helping her peers by helping with patient lists, making sure stock is topped up in clinic rooms and making others aware of clinic changes.

We have no doubt she will complete and pass her course in the next few months. Becky has lifted the workload set on all of us in the coastal audiology department and we are very grateful to have her.

Alexandra Jones, Student Midwife | **Scarborough** | **Nominated by Amy Halliday, patient**

Alex was so lovely, professional, and supportive. She just has something special about her. She could read a room perfectly and knew where she was needed and what was needed. Whoever has her as their midwife when she's fully qualified are going to be very fortunate – she is certainly in the right job.

I had to have emergency surgery under general anaesthetic just after having a traumatic birth and my baby only a few hours old. Lots of staff were rushing about and having Alex with me made me feel so much better. I could tell she knew how scared I was, and she just put her hand on my arm and said "you'll be ok, try and relax. I'm here through it all." I instantly felt not so alone and it meant everything. She came in to check I was ok throughout her shift which was nice as she didn't have to. All my family that met her think she's amazing too and we are so grateful to her. Wouldn't ever be able thank her enough for everything.

Louise Preston and Tony Pemberton, Senior Healthcare Assistants	**Community**	**Nominated by Mary Welford, colleague**

During a visit to a patient with complex care needs, Louise and Tony were faced with an emergency, whereby the patient rapidly deteriorated and required emergency help. Both Louise and Tony dealt with the situation rapidly escalating to the appropriate professionals, ensuring that the patient got the most appropriate care. Due to being based within a rural area, they were faced with further problems, such as a lack of phone signal and remote location. However, they worked around these barriers and were able to provide lifesaving care to the patient, whilst waiting for the emergency services to arrive. Both Louise and Tony dealt with the situation with the upmost professionalism and were able to utilise their wideset skills, knowledge, and experience to keep the patient safe, before handing over to the paramedics. They are both an asset to the South Hambleton and Ryedale (SHaR) district nursing team.

York Materials Management team and Scarborough/Bridlington Stores team	**York, Bridlington and Scarborough**	**Nominated by Samantha Devall-Rowntree, colleague**

This is a cross site nomination for the Scarborough and Bridlington stores team and York staff in the materials management team. Week commencing 6 February the NHS supply chain online ordering service, experienced severe server disruption. Over a period of three days, this significantly impacted on the ability of our materials management team at York, and stores teams at Scarborough and Bridlington hospitals being able to place crucial orders for Trust wards and departments.

It was due to the teams' hard work, determination, patience, and in some cases placing orders on an evening when staff got home, that supply chains major server disruption caused minimal impact to our ward's routine orders and delivery schedules. They displayed a fantastic example of cross site team working.

Kim Hartnett, Midwife	**Scarborough**	**Nominated by Lucy Brice and Georgia, colleagues**

Kim always goes above and beyond for both her colleagues and patients. Maternity services are lucky to have such a dedicated member of the team, offering her time, care, and support to women whether this be during or outside of her working hours. The bereavement support you offer for women and their families is immeasurable. We appreciate all the work you do.

Jan Mortimer, Healthcare Assistant	**York**	**Nominated by Dawn Lowe, colleague**

Jan has been amazing recently; we have been under a lot of pressure, partly due to staff shortages. She has coped so well and been helpful and kind to the patients, sometimes single handily carrying out two jobs at once. I would just like her to know we appreciate all the hard work, which does not go unnoticed.

Ed Liddament, Medical Laboratory Area Supervisor	**York**	**Nominated by Biochemistry Biomedical Scientists**

Ed was recently promoted and has made a huge impact to the team - helping improve workflow in the evening when there is reduced staffing and a high workload. He is great leader and is good at motivating the team to ensure the work is processed in a timely manner. Ed always checks in with everyone to make sure his team are happy. He leads by example and always gets stuck in to help the blood sciences laboratories. Ed also has a great relationship with the biomedical scientists and deals with any issues to ensure workflow is maintained.
Ed has a great personality and sense of humour and puts a smile on everyone's face.

Jason Angus, Healthcare Assistant | **York** | **Nominated by Lauren Beeby, relative**

Jason was the wonderful healthcare assistant who went above and beyond just to help my little boy feel a little bit better. His enthusiasm and attention to detail and his overall attitude towards his role on the paediatric emergency department was massively appreciated.

I was aware of him not just helping my child, but hearing his interactions with other children too, and he is just phenomenal in his role.

David Brown, Security Officer | **York** | **Nominated by Karsten Weston, colleague**

Security was called to the emergency department (ED) to deal with two drunk males within the ED reception area. Dave was one of four security personnel that arrived, with me arriving a short time after, as the males were restrained in the corridor.

As Dave detained one male he sustained torn tendons in two fingers, but still managed to keep the male detained until police had arrived to arrest the males for drunk and violent disorder within the hospital grounds.

With the persistence of Dave's determination on keeping the male detained with these injuries, it highlights how far the security team will go to make sure the right course of action is taken, and that safety is a priority.

Julie Southwell, Leah Moorhouse, Lydia Szczerbicki, Eve Turner, Amanda Smith, recruitment | **Trust-wide** | **Nominated by Eleanor Katsarelis, colleague**

I have worked in the recruitment team for just over a year now and I am sadly leaving the team to progress with my career. From the moment I joined I was fully supported and welcomed into the team; the senior team have always been there to support me and the wider team with anything needed. They always make me feel valued and have given me lots of opportunities to develop myself which I am grateful for. Daily I see how much pressure they are under, yet they are always happy to help. They truly are an asset to the Trust. I will miss working with them deeply.

Dr Laboi and Peritoneal Dialysis nursing team | **York** | **Nominated by Sarah Duffy, relative**

The peritoneal dialysis nursing team and Dr Laboi cared for my mum over the last six years of her life.

Their care was always person centred and focussed upon mum's quality of life. Care was not only for mum but extended to my dad's wellbeing, given he was her carer for several years. The team is obviously exceptionally busy but when mum was admitted to hospital pre-Christmas and for the last time, Geraldine, Sara, and Caroline made time to visit her on the ward and to update my dad on her condition when it was difficult to access the ward due to infection. As mum's condition deteriorated Dr Laboi offered to speak with us as a family to go through her treatment path and end of life care, despite having been updated fully by the doctor on the ward. We were happy for Dr Laboi's energies to be directed into treating other patients as well as he had treated mum.

Their efforts and kindness throughout the last six years of mum's life were appreciated and recognised by us all.

Gill Valentine, Sister **York** **Nominated by Dr John Heritage, relative**

My wife was admitted to York Hospital via the emergency department on 12 February. When I left in the early hours, she was due to be treated conservatively and this remained the case when I brought in a bag with her possessions.

However, late on Monday afternoon, she required emergency surgery and was sent to recover in the intensive care unit (ITU). Between leaving the emergency department and arriving at ITU, her possessions had disappeared, despite efforts on the part of the ITU nursing staff to locate them.

Sister Valentine was kind enough to take time to discuss this and broader issues relating to my wife's care. She promised that she would try her hardest to locate the missing items. Furthermore, she explained the likely timescale required to investigate this. She clearly went out of her way to get this matter sorted and she phoned me with the good news that my wife's possessions had been located and returned to her. Since the missing items included the only shoes that fit my wife's feet, due to her lymphedema, the loss of these would have been devastating. Sister Valentine has returned my wife's mobility to her, for which I am very grateful.

Jenny Marsden, Tina Brownwood, Fiona Brown, Tracy Amesbury, Stoma Care nurses **York** **Nominated by Michael Holdsworth, patient**

I cannot thank Jenny, Tina, Fiona, and Tracy enough for all their patience in dealing with my issues.

If it wasn't for them, I don't know where I would be now. They deserve a medal. Thank you from the bottom of my heart.

Christopher Swain, Healthcare Assistant | **Scarborough** | **Nominated by Julie Thompson, relative**

My mother was on chestnut ward for two weeks. This was a hard time for her as she has spent a lot of time in hospital over the last six months.

When she was in this time, I noticed that when Christopher was on a shift he would go above and beyond to make her stay more comfortable. I could see he did this with everyone in his care duties on the bay. This made it easier on the family knowing that she was well looked after.

Nicky Richards, Sister | **Scarborough** | **Nominated by Linda Best, colleague**

Whilst I worked as a domestic on Aspen ward Nicky always went above and beyond to make sure patients and staff were cared for.

Nothing was ever too much trouble. She includes all staff in her team and the care she gives to patients is second to none. Nicky is a true inspiration and a credit to Scarborough hospital.

Radiology Team | **Scarborough** | **Nominated by Linda Best, colleague**

I joined the radiology team in January 2023 and from the moment I walked in they have included me and made me feel like I have always worked there.

It is a pleasure to work within this team.

Daisy Lamb, Healthcare Assistant **York** **Nominated by Gemma Reidford, patient**

Daisy has been the most fantastic healthcare assistant that I have ever met during my transplant journey. Not a single thing was too much trouble for her.

She didn't judge me for anything I said or did or how I acted which is such a rare trait in a lot of nursing staff. She fully went out of her way to ease my anxiousness; she sat with me when I cried in pain and calmed me down and then chased the doctors to sort my medication even though I could see how busy she was. I can honestly say that if Daisy had not been on shift today, I would have had a panic attack and ended up self-discharging, resulting in me being very poorly at home. She didn't stop until she had sorted absolutely everything and came back to check on me every half an hour or so to make sure I was okay.

Daisy, you are fantastic. Thank you from the very bottom of my heart.

Helen Harrison, Haemophilia Specialist Nurse **York** **Nominated by Katy Johns, relative**

Helen provided outstanding care for my daughter when she was admitted to York hospital for surgery.

My daughter was incredibly anxious due to birth trauma and suffering with von willbrands increased her anxiety. Helen ensured that there was a safe plan of care for her, she came to the day unit, liaised with surgical team, and provided reassurance to my daughter. She has provided care for my daughter for many years. She is always compassionate, caring, a patient advocate, efficient, pleasant, and supportive.

Helen always goes above and beyond to ensure patients feel well cared for.

Nerys Pickup, Healthcare Assistant	**Scarborough**	**Nominated by a colleague**

Nerys has exhibited openness, selflessness and compassion when dealing with patients and colleagues. She is outstanding and very thorough in care giving. An exceptional team player.

Natasha Scott, Gynaecology Registrar	**York**	**Nominated by Harriet Williams, patient**

Huge thanks to Dr Scott for her compassion, understanding and sensitivity in dealing with my care last weekend. I've had enough intimate examinations to know that what she provided was really the gold standard of examinations, ensuring I felt respected, comfortable, and most of all, listened to, throughout the procedure. Top marks for an emergency surgery consenting procedure undertaken both efficiently and diligently. A faultless provision of top-quality care delivered with kindness, humanity, humility, and a sense of humour to boot. Really impressive and easily passed the family and friends' test.

David Moate, Senior Medical Engineer	**York**	**Nominated by Stephen Palmer, colleague**

Dave on several occasions has gone out of his way to help teach new and existing staff in other departments about electrical safety. Not only does his deep understanding of the subject show, but he goes the extra mile to create extra learning for the trainees to understand the basic principles and have in-depth discussion with the seniors. He always makes time to teach the technicians with no ask for anything in return. This teaching is invaluable to new and existing technicians within the department that use this information in their day-to-day role ensuring the safety of medical equipment within renal.

Ophthalmology Nursing and Healthcare Assistants team | **York** | **Nominated by Zoe Dunning, colleague**

The whole team of nurses and healthcare assistants in the ophthalmology department have gone above and beyond in supporting the administration team with the mammoth task of reprinting and sending appointment letters out to all our patients for the next two weeks.

Their assistance has been much appreciated and invaluable - thank you so much team!

Dr Arif, Registrar | **Scarborough** | **Nominated by Becky Godding, relative**

Dr Arif makes decisions based on my daughters needs at the time of admission and gets a thorough plan in place and has it started as soon as it is possible.

Dr Arif listened to what has happened for me to bring my daughter to hospital and always asked for my opinion and checks I'm okay with any plans made.

My little girl responds exceptionally well to Dr Arif and he makes me as her mum feel valid in my daughters care and always goes out of his way to either answer or find an answer by speaking to others in the team with any query I may have.

David Sellers, Catering Services Operative | **York** | **Nominated by Christine Shaw, colleague**

I am a healthcare assistant (HCA) on the emergency assessment unit (EAU) and Dave is our regular server in the evening. As EAU is not a regular ward, we do not get individual meal cards for the patients but get a bulk order of food, which can be a lot of work. And as our patient service operative finishes at 5pm it is down to the HCAs to ask the patients what they want from the menu and serve the food. However, we sometimes find ourselves short staffed and running behind and Dave always steps up. Even though it's our job to do these things he never thinks twice about not only doing his job, but often helping with ours as well. He asks the patients; he helps deliver the food and to clear when he sees that there is only one HCA. We never know who will come in at the last minute and he is always helpful getting meals for special dietary requirements at short notice.

He does all of this without grumbling in fact he always has a smile on his face, is always cheerful and is absolutely a pleasure to work with. He is an amazing member of the team who is always willing to go the extra mile for the patients.

Jen Harford, Peter Pavey and Toni Evans, Healthcare Assistants | **Scarborough** | **Nominated by Agi Bustya, colleague**

These healthcare assistants (HCA) are excellent, amazing, and very helpful particularly with assisting the adult RNs to look after the paediatrics patients. When I had shifts in first assessment looking after adults and paediatric patients at the same time, if I was busy, they were caring for the paediatric patients to check their vital signs and if needed escalating the patients, then alerting me and we raised the concerns to the senior doctors. I would like to say a massive thank you to them for all their hard work and the teamwork they carry out in the emergency department. They don't just look after the children, they entertain them, feeding them, playing with them, and supporting the parents. They are brilliant HCAs and bring professionalism and high standards to the department.

Michelle Niazi, Staff Nurse | **York** | **Nominated by a relative**

What an absolute privilege it was for myself and all my family to have Michelle as our nurse the day we all dreaded when my grandad became very unwell and was looked after by Michelle and her colleagues on the intensive care unit (ICU) in York.

I don't know what we would have done without her, she was amazing. She showed empathy and kindness throughout the whole process of looking after him as the patient and us as the family. Thank you again. We need more nurses like you.

James Ferguson, Staff Nurse | **York** | **Nominated by Rachel Walton, relative**

On Saturday night 18 February I arrived at York hospital with my 82-year-old gran. She has fallen and badly broken her elbow, finger and cracked her head open.

I cannot thank James enough. The care he provided to my gran was outstanding. He was kind, caring and extremely patient. He made my gran feel at ease and reassured her she was in very safe hands. He even went the extra mile by helping me safely move my gran into the car as she's totally immobile. What a fantastic member of the York hospital team. Thank you so much we will never forget the help you gave us that night.

Peter Pavey, Healthcare Assistant | **Scarborough** | **Nominated by Terri Rogers, relative**

My son appeared in the emergency department due to a burn and Peter was straight on with what had to be done and made everything calm. He reassured us that everything would be ok and always had a smile. Thank you so much.

Loraine Rankin, Clinical Coordinator	**Community**	**Nominated by Susan Birkitt, colleague**

Since joining the team in October 2022, Loraine has been an asset to the team. She is a great support to the whole team and goes above and beyond in her role to support her colleagues and patients. We just wanted to make Loraine aware of how valuable a job she has been doing to date. Thank you so much Loraine.

Sofia Walker, Staff Nurse	**Community**	**Nominated by Susan Birkitt, colleague**

Since joining the team in October 2022 as a newly qualified nurse (NQN) Sofia has been an asset to the team. Sofia has been keen to learn and goes above and beyond to support both her colleagues and her patients. We just wanted to make Sofia aware of how valuable a job she has been doing to date. Thank you so much Sofia it is pleasure to have you working on the team.

Suzi Greening, Midwife	**Scarborough**	**Nominated by Mary Joy Dizon, patient**

I was pregnant for the first time and had been very anxious about my whole pregnancy journey as I moved to the UK only two years ago and only have my husband and a friend to support me. I have been seeing different midwives every prenatal visit because the midwife I was seeing went on maternity leave. All of them are really kind, but I really appreciate midwife Suzi who took an initiative to handle all my community visits so we can establish rapport and I can have continuity of care.

That simple act of kindness made me feel very at ease and decreased my anxiety and helped me a lot throughout my pregnancy. I had an additional support throughout my whole pregnancy, right until after I had my baby.

Victoria Beattie, Staff Nurse **York** **Nominated by Ashleigh Newsome and Alexandra Burgess, patients**

Nomination 1

I found out I was pregnant and was having a bad time as I had been bleeding for over two weeks and I knew something was wrong. I went for a scan on my own and Vicki was amazing she talked me through every step and made me feel at ease. I then had to return in two days for more bloods and to find out if I was 100% miscarrying. I told her I was bleeding more and she got a doctor to see me straight away and she stayed by my side while I had an examination by the doctor. She kept reassuring and checking I was ok. Vicki did everything and more for me while waiting for the results.

Unfortunately, my results came back as a miscarriage and being there by myself I felt so supported whilst being told the worst news I could've expected, Vicki made me feel like I wasn't alone. I couldn't have got through it without her. She is a brilliant nurse.

Nomination 2

I came into hospital distraught as I was suffering bleeding whilst only 11 weeks pregnant. Vicki showed me so much compassion and understanding and went out of her way to get me a scan that day understanding I was too upset to wait. She constantly checked with us whilst we waited and was just so kind. The sonographer was lovely and helped Vicki make sure I got a scan. Without this help I would have struggled with waiting and not knowing due to the chronic anxiety disorder I have. When we found out the baby was okay Vicki gave me the biggest hug and was genuinely delighted and pleased for us. She truly defines what it is to be a nurse.

I cannot thank her enough for helping us.

Innocent Danat, Staff Nurse | **Scarborough** | **Nominated by a colleague**

He uses every opportunity available to teach and guide staff to promote excellence at work. He shows so much compassion and kindness, and he does this willingly and is ready to help. He goes the extra mile to care for patients even staying back after the end of a shift regardless of what time it is and is very hardworking. He is so knowledgeable that he anticipates deterioration in patients and aims to prevent it. He does not discriminate and carries the team along. Always ready to listen to the patients and their relatives.

Tracy Keytor, Ward Clerk | **York** | **Nominated by Rose Eyes, colleague**

Tracy passed on information to the nurses to ensure a family were able to visit their loved one before they passed away. Without her, the family would not have visited and got to say goodbye. She went over and above her duties to make sure the family were informed correctly and very much deserves a star award.

Rajinder Dhaliwal, Junior Doctor | **Scarborough** | **Nominated by Lisa Metcalfe, patient**

After presenting to a pharmacy for advice I was advised to call into the walk-in clinic at Scarborough hospital, a service I didn't know existed! I knew I didn't want to clog up the emergency department as my symptoms weren't an emergency. It seemed reasonably quiet when I arrived but this aside, I was seen very swiftly by a lovely triage nurse who was efficient, friendly, and keen to help. I was then called for by Dr Rajinder Dhaliwal who gave my symptoms so much thought and attention. He went above and beyond to try and find the best way to diagnose, treat and advise. So many people only think to comment on the negative experiences they have in life. I'm here to say thank you for the positives. Two dedicated members of Scarborough hospital who did a marvellous job for a 'walk in'.

Max Cameron, Cardiology Registrar | **Scarborough** | **Nominated by Sarah Moss, colleague**

There was a patient on the respiratory ward who needed an emergency chest drain out of hours. Max went completely out of his way, despite not being on call himself, and stayed to help organise this. Max offering to stay behind meant the patient received their treatment in a timely fashion and ensured he was safe overnight. Max showed a great dedication towards patient care and is a fantastic example of our Trust values put into practice.

On behalf of the patient and the respiratory team thank you very much Max, your help was very much appreciated!

Sherrie France, Healthcare Assistant | **Scarborough** | **Nominated by a colleague**

I recently had a bank shift on Chestnut ward. All the staff were lovely but Sherrie went out of her way to show me round, and ensure I was welcomed by the team. She is a kind and caring healthcare assistant who kept spirits high when we were very short staffed. Thank you for a lovely shift.

Emma Barber, Healthcare Assistant | **Scarborough** | **Nominated by a colleague**

I would like to nominate Emma for a star award for her kindness and support of a young person and parent who were recently on Rainbow ward for almost a month. The patient and parent have spent a lot of time on Rainbow ward and all the nursing staff have developed really good relationships with the patient and family. However, weeks and weeks of being resident on the ward was really starting to take its toll on this parent's wellbeing. The patient mentioned has complex needs and limited ability to communicate meaning the parent does not ever leave them alone. Emma volunteered to come in on her day off to support the young person and provide 1:1 care for a full 24 hours, including staying overnight, so the parent was able to have a break with some time at home with their other child and partner. This time made such a big difference to the parent and family and shows the trust and faith the parent had in Emma to properly care for her child in her absence.

Laura Taylor, Healthcare Assistant | **Scarborough** | **Nominated by a visitor**

Laura is deserving of a star for a variety of reasons. Going above and beyond for every patient, as well as always remaining kind, caring, and compassionate. Laura works brilliantly within the team on the ward, and she always manages to jazz up everyone's day.

Chloe Wilson, Healthcare Assistant | **Scarborough** | **Nominated by a colleague**

Chloe is always such a happy person no matter what the shift throws at her. She is hard working and she is always willing to help throughout the ward and keeps moral high.

Dr Sleeba Jacob, Consultant | **Bridlington** | **Nominated by Rich Marwood, patient**

Just to say I had a telephone consultation with Doctor Jacob who I found to be compassionate and courteous and with a genuine professional urge to help me. I now have some hope. Thank you, top man.

Layla Everard, Midwife | **York** | **Nominated by Kiera Goodall, patient**

Layla was my midwife and everything went well during my pregnancy, Layla was always calm and professional. It was after my daughter Isla was born when we realised how special Layla was as she stepped up. I went through a very difficult time breast feeding and it was four weeks before Isla regained her birthweight. I would have given up if it wasn't for the amazing support from Layla. She kept in touch offering advice and emotional support. My family and I were truly touched and hope that she receives the recognition she deserves.

Mohamed Yassin Ahmed, Junior Doctor | **York** | **Nominated by Jacqueline Tang, colleague**

Yassin is always reliable, efficient, polite, and responsible. The thing that really touched the team was that he always went above and beyond without any complaints. His working ethos is excellent and patient centred.

There was a case, that the patient an asylum seeker presented in labour and couldn't speak any English. Yassin stayed well beyond his working hours to help with the translation and communicate between the couple and the team on call. He has also used his expertise to put the couple at ease. Our team was well communicated with through Yassin and this enabled us to deliver the care the couple needed safely and efficiently. It is not often trainees are recognized when they went above and beyond. This is only one of many examples that Yassin has positively contributed to the department.

Yassin's hard work deserved to be recognized.

Roberto Fanti, Occupational Health Advisor | **York** | **Nominated by Karen Percival, colleague**

The system for retaining staff health and employment records is changing from Cohort to Cority. This system is totally alien to what we have used in the past and Roberto who is a trained nurse, has taken this project on as he has brilliant IT skills in not only setting up how the website looks, but also in the more user-friendly aspects for us who are not so tech savvy.

He has headed teaching sessions not only for us in occupational health but also HR and recruitment and has been able to iron out all the issues presented by each department. We have all turned to Roberto over the last few weeks to guide us and he does this without complaint. Even though Roberto has this knowledge it is and has been totally out of his comfort zone and we are all forever grateful for him working on this project.

Jo Blades, Learning Disability Liaison Nurse	**Scarborough**	**Nominated by Georgina Cherry, colleague**

Thank you to Jo for all her support and training me up for my position as the new learning disability nurse for York hospital. I have learnt a great deal from her and have gained a huge amount of knowledge in this field of nursing, which was all brand new to me. The support is really appreciated and Jo continues to support me every day - she is always at hand over the phone and encouraging me. No question is too silly and no task too much!

Really excited for our plans for the service and I couldn't ask to work with anyone better. Thank you!

Diabetic Inpatient Specialist Nursing Team	**York and Scarborough**	**Nominated by Charlotte Brown, colleague**

Tricia, Catherine, Sarah, and the rest of our amazing diabetic nursing team support not only our ward, but all inpatient areas within the York and Scarborough hospitals. Without them we would not be able to prevent admission within the emergency department and nor would we be able to safely support and manage all our inpatient patients with the diabetic care. They go above and beyond to support ward nurses especially with providing around the clock advice, prevention of poor medical management and optimisation of diabetic care.

As one ward alone I do not feel the team get the recognition for the amazing job they do. Thank you from Ward 11 and the surrounding inpatient units.

Toni Hugill, Ward Clerk | Scarborough | Nominated by colleagues

Nomination 1

Toni is extremely helpful - when coming to medical records, she will collect and deliver post to us and always rings the bell to the department to see if there is anything that she can take back with her to the other side of the hospital. She always cheerful and helpful to both staff and visitors with a smile on her face.

Nomination 2

Toni is a wonderful person and nothing is too much trouble for her. For instance, if medical records have notes for the other side of Scarborough hospital she always asks if we have anything to take. This can be as much as three or four times a day on her travels. This is not just one department that she takes notes to it can be quite a few.

I feel that Toni should be recognised for going over and above her role as a ward clerk. Toni is always smiling and will go to the post room to bring the post for us as well. Her demeanour is always pleasant and is an asset to the NHS for all the help she gives to everyone without her thinking she has done anything special.

Endoscopy Team | York | Nominated by Amy Hesp, a patient

I have attended the endoscopy department at York hospital many times due to having inflammatory bowel disease (IBD) for nearly 20 yrs. During my recent visit the team were, as always incredible. They are kind, supportive and really go out of their way to make sure your experience is a positive as it can be. They really are all wonderful.

Claire McKee, Administration Team Lead and Clinic Co-Ordinator

York

Nominated by Admin Reception Team Lisa, Karen, Emma and Rachel, colleagues

Claire joined a disjointed team who were also fairly new recruits themselves. We had new team leaders in quick succession and little or no official training on our own workloads with training done in-house. We have always been a happy close team, but moral was low and the workload disjointed, huge and behind. Claire came along and immediately the team seemed to start to blend. Our worries about workload, no confidence in the system in place and training was heard and weekly staff chats were implemented. Claire gave us individual mentoring on things we felt we were lacking. This meant that she had to learn CPD fast and she did. Claire saw where the office paperwork and policies surrounding booking in were lacking and unnecessary and changed them to make them user friendly and streamlined. Within weeks we felt like we were making a chink in the backlog of work. We have had many changes recently and Claire has always told us not to worry and she is such a fabulous team leader that staff changes have been seamless. Recently a staff member left abruptly and Claire took it in her stride to learn all about the education side of diabetes so she could order lifesaving pumps and organise lifesaving sessions and education for our patients. It is a massive task she has essentially taught herself while still doing her job, recruiting for the education/pump post, and supporting us in ours. We all feel that we can go to Claire with anything. She is compassionate and a fantastic friend and a boss we all admire and respect.

Her job is far from easy and we know it comes with massive stress factors, but she never lets that get in the way of supporting us. The nurses often come to us and say what a fabulous team we are. Happy, approachable and the best team they have had. Claire also supports us out of work by setting up a message group for support when we need it. Claire is the glue that holds us together. She makes a real difference every day at work. She is the embodiment of all the values the hospital holds and deserves recognition.

Doreen Hartley, Volunteer | **Harrogate** | **Nominated by Christine Brindley, colleague**

Doreen is a volunteer in our department who supports us three and a half days a week. The most amazing thing about Doreen is that she has just celebrated her 90th birthday and shows no signs of slowing down.

Despite not being a paid member of staff Doreen has a fantastic work ethic and takes her role very seriously. We have had some severe administration shortages in the last few months and Doreen has been instrumental in supporting us. She is placed on our reception desk and deals with patients attending for appointments and triages drop ins, allowing our team to get on with their work with less interruptions. Doreen supplies us with biscuits and a ready smile when we are working under pressure. She has fantastic interpersonal skills and our patients respond very positively to her.

The whole team love Doreen to bits and feel that she needs some recognition for her amazing contribution to our service.

Ward 15 Team | **York** | **Nominated by Sue Elderton, colleague**

Ward 15 recently had a patient that has been with them for over 100 days. This lovely lady with learning difficulties has presented the staff with numerous new challenges of which the ward had little specialist experience.

However, the ward 15 team took this special lady into their fold, learned about all her little needs and ways and the patient became part of the family. She was treated with the kindest and most caring compassion, washing her clothes, providing her favourite sweet treats, and even waving her off to her new home with a teddy bear gifted by staff.

As Matron I am so proud of my team, and all others who had such massive involvement in her stay, including their determination to find the best forever home for her.

Phil Michulitis, Capital Planning Project Manager | **Scarborough** | **Nominated by David Thomas, colleague**

As the project manager within the Scarborough capital planning team, Phil has led on delivering a highly complex project for care group two to expand the location of our same day emergency care (SDEC) service. While this sounds straightforward, it has been anything but. The space identified was already occupied so three-way move was required and involved re-purposing the locations, all of which were in varying degrees of physical condition.

Using his extensive skills and experience Phil drew up plans for each of the spaces maximizing the money available. This has not been easy as the three locations have required significant adaptations to accommodate the new teams, in particular the new clinical space for SDEC which was in a state of major disrepair and has required significant modernization. But, in going the extra mile, Phil has repeatedly reached out to the teams concerned, sitting down with them to go through the plans, listening to their needs and concerns and altering plans accordingly, whilst remaining within budget.

Going even further, Phil recognized the need for additional equipment storage to support these re-locations and came up with a genuinely innovative and cheap solution to provide storage cupboards meaning that the new accommodation will not be cluttered with equipment; the storage cupboards display a level of ingenuity and lateral thinking that means we get value for money out of every single pound spent.

The impact of Phil's efforts means we will be able to treat an additional 20 patients per day in SDEC which will help to decompress the emergency department.

Phil is an absolute pleasure to work with. He operates at a pace that is in tandem with the needs of the acute and emergency service and he never fails to deliver. This unsung hero is hugely worthy of a star award.

South District Nursing Team	**Community**	**Nominated by Rebecca Bradley, colleague**

I would like to nominate the south district nursing team for a star award following some recent feedback received from a relative of a patient the team had cared for.
The team received a thank you card from the relative who wanted to express sincere gratitude to all the team who looked after her husband. With a special mention to Scott who was so kind, caring and compassionate and offered gentle encouragement to help and support the patient. Having been previously unaware of the service provided in the community until it was needed, the patient experienced exceptional care and the relative cannot praise the team highly enough.

Dominque Phillips, Service Manager	**York**	**Nominated by Gill Ratcliffe, colleague**

What a helpful lady she has given me so much support when I first started my project, absolute star.

Christopher Pilson, Service Improvement Facilitator	**York**	**Nominated by Gill Ratcliffe, colleague**

What an amazing guy another great help with my project.

Helen Ketcher,	**York**	**Nominated by Gill Ratcliffe, colleague**

Another great help when I started this project supporting me in some difficult times.

Amy Meek, Generic Therapy Assistant | **Community** | **Nominated by Stuart Goodall, colleague**

We are incredibly fortunate in the York community therapy team to have excellent therapy assistants who support us in our day-to-day work. Without their support, our work would be severely compromised. Amy epitomises this in her deeds and actions daily.

For example, Amy has been delivering face to face rehab with a dementia patient recently referred to our team due to the level of deconditioning involved. When I spoke to the patient's wife, she was effusive in her praise for Amy. She stated how kind, diligent and patient Amy had been and how well the patient responded to her. Thanks to Amy's input, including her support and guidance with the patient's wife, the patient has gone from being largely bed bound to mobilising short distances with a frame and being able to sit out in his riser/recliner chair. Amy is a wonderful ambassador not just for our team but the wider Trust. She is an incredibly valuable and valued member of our team.

Lynie Balicao, Staff Nurse | **Scarborough** | **Nominated by Linda Staves, patient**

Lynie was exceptional at managing the busy emergency department, maintaining her positive energy to the end of her 12-hour shift. She was very kind, and observant of everyone's needs.

I was reduced to tears after I became overwhelmed with pain. I already deal with osteoarthritis, back and fibromyalgia pain - so the addition of a fractured ankle was too much. She sympathised with me understanding there were no beds, despite being promised, and painkillers had no effects. So, she came up with pulling a chair opposite to stretch my hips and knees, which relieved the pain of sitting in a chair for hours. She brought blankets, and looked for a pillow, but none were available. Lynie made me laugh despite my misery and exhaustion, so she is extra special.

Ebony Carlton, Children's Occupational Therapist | **York** | **Nominated by Ceiri Morgan, Colleague**

Ebony started with our team in August last year, and in only six months she has thrived and has truly settled into the role. As a new starter Ebony was nervous, but excited, to start in our specialist area, and she has really proved herself as a confident and competent therapist. Ebony has impressed us with her flexibility, her willingness to learn and her motivation to challenge herself and work out of her comfort zone to develop herself both professionally and personally. She is never shy to ask for help when she needs it and is always the first to offer help if someone else needs it. Since starting with us, Ebony has played a vital role in reducing our waiting list, and her verbal and written communication skills are fantastic. She has already forged excellent working relationships with our team and wider team and is brilliant with the children she works with. When she has had a tough day, she is positive and finds something to smile about. Ebony has absolutely embraced her new job and we are so happy to have her on the team.

Kirsty Catterson, Domestic Assistant | **York** | **Nominated by Jade Waudby, colleague**

Kirsty is the one face that is guaranteed to bring a smile to your face when you walk on shift. She always greets you with a lovely warm smile and genuinely cares about her team members.

Kirsty goes above and beyond to help everyone on the ward, she is a real team member and is willing to help in any way she can. She has worked on the ward during some busy shifts and when there's rooms to be done, no matter how many, she is straight on the case to help ease the pressure on the ward.

I wanted Kirsty to know that I appreciate it when she's there to listen to our daily moans, welcomes with a cup of tea and a huge smile.

ICU Team | **York** | **Nominated by Alexandra Damazler, colleague**

The medical and nursing staff from the intensive care unit (ICU) cared for a teenage paediatric patient who was extremely unwell in resus on night of 5 March. He required intensive management and the ICU team attended resus and were extremely helpful, friendly, and supportive. They then went out of their way to ensure the patient continued to receive the best possible care, including tracking down rarely used medications and fluids, and admitting him to adult ICU, all without argument and with a smile, to manage his ongoing care needs overnight.

Without this the patient would have required transfer out of the Trust, potentially hundreds of miles away - putting his physical and mental health further at risk. The team went out of their way to make the experience as smooth as possible for the patient and his family, and to support the paediatric team in his management.

Diane Schofield, Support Team Coordinator and Lindsay Brooks, Staff Nurse | **York** | **Nominated by Julia Precious, colleague**

I recently won an award from North Yorkshire safeguarding partnership to say thank you for a contribution in line with NYSCP's 'Being Young' in North Yorkshire Strategy, for work that work underpins their vision that all children and young people are safe, happy, healthy, and able to achieve in North Yorkshire.

I would like my colleagues to be recognised too because it is due to a team effort, and a lot of hard work by all that this recognition has been achieved. This showcases the great work undertaken by the specialist clinical outreach team based in sexual heath.

Ellie Brook, Staff Nurse and Antonia Lee, Healthcare Assistant	**Scarborough**	**Nominated by Emma Pemma, colleague**

Ellie and Antonia showed enormous courage and bravery during an unexpected medical emergency. They remained calm in a scary situation while maintaining a professional manner. The pair continued to look after their patients with full respect and in a professional manner even after experiencing a huge shock.

Grace Penn-Timity, Staff Nurse	**York**	**Nominated by Rachael Poole, relative**

Unfortunately, I had to take my father to the emergency department at the end of January with heart trouble. It was a very long night, but we were moved through from the initial waiting area to another waiting area after several hours. The room was almost full - being Friday night there was the usual array of challenges and 'interesting customers'.

Soon after we arrived, Grace came to the front of the room and in a very clear and compassionate way, let everybody know that there was a wait, all the staff were doing their best and the order in which things would happen. She then let people know where to sit depending on whether they were going to a ward and called people by name who needed to go elsewhere. She let everyone know there was water and snacks available to anyone who needed it. Eventually we were part of a small group needing to go elsewhere and Grace was kind, caring, and with a sense of humour in taking us to the new location and performing a handover with the team there.

Even in a very busy, very stressful department approaching midnight, she went out of her way to give everyone a personal service, whilst making sure to keep the whole room informed, in a positive and efficient manner.

Thank you so much Grace, you are amazing.

Sam Calpin, Waiting List Coordinator **York** **Nominated by Amy Hesp, patient**

Without Sam I would not have been able to have my colonoscopy. I have two small children at home that I look after so having a colonoscopy takes a lot of planning. Sam went out of his way to really listen to my problems and help in any way he could. Initially I was told I had to be at the department for 08:00 or 13:00 as I was classed as high risk of covid and needed to be first on the list. Once I explained to Sam that I was not as high risk as the computer or the policy he worked from claimed and that this would mean I wouldn't be able to have a colonoscopy, he spoke with various members of his team, rung me back and managed to fit me in at a time that suited and I could work it around my mum duties at home. Sam, you are wonderful and your patient/customer care is incredible and you should be rewarded for going the extra mile.

Jay Amin, Healthcare Assistant **York** **Nominated by Amanda Marshall and Christina Sloper, colleagues**

Jay was so helpful and polite in assisting us to check the patient's skin and assisting him into bed. Nothing was too much trouble for him even though he was extremely busy with his own jobs. They are very lucky to have this young man on their ward as he went above and beyond his role to assist us in our job on the transfer team.

Aly Harrop, Bed Manager **Scarborough** **Nominated by a colleague**

Aly came into be matron of the day, and the oncoming bed manager was unwell. Aly insisted the night bed manager go home and then did both matron and bed manager roles until someone else was able to come in and take over the bed manager role. Helping to keep the service running.

Ann Ward, Medical Secretary | **York** | **Nominated by Andrea Ward, colleague**

Recently one of our patients who is undergoing treatment for breast cancer contacted Ann regarding her appointments. This patient had been subjected to severe trauma earlier in her life and has been left with PTSD. Undergoing cancer treatment and everything associated with it is even more difficult for her and it is essential to take time with all communications with her.

The patient phoned Ann regarding an appointment and was extremely distressed. Ann coped fantastically with this consultation, giving her time to talk, and supporting her so well that she felt able to share all her trauma with Ann and felt very supported and cared for by her. I think this is fantastic and want Ann to be recognised for making the time in a very busy day and for being perceptive enough to deal with this so brilliantly.

Paulina Lawniczak, Chemotherapy Nurse | **York** | **Nominated by Sally Vaughan, colleague**

Paulina took part in the NHS Elect facilitated happier working lives programme alongside colleagues from her clinical service. Paulina took a lead in attending the sessions and coordinating the activity that her team undertook as part of the programme. Paulina's smile and engagement really stood out to the NHS Elect team who were impressed with her ideas and drive to get actions completed. Paulina presented the journey her and her team went on as part of the programme to colleagues from NHS Elect and York at the final session of happier working lives.

This wasn't something Paulina had much experience of previously, however her enthusiasm and attention to detail were praised by everyone. Paulina's dedication to the programme and its ethos are to be celebrated. Paulina worked exceptionally hard and I know her team are grateful to her for her energy and commitment to supporting them to have happier working lives.

Kerell Jolly, Scrub Practitioner Nurse | **York** | **Nominated by Sally Vaughan, colleague**

Kerell took part in the NHS Elect facilitated happier working lives programme with colleagues from across maternity and theatres. Kerell took a lead role in attending the sessions and driving the programme forwards on behalf of her team. Her enthusiasm and engagement in the sessions really stood out to the NHS Elect team, who were impressed with her dedication to ensuring everyone enjoyed their working day!

Kerell produced a brilliant infographic of her team's journey which she presented to colleagues from York and NHS Elect at the final happier working lives session. Kerell is an exceptional member of staff who I would be proud to have working within my team or organisation. Even when things were challenging, she continued to work hard and always shared with us her wonderful personality and fantastic smile. It is obvious to me that Kerell deeply cares about her job, her patients and her colleagues and I would like her to receive a star award to celebrate how valuable her input into this programme and to her wider role has been.

Nicola Allan, Urology Practitioner Nurse | **York** | **Nominated by Sarah Hillery, colleague**

Nicola was first on the scene of a serious road traffic collision. We received a compliment from the paramedic who attended describing Nicola's quick-thinking and bravery.

She provided medical care and support to two injured persons, one of whom had potentially life-threatening major trauma, remained at the scene for a long period of time after the incident assisting the police with their investigation, offered shelter and a lift home to a victim whose car had been written off in the crash. The paramedic stated that 'she did an excellent job and positively contributed to patient care and scene management'.

Leanne Allan, Outreach Nurse | **Scarborough** | **Nominated by a colleague**

A colleague had a cardiac arrest on a ward, an extremely challenging and difficult situation. Leanne was soon to arrive and took control, leading the arrest in an exemplary way. Her professionalism, and ability to get the team to work together is inspirational. I will certainly be learning from Leanne's leadership and clinical skills and applying them to my own practice. Amongst all that had happened she was able to demonstrate compassion towards the staff that were dealing with an extremely emotional situation of seeing a colleague have a cardiac arrest and have CPR performed on them.

Beth Greaves, International Recruitment Advisor | **York** | **Nominated by Donna Walker, colleague**

I have nominated Beth for a star award for her high-level support for the international nurses from upon arrival into the UK to helping with their search for a new home. The level of support that Beth shows each nurse is outstanding with not only the team fully appreciating her support, the nurses are also often feeding back to me their own appreciation towards Beth. Beth very often works over and above her role including keeping in contact with nurses who are struggling outside of her working hours. One example is that Beth changed her own plans to support a nurse with a house viewing on a weekend and drove to Scarborough for the viewing alongside the nurse. I know that every nurse would agree with me that Beth deserves the recognition for her outstanding and continuous support. Beth truly lives and breathes the Trust values.

Nina Wilson, ID and Car Parking Admin Assistant | **Scarborough** | **Nominated by a colleague**

I would like to nominate Nina as she is very kind and always helps and supports everyone she comes into contact within the hospital, she always gives 100 percent.