

# Operational Plan

2016/17

V0.05



## **Approach to Activity Planning**

### **Demand & Capacity**

Directorates have been involved in robust elective care demand and capacity modelling work using the Interim Management and Support (IMAS) tool (over the last 12 months). This work has now been undertaken at specialty level and includes monitoring of outturn, growth, activity profiles and case mix. This will enable the Trust to model capacity required to support current demand, forecast growth and determine additional activity to ensure high confidence in meeting the elective care standard. This model has been shared with Clinical Commissioning Group (CCG's) and there is high confidence levels regarding its application.

Modelling continues in outpatient services regarding advice and guidance and new to follow up ratios. This is through redesign and focus on delivery of clinical review, through alternative models, which potentially could reduce the number of face to face contacts releasing additional capacity.

Whilst a specific demand and capacity tool has not yet been agreed with commissioners for emergency activity, the organisation has a wealth of high quality information and intelligence on demand, flow and variation. Once clinical models have been developed and agreed, this can soon be applied to our clinical information systems to establish agreed activity profiles for 2016/17.

The Trust's recovery plan, in responding to and enabling appropriate access for emergency care, is focusing on alternative models of care that can respond to increasing demand and variation in attendance levels. Examples of this work include ambulatory care models, access to acute assessment areas in both medicine and surgery, primary care interface at the front door, discharge to assess and an increased ability to transfer to step down and intermediate care beds within the community.

Risks around recruitment and retention of workforce remain; however, the Trust is heavily engaged in workforce planning in relation to specialty specific models being explored together with other initiatives centred around recruitment, retention and role adaptation including work on creating enhanced roles for bands 1 to 4 and advanced clinical practitioners.

### **Planning Assumptions**

The specialty level demand and capacity data collated has been profiled and shared, at a high level, on the Unify template. Elective activity for 2016/17 has been profiled together with growth and a clear understanding of avoiding backlog, to secure robust arrangements going forward. Risks remain around increased acute admissions, which result in reduced elective capacity together with capacity constraints in other parts of the wider system and prevents timely discharge of patients. Delayed discharges is a System Resilience Group priority and patients are being offered transfer to Bridlington

for treatment with a limited number being treated through private capacity or waiting list initiatives in order to boost elective capacity.

Activity profiles for urgent care require further and continued modelling as new patient pathways and delivery of care evolve.

## **Planning**

Developing demand and capacity plans for elective activity will require support and continued partnership working arrangements with the independent sector particularly around challenged specialties such as orthopaedics and ophthalmology. However, in order to support delivery one of the key objectives is to work towards the separation of elective and emergency care work.

The Trust is committed to investing in Bridlington Hospital to create a surgical centre of excellence, which builds on work already undertaken by moving elective orthopaedics to Bridlington, in order to protect the capacity at Scarborough. The Trust is also working with commissioners to redesign emergency care at Scarborough in particular on senior assessment and ambulatory care.

An application has been made to NHS England to develop a new model of acute and emergency care at Scarborough Hospital, and the Trust has recently been notified that the application has been successful. This means that the Trust will be part of a new national programme of work, focussed on developing sustainable models of acute care in small rural hospitals. The model has been designed to address the number of transfers between different wards, delays to admission from the Emergency Department and a reduction in the number of multiple assessments. The focus will be on a single streaming and assessment process and all patients will be deemed ambulatory unless a senior decision maker decides to admit. A key feature will be the use of an innovative multidisciplinary workforce of advanced clinical practitioners, Band 4 non-registered practitioners and a combined General Practitioner/Acute Clinician role.

The Trust is in the process of developing a Urology One-stop Service. The building work for this development has started and should be finished in October/November 2016. The service will be provided at Malton Hospital and take all new adult referrals from Bridlington, Scarborough and York and will deliver diagnostics (x-ray, ultrasound, flexible cystoscopy, urodynamics and trust biopsies) as well as clinical review. The aim is to centralise this work to ensure patients are seen quickly, save on multiple attendances and are either discharged home or have a plan for surgical intervention back at the hospitals in Bridlington, Scarborough or York.

## **Key Operational Standards**

The Trust can confirm that the activity planning undertaken will ensure that the Referral to Treatment Incomplete standard is maintained as well as internal cancer standard delivery (with the exception of 62 days first treatment) and diagnostic waiting times.

As highlighted in the Targets and Indicators section of the Monitor Annual Plan, the Trust has declared a risk regarding the delivery of the 62 day cancer standard. This risk is threefold; capacity in tertiary centres, internal pathways which require remodelling and delivery of the standard for cancers that interact with more than one tumour site. Whilst the Trust has declared a risk to delivery, it has proposed an 85% (compliant) trajectory from Q1.

Delivery of the Emergency Care Standard (ECS) remains a key priority for the Trust. Workforce shortages, increased attendances and admissions all remain risks to delivery. The Trust is working closely with local CCGs to implement and embed mitigating actions. These include; Ambulatory Care models, restructured 'Front Door' models, workforce skill mix reviews and improved working relationships with Urgent Care Centres (UCCs). Winter planning will be undertaken from Q2 16/17 and this will include flexible escalation beds, scaling back elective work and utilising surgical wards for medical patients; all similar to changes implemented as part of the 15/16 Winter Plan.

Activity will be monitored closely through the Contract Management Boards, where remedial actions for managing unplanned changes in demand will be agreed.

## **Approach to Quality Planning**

### **Quality & Safety**

The Care Quality Commission (CQC) reviewed the Trust's services in March 2015. The context to this review included the recent integration of two community services (Scarborough, Ryedale & Whitby and York & Selby) plus the integration of the former Scarborough and North East Yorkshire Healthcare NHS Trust. All these services had financial, operational, quality and safety performance issues.

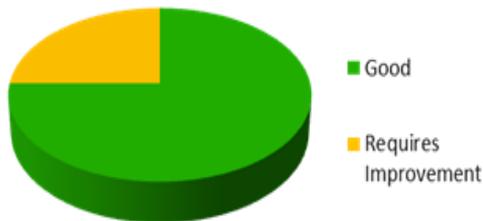
Notwithstanding this context the CQC commented that:

- The Trust was caring and compassionate
- Patients are treated with dignity and respect
- The Trust is committed to best treatment with best outcomes
- The Trust was open and honest

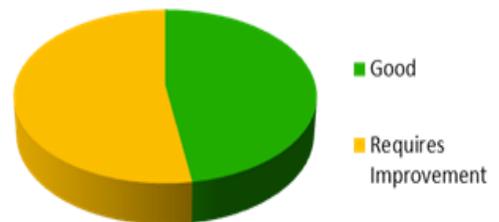
The report went on to comment on many examples of innovation and in particular excellence in End of Life Care. The CQC praised Community Services and the Community Hub developments and commented on the Trust's positive approach to partnership working and clinical alliances.

A summary of the CQC assessment for each of the Trust's main sites and Community Services and each of the CQC domains is provided below.

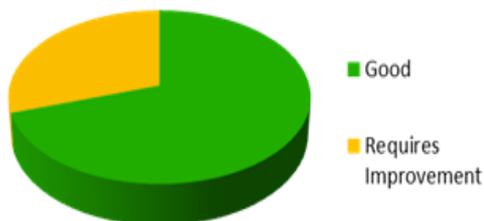
York Hospital



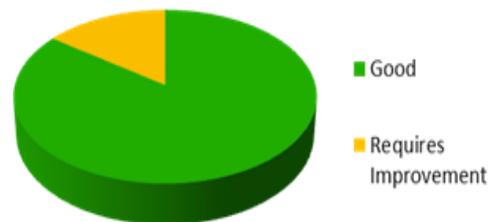
Scarborough Hospital



Bridlington Hospital



Community



The CQC gave an overall Trust rating of “requires improvement” this was largely influenced by shortages in nurse staffing resulting in an over reliance on agency staff and the on-going difficulties with meeting the emergency care standard that have been acknowledged as a whole system issue.

There were a small number of other key improvement themes including uptake of statutory and mandatory training and performance against key national targets. An improvement action plan has been developed, implemented and is monitored regularly by the Board sub-committees and Board of Directors.

**Quality Improvement Governance Systems**

This year a detailed and planned approach to quality planning has been undertaken and a timetable that includes plans for consultation with key

stakeholders, both internal and external has been agreed by the Board of Directors.

A steering group, led by the Chief Nurse working with the Foundation Trust Secretary and leads from Patient Safety, Patient Experience and Healthcare Governance have led consultation exercises to agree organisational priorities with agreed timeframes. These have also taken into account actions from the CQC inspection from March 2015 and risks to quality and safety as well as aspirational developments for quality development and improvement.

Executive Lead: Beverley Geary, Chief Nurse

## **Quality and Safety Priorities for 2016/17**

### Patient Safety

Reduce avoidable mortality - by the End of March 2017, we will ensure that:

- Ensuring that all patients admitted urgently to our acute hospitals have a review by a medical consultant within 14 hours of admission
- Promoting screening for severe sepsis and early intervention of Sepsis 6 throughout our hospitals (national CQUIN)
- Revision and enhancement of our approach to mortality review by ensuring that in all cases of death in hospital a mortality review is completed that where the death is identified as avoidable an independent case note review is undertaken.

Reducing harm to patients - by the End of March 2017, we will ensure that:

- Reduce the number of patients who experience serious harm from falls and pressure ulcers by 10%.
- Increase the overall number of incidents reported by 10% when compared with the number reported in 2015/16.

### Clinical Effectiveness and Outcomes

Monitoring critical medicines and antimicrobials - by the End of March 2017, we will ensure that:

- Ensure effective care for patients receiving insulin and those in need of capillary blood glucose monitoring (local CQUIN).
- Implement a system of electronic prescribing and medicines administration.

Reduce hospital associated infections of C. diff, MRSA bacteraemia and MSSA by - by the End of March 2017, we will ensure that:

- Ensuring safe prescribing and monitoring of antibiotics (national CQUIN)
- Improving management of short-term use of urethral catheters for patients in acute medicine (local CQUIN).

### Patient Experience

Volunteering - by the End of March 2017, we will ensure that:

- Volunteers already make an important contribution to the experience of patients, carers and visitors to the hospital. We will develop and grow this contribution through:
  - Increasing the number of active, registered volunteers in the Trust by 25%
  - Ensuring our volunteers are best supported by reviewing and strengthening the Trust's approach to induction, supervision and training.

### Learning from Complaints

- Our Patient Experience Strategy is to listen, report and respond and learn. To provide assurance that we are completing this cycle and delivering improvements from feedback we will pilot and evaluate a system for case file audit for complaints. A sample of closed cases will be audited for:
  - Compliance with Trust policy and best practice for case handling
  - Evidence that lessons learned have been completed.

### Friends and Family Test

- Across the Trust the Friends and Family Test will achieve a 90%+ score for patients reporting they would recommend the Trust to their Friends and Family if they needed similar care or treatment.
- The Trust will achieve an average response rate of at least 20% for inpatient and maternity and to increase this to 25% by year end. To achieve an average response rate of at least 15% for the emergency department.

### End of Life Care

We will also re-launch PALS with new information for patients, carers and staff about the support it provides and a more visible presence in our hospitals.

- Enhance our partnership working with paediatric services and mental health agencies, with a focus on adolescents we will develop shared

pathways of care for those patients at risk of suicide who need acute hospital care.

A revised patient experience strategy setting out the priorities for the next 3 years has been approved by the Board of Directors. Initiatives' including increased collaboration with patients and families', the development of a volunteer strategy and working with individual directorates to provide local information reports to improve the patient experience will be monitored by the Patient Experience Steering Group.

### **Top Three Risks to Quality**

**Increased acute admissions** – Increased acuity of patients in the Emergency Departments and increased acute admissions prevents the timely transfer of patients. The complex needs of patients awaiting discharge, who are medically fit for discharge, delays rapid availability of acute beds. Our plans to reduce risk include working with our local commissioners and partner organisations on admission prevention, a discharge to assess model and improved discharge planning for those patients with complex needs. Across the Trust we will focus on early senior clinical review of patients.

**Inability to recruit medical and nursing staff resulting in significant increase in agency and locum spend** – the Trust continues to make progress in relation to reducing nursing agency spend (July 15 - £1.5m, Sept 15 - £1m, Jan 16 - £0.5m) and will continue to pursue further reductions over time. Whilst recruitment remains challenging, a number of successful local and European recruitment campaigns were undertaken at the end of last year. Newly qualified RNs are currently in an extended preceptorship period and those RNs appointed last October are now within the budgeted establishment. A blended approach has been used with the European recruitment and appointees are coming through as and when their PIN numbers are received.

The European campaign continues and new staff are being appointed. In addition, the Trust is currently working with educational partners to develop training programmes for new roles and also to increase the recruitment opportunities' for newly registered nurses.

In order to reduce agency spend a number of new incentives have been introduced (since November 2015) for staff working on the internal Trust bank. These incentives are intended to make working on the bank more attractive therefore increasing bank fill rates and as a consequence reducing agency expenditure.

Incentives include;

- increasing the hourly rate of pay for bank work by 5%
- allowing bank only workers to be able to continue to the top of the pay scale to the top point of the band (rather than being halted at the third point as was the case with NHS Professionals)

- for substantive staff picking up bank shifts during the winter period (1 December to 31 March), bank work undertaken would attract an additional payment of 15% on top of the basic rate
- staff working on the bank at a lower band than their substantive role could be paid their substantive rate for that work, e.g. band 6 substantive worker can receive their band 6 rate for a band 5 bank shift

As well as these incentives, new processes have been implemented to add additional scrutiny and the need for senior level approval for requests to seek shifts which would be non-compliant with the new National Agency rules, i.e. above the capped rate or off framework. The Trust is committed to moving away completely from off-framework agencies with a trajectory for minimal use by April 2016.

The Trust has had some difficulties with recruiting to some medical specialities and some nursing posts. This will be managed by appraisal of clinical pathways and redesign of services where necessary. In addition, alternate roles such as physician assistants and advanced care practitioners are being considered together with expanding the responsibilities and number of non-registered nursing workforce. The Trust is only using off-framework agency staff when patient safety is considered to be at risk. In hard to recruit posts the Trust is revising terms and conditions and offering enhancements.

**Ability to meet national targets** – The achievement of targets remains challenging, however, following introduction of the operational recovery plan in April 2015, the Trust has seen some noticeable improvements:

- Diagnostics – achieved 5 consecutive months up to and including Jan 2015/16
- Cancer – Following a challenging period the Trust has seen a demonstrable improvement and achieved all its targets in December 2015
- Breast Symptomatic - following the centralisation of the services for symptomatic breast on the York site, the Trust has been compliant with this access target
- 18 weeks – following changes in April 2015 to the RTT standard, the Trust has met the 92% incomplete target throughout 2015/16

However, the biggest challenge remains around the Emergency Department target and the ability to meet the 4 hour 95% target.

### **Well-Led Elements**

The Well Led review has been completed by the Trust in conjunction with Grant Thornton and was reviewed by the Board of Directors in January 2016 and an Action Plan is currently being formulated.

## **‘Sign up to Safety’ Priorities for 2016/17**

The Trust joined the Sign up to Safety Campaign in July 2014 and continues to make good progress with safety pledges.

Put safety first – The Trust is enhancing its strategies for reduction of mortality by expanding the remit of the Mortality Review Group and revising the mortality review proforma. In addition, the Trust will continue to reinforce the recognised good practices of multidisciplinary ward rounds, early consultant review and implementation of care bundles.

The Trust mandates the use of the Post-take Ward Round Checklist on the acute medical units and has recently developed this approach in the general surgery assessment units.

The Trust has introduced a screening tool for patients with severe sepsis in the Emergency Departments, Obstetric Departments and Paediatric wards and advocates early intervention of the Sepsis 6 bundle of care.

The Trust continues to promote better management of patients with diabetes and has negotiated two local Commissioning for Quality and Innovation (CQUIN) schemes for 2016/17, which will ensure a detailed focus on improvements.

The Trust will aim to reduce avoidable harm from Healthcare Associated Infection (HCAI) and have negotiated a local CQUIN scheme of 2016/17 to ensure a focus on the reduction of urinary catheter associated infections for patients in acute care.

The Trust will continue to monitor and benchmark rates of healthcare associated infection, through audit, surveillance and Post Infection Review (PIR) aiming to reduce rates to below the national mean. Clostridium difficile (C.diff) incidence continues to increase regionally and nationally. PIR and antimicrobial compliance audits highlight that prescribing in line with formulary continues to improve, but due to the acute nature of illness, particularly amongst the elderly, the need for essential antimicrobial therapy leads to sporadic cases in a population that naturally carries C.diff as part of their normal bowel flora.

Monitoring of the indication and appropriate use of broad spectrum antibiotics to reduce the risk and incidence of C.diff will be continued by the Antimicrobial Stewardship Team in particular in relation to sepsis management when such treatments are prescribed. A lack of permanent decant space continues to compromise the Trusts ability to deliver an annual deep clean programme and proactive hydrogen peroxide vapour (HPV) disinfection. Similarly a lack of isolation capacity poses a risk for the Trust.

A new Infection, Prevention and Control (IPC) Governance structure has been developed to reinforce that IPC is an organisational priority. A work plan to reduce infection, promote prevention and explore ways to reduce the risks

(including developing a deep clean programme) will be presented to the Board in the first quarter of 2016/17.

Good progress has been made on reduction of severe harm from pressure ulcers and patient falls and the Trust will continue to monitor progress with improvement plans.

Continually learn – The Trust will continue to use the information available from the Friends and Family surveys, Patient Advice and Liaison Service (PALS), formal and informal complaints and the national patient survey to identify improvements and actions and continue to publish information relating to complaints and patients feedback.

As a commitment to developing its culture of safety the Trust undertakes Patient Safety Walk Rounds by Non-Executive and Executive Directors and provides a monthly summary report to the Executive Board and the Board of Directors.

The Trust is refining its systems for mortality review to ensure they are sensitive and valid for its community hospitals.

The Trust aims to learn from incidents, complaints and litigation by reflecting on practice and where necessary, changing systems of work to ensure that patients are safe and that repetition of avoidable harm is prevented. The Trust continues to refine, improve and share learning from the Post Infection Review (PIR) process.

Being honest – The Trust promotes its Being Open Policy to ensure that the Trust's systems and processes support a culture of transparency and openness and meet the requirements of the Duty of Candour.

The Trust involves patients in safety by asking them to let us know if they notice anything of concern and alert us to non-compliance, for example with hand hygiene.

The Trust aims to involve patients as much as they wish in decisions about their care and treatment and particularly before consenting to treatment.

The use of safety briefings has been extended, particularly at Scarborough Hospital with support from the Improvement Academy.

The Trust has enhanced the dissemination of learning from serious incidents with our publication Nevermore.

Collaboration – The Trust uses benchmarking data and internal and external peer review to support analysis and facilitate learning. In addition, work continues with local commissioners to understand and agree where changes in pathways of care will develop more effective care.

The Trust continues to work with partner organisations including: NHS Improvement Academy, York University, Bradford University and the Global Sepsis Alliance.

Support to improve and celebrate progress – The Trust supports its clinical staff to develop skills and motivation, promote leaders to develop patient safety behaviours and skills and improvement in statutory and mandatory training through the Learning Hub together with enhancing doctors training.

The Trust continues to encourage reporting of errors and incidents in order to learn lessons; it will not tolerate neglect or wilful misconduct.

The Trust recognises the valuable contribution its staff makes to safe and effective patient care and profiles achievements at our annual Celebration of Achievement Event.

Last year the Trust launched its trust wide annual Patient Safety Conference, which gave staff an opportunity to showcase the vast amount of successful improvement work that is taking place throughout the organisation. A Junior Doctor Safety Improvement Group was also developed, which is led by doctors in training specifically for doctors in training.

### **Association of Medical Royal Colleges' Guidance on the Responsible Consultant**

The responsible consultant is clearly identified on the clinical record and we transfer patients to a different consultant based on patient's needs when clinically appropriate. There is a named nurse allocated to care for a group of patients on a shift by shift basis. We have a plan to ensure that all patients are aware of their named consultant and nurse.

### **Seven Day Services**

The Trust has a significant complement of 7 day services in place, with many specialty rotas providing full 365 day cover. However, the Trust recognises there are areas where a further extension is necessary to establish true equity of care.

Elective and planned care is routinely provided where demand exists on evenings and weekends. The Trust expects to increase its offering on this basis.

The Trust will ensure that 7 day working is affordable by improving job planning in the delivery of acute and urgent care and managing the impact on elective work. The Trust plans to extend senior clinical review over 7 days.

### **Quality Impact Assessment (QIA) Process**

The Trust has a well-established and embedded QIA process and follows the following process:-

- all Cost Improvement Programmes (CIP) schemes are self-assessed by the Directorate teams, including senior clinical input, against the Trust's risk assessment framework
- the schemes are independently reviewed by a senior clinician and a senior nurse
- there is then an escalation process for any schemes that have been highlighted as high or extreme risk to the Executive team including the Medical Director and Chief Nurse
- the summary information is also provided to the Finance and Performance Committee and ultimately the Board of Directors as part of the monthly efficiency report
- this process is an on-going process so new schemes are assessed as they are added
- the Trust also has a comprehensive patient safety, quality, workforce, finance and performance report which provides details of all relevant quality & safety indicators

In addition to this KPMG stated in their report, following an audit of the CIP process:

*'We have not seen the model proposed by YTH for CIP quality impact assessment implemented at other Trusts. However, our view is that it offers a unique advantage over traditional paper-based reviews carried out by a Trust medical and nursing director: discussion at directorate-level by clinicians is likely to produce a different level of challenge and front-line realism into assessments. We therefore encourage its adoption, with the recommendation that the process is reviewed by the Finance & Performance committee prior to FY 14/15'*

### **Triangulation of indicators**

The Board of Directors are provided with data and key performance indicators. The Trust's performance information pack was recently reviewed by Grant Thornton LLP as part of an extensive Well-led Review. The pack was rated "green" and Grant Thornton LLP commented on the high standard of information and data quality assurance processes.

Triangulation is received from an integrated performance report covering all aspects of performance including; finance, staffing, access, quality and safety. This information is routinely presented monthly; but also includes data feeds refreshing many indicators daily or even in real time.

Triangulation is supported through the Board of Directors and through a Board sub-group meeting structure examining specifically finance and performance and quality and safety issues. Key indicators used include a finance report detailing a key analysis of income and expenditure variances, a detailed analysis of cash and other finance metrics. This is set alongside quality and safety reports from the Chief Nurse and Medical Director drawing key performance metrics and issues from the Trust's comprehensive performance

report to the Board's attention. Key metrics include workforce turnover, vacancy rates, recruitment progress, patient safety indicators from the safety thermometer (such as infection control, falls and pressure sores), mortality indicators and compliance reports relating to key aspects of medical and nursing practice (such as thrombolysis assessment, antimicrobial prescribing and dementia screening).

### **Quality & Safety and Finance & Performance Sub-committees**

These Board committees meet before the Board and consider the indicators specific to each committee. The detail discussed and assurance obtained by each committee is then presented to the full Board meeting held 8 days later. This information is then discussed and triangulated by the Board. Grant Thornton LLP commented "We saw many examples of performance information being used to hold management to account, at Board and committee meetings....".

### **Workforce Strategy Committee**

This committee meets every two months to consider key workforce indicators, such as staff turnover, recruitment statistics, vacancy rates, appraisal performance, sickness rates and many other workforce metrics. The committee routinely reports through to the Board on their findings and also on assurance they have obtained.

### **Data Quality Group**

This is a sub-group of the Audit Committee and considers the quality of the information being presented to the Board. The group specifically reviews the internal audit work programme and seeks assurance that all aspects of data quality are being appropriately investigated. As part of its work programme the group receives presentations from key management individuals into all aspects of data and data quality and has the opportunity to directly question and seek assurance from Trust "experts".

## **Approach to Workforce Planning**

### **Workforce Planning**

In line with Health Education England (HEE) the Trust undertakes an annual workforce planning programme that forecasts workforce requirements for the following five years. Both the Medical Director and the Chief Nurse are consulted during the completion of the return and it is a requirement that those individuals complete specific narrative sections of the submission.

## **Board Approval**

Members of the Board of Directors sign off the annual workforce planning return that is submitted to HEE to inform commissioning of training and education at national and regional level.

## **Links to Clinical Strategy**

The Trust is committed to ensuring the Keogh Standards are achieved across the acute pathways in order that services are delivered seven days a week. To support this aim, a task and finish group has been established to oversee this process. An integral part of this is the review of job plans and rotas to ensure they offer maximum direct clinical care within the confines of the national contract. It is anticipated that a new acute model will be required at the Scarborough Hospital site to help support delivery given the on-going recruitment and workforce challenges.

Detailed below are some speciality specific models being explored:

### Acute & Emergency

The Trust is developing workforce models to ensure patients are seen quickly with the appropriate treatment plan put in place. This is with the aim of reducing admissions or reducing the amount of time spent in hospital where admission is unavoidable.

To support the model skill mix reviews have been underway and the Emergency Department in Scarborough Hospital have successfully integrated Advance Care Practitioners into their workforce structure.

### Planned and Elective

The Trust is examining ways of maximising facilities to increase planned and elective activity. This includes:

- the expansion of the Bridlington Hospital site in order to support increased elective activity, which supports the separation of acute and elective activity on the Scarborough Hospital site;
- Maximise throughput and utilisation of theatres; and
- Extended operating hours during the week along with routine weekend working
- Urology One-stop Service at Malton

### Community Hubs

The Community Hubs are a pilot example of the direction of travel for the local health and care system. They demonstrate the 'one team' approach to service delivery that brings different professions (GPs, Consultants, District Nurses and Local Authority Staff), together to work in an integrated way supported by generic workers who have competencies across a range of traditional disciplines. As the 'system' moves to providing support to allow individuals to take responsibility for their own health needs and to promote wellbeing, the workforce will need to be equipped with the skills to adopt a more coaching

approach rather than our traditional paternalistic outlook and the dependency this creates. The workforce will be managed with a matrix approach with line management, professional leadership and multidisciplinary team (MDT) leadership all potentially coming from different individuals.

### **Local Workforce Transformation Programmes**

Links to the Organisation's use of the Calderdale Framework workforce transformation model, as supported by HEE, Y&H. Measurements would be efficient use of resources, staff working to full potential, increased staff engagement, improved quality and safety with staff working to agreed protocols and standards, reduced expenditure as staff on lower bands take on tasks that would traditionally be delivered by registered practitioners.

For example: within the Emergency Department at York, clinical skills and tasks that can be delegated to an unregistered support worker were identified, thus freeing up the registered nurses to work more productively, utilise their skills more effectively, whilst maintaining service delivery, appropriate skill mix, and effective/productive use of registered nurses time. Agenda for Change (AFC) band 3 senior healthcare assistants already in post and AFC band 4 assistant practitioner role to be implemented April 2016. Initially replace 6.0 whole time equivalent (WTE) AFC band 5 with 6.0 WTE AFC band 4 assistant practitioners

The Support Staff Learning Team continues to deliver a portfolio of learning aimed at up-skilling AFC bands 1-4 non-clinical support staff. In particular these programmes are designed to re-engage existing learners or new staff and provide a range of 'bite size' programmes that target core elements of learning, resulting in a product that is now also being accessed by non-registered health staff. These programmes will be embedded and built on during 2016-17.

Elements of provision are now accessible via the Trust's online learning system. This portfolio will grow in 2016/17 as we ensure that learners, where possible, are offered a choice of provision, the opportunity to undertake learning at their own speed, at a time convenient to them.

2015/16 Maths and English pilot activity with Yorkshire Ambulance Service (YAS) and York College proved to be mutually beneficial and will continue in 2016/17. Open to anybody that has a need, these courses have been accessed by staff wanting to achieve GCSE equivalent either as a return to learning, or, for further progression in the organisation.

## **Reliance on Agency Staffing**

eRostering is used in a number of ward areas and is being rolled out further at the Scarborough Hospital site. Exception reporting is provided regularly and presented to senior nursing staff, including roster creators, those who give final approval for rosters (e.g. matrons) and the Corporate Nursing team. Advice is available on best practice rostering and there are organisationally agreed principles around this to ensure effective rostering. Work has been undertaken to improve the benefits of working on the internal nurse bank, including enhanced rates and weekly pay to reduce reliance on agency.

## **Alignment with Local Education and Training Board Plans**

The annual workforce plan is aligned to the Local Education and Training Board (LETB).

The Trust will sign Talent for Care / Widening Participation, Partnership Pledge to evidence commitment to developing our non-registered workforce.

## **Triangulation of Quality and Safety Metrics with Workforce Indicators**

Trust, site and ward level dashboards incorporating workforce and patient safety metrics are examined and published. In addition, the Early Warning Trigger Tools are utilised across ward areas to proactively identify patients who require attention.

## **Monitoring of Quality Impact Assessments**

Achieving CIP from the workforce is a subset of the Trust's Turnaround Avoidance Programme (TAP) that was launched in July 2015. There are a variety of measures being explored and all are subject to quality impact assessments.

## **New Workforce Initiatives Agreed with Partners**

Our workforce planning return for 2015/16 described a need over time for an increase in AFC bands 1-4 staff undertaking preventative activities as a result of the changes described in the Five Year Forward View. To deliver this it was determined new roles would need to be developed. These are detailed below:

Bands 2-4 (clinical) development continues, with career progression from band 2, to band 3, to band 4. Roll-out within the organisation to newly recruited band 2 health care assistants (HCAs) of Level 2 Diploma, designed and accredited in partnership with National Open College Network (NOCN), funded through the Support Staff Learning and Development fund (SSLDF).

Band 4 Assistant Practitioner role to be piloted (see above) and links with HEE proposals re Nursing Associate role. Foundation degree/level 4 discussions in progress with Coventry University (Scarborough Campus), York St John University, and (continue with) University of York in support of

the academic requirement for level 4 attainment to support role. Our vision is for such a role to be across Nursing and AHPs (Allied Health Professionals).

Work is also in progress to produce a Health & Social Care Apprenticeship Framework to meet the needs of the Trust, and enable potential employees another entry route into our workforce. Again supporting the HEE Apprenticeship Initiative, we are working with Skills for Health to produce both a Strategy and Framework, by end March 2016, with the aim of piloting a first cohort mid/late summer.

Working in partnership with Support Staff Learning Team, Recruitment, and York College & York High School, to develop and deliver a pilot generic apprenticeship programme targeting 16 year olds. This will include options to shadow in different areas within the Trust so as to inform future career choices for the apprentices. If successful, this will be rolled out to Scarborough Schools in 2017 where the need to 'grow our own' staff due to high local vacancies is important. Funded from HEE/SSLDF bids

Continued funding support for the use of apprenticeship frameworks for new/hybrid roles as they are identified.

Advanced clinical practitioners (ACPs). There are 7 qualified ACPs in the organisation and another 11 due to complete training in June 2016. They are autonomous practitioners working in high risk areas such as Emergency Department (ED) and Acute Medical Unit (AMU) where the numbers of doctors is below establishment, due to national specialty shortages and local geographic issues. Based on this new workforce model it has been possible to develop a new Ambulatory Care Unit. A third cohort for Scarborough ED is being considered for 2016/7 to develop ED services. Funding to support the training element of this role was sourced from HEE Workforce Transformation bids.

There are on-going discussions around involvement in a Physician Associates programme being developed by HYMS

### **Agency Rules**

Whilst the Trust's main objective is to reduce agency usage, there remains the requirement to use agency staff where we are unable to fill substantively or via the Trust Bank. When we need to do this we are approaching approved framework agencies in the first instance and only going off framework as a last resort. To ensure that all agency usage is purchased at a competitive rate we have undertaken intelligence gathering from our neighbouring Trusts to ensure we are not alone in the implementation of the Monitor caps. This has facilitated discussions to reduce the rates further.

Senior nursing staff are involved in managing day to day changes to staffing to ensure appropriate levels of staff and skill mix in all areas. Vacant shifts only go to agency for fulfilment once all opportunity to fill via the internal nurse bank has been explored. Any consideration of approaching off framework

agencies or booking shifts above the capped rates is only done with director approval.

## **Workforce Risks**

The Board of Directors receive a monthly workforce report detailing key workforce matrices. Included within this is the up to date nursing vacancy position and level of agency expenditure. In addition the Workforce Strategy Committee, a sub-committee of the Board of Directors receives further detailed information relating to all workforce matters.

All Clinical Directorates are subject to a monthly performance meeting where their specific challenges are examined and solutions explored. Monthly reports are submitted to NHS England of the Trust's actual staffing against plan.

## **Approach to Financial Planning**

### **Financial Forecasts and Modelling**

#### **Forecast Outturn 2015/16**

The Trust continues to operate within the context of the difficult national economic situation and its impact on the NHS.

For the end of the 2015/16 financial year, the Trust is forecasting an income and expenditure deficit of £16.4m, and a FSRR of 2. This forecast includes technical adjustments for impairments (£0.3m) and loss on the transfer of Whitby hospital to NHS Property Services (£4.6m); and restructuring costs of £0.6m all of which are discounted by Monitor in their assessment of the Trust's underlying performance, and presents a normalised deficit of £10.9m. The Trust is forecasting a cash balance of £10.3m, and that it will achieve its CIP plan for the year of £25.8m. The underlying Income and Expenditure position placed the Trust behind its operational plan.

The Trust's financial position was primarily influenced by three key dynamics:

- An inability to recruit medical and nursing staff into substantive posts resulting in a significant increase in the use of locum and agency staff. A contributing factor to this is the shortage nationally of professionals in key specialties resulting in provider organisations competing from a small pool of staff.
- A significant increase beyond planned expectations in ED attendances and acute admissions, coupled with capacity constraints elsewhere in the health/social care systems preventing the timely discharge of patients and reducing capacity for support in the community. These dynamics caused a reduction in elective capacity, losing income at 100% of tariff, replaced by additional non-elective patients, reimbursed at 70% of tariff.

- As the consequence of the above, the Trust faced the additional burden of incurring penalties for failing to deliver the 4 hour ED waiting time, Ambulance handover times, and RTT.

The Trust's financial plan for 2016/17 seeks to recognise these issues and accommodate the cost of solutions within the overall plan. These plans are now described in a way so as to align with the Normalised Surplus Bridge with the APR template.

### Adjusted Opening Baseline for 2016/17 (-£17.6m)

This adjustment takes into consideration the removal of prior year pass-through income/expenditure and prior year non-recurrent items as well as adjusting for the full year effect of 2015/16 initiatives giving the adjusted opening baseline for 2016/17.

	<b>£m</b>
2015/16 deficit after tax from continuing operations	-16.4
<u>Add back:</u>	
- Loss on transfer by absorption of Whitby hospital	4.6
- Impairments	0.3
- Restructuring costs	0.6
<b>Normalised deficit 2015/16</b>	<b>-10.9</b>
<u>Adjustments to Operating Baseline:</u>	
(a) Reverse prior year clinical pass through income and costs	
- Income	-45.9
- Costs	45.9
	<b>0</b>
(b) Reverse non-recurrent CIPs	<b>-14.4</b>
(c) Full year impact of prior year recurrent CIPs	<b>0.5</b>
(d) Reverse non-recurrent impact of delayed Whitby transfer in 15/16	
- Income	-4.7
- Costs	4.6
	<b>-0.1</b>
(e) Reverse non-recurrent agency and bank premium	<b>3.3</b>
(f) Reverse non-recurrent non-clinical income and associated costs	
- Income	-3.7
- Costs	2.4
	<b>-1.3</b>
(g) Reverse non-recurrent escalation costs	<b>3.3</b>
(h) Reverse non-recurrent use of reserves	<b>2.4</b>
(i) Other issues	<b>-0.4</b>
<b>Adjusted Opening Baseline</b>	<b>-17.6</b>

## **Activity (-£2.5m)**

The Trust adopts a bottom up approach to capacity and activity planning. Individual directorates developing their own local activity and capacity plans predicated on assessed growth assumptions, known service developments/ changes, and requirements to meet required access targets. Following confirm and challenge meetings with senior managers from the Trust's Contracting and Operations directorates, plans are agreed and valued based on the national tariff and local agreed pricing structures, to provide an aggregate income and activity plan for the Trust.

At a corporate planning level a contingent sum of £9.3m has been deducted from the aggregate income plan to recognise (a) potential service areas that may be subject to challenge and not agreed by commissioners during contract negotiations (£4.3m), and (b) the impact of QIPP plans by commissioners (£5m). At this stage the contract negotiations and discussions with commissioners regarding their QIPP programmes are continuing, against which the Trust can test robustness of this provision.

Additional income from demand and volume changes has been assessed at £6.2m after the corporate adjustment referred to above has been applied, whereas the cost of delivery is assessed at £8.7m after assumed savings resulting from QIPP schemes, and reductions in negotiated contract levels.

## **Price/ Tariff changes (-£9.4m)**

In line with national guidance the Trust has modelled an overall 3.1% inflationary impact on costs and a net 1.1% tariff increase on relevant clinical income, after netting off the expected 2% efficiency within tariff. At a local level, for non-NHS clinical income and income from non-clinical services the Trust has assumed an average price increase of 1.0%. Overall the assessed impact of these assumptions is to place a net £9.4m pressure on the Trust's I&E forecast position. The key elements underlying these assumptions are detailed below.

### Tariff Changes (+£5.2m)

The proposed changes to the national tariff, together with changes to local prices has been assessed to provide a net £5.2m benefit to the Trust, and is comprised:

- The net impact of 1.1% increase in the national tariff for relevant clinical services has been assessed at £4.2m.
- The suspension of the specialist services risk share will benefit the Trust by £0.1m.
- Currency & relevant price changes provide a benefit of £0.4m
- The impact of a 1% average increase on non-NHS clinical income and income from non-clinical services £0.5m

### Cost inflation (+£14.6m)

The 3.1% assumed for cost inflationary issues totals £14.6m, and is comprised:

- Provision for cost of living pay increases and general price increases not covered below of £5.4m.
- Assessed cost increase of £2.5m due to incremental progression and clinical excellence awards
- The Trust has received notification that its CNST premiums are to increase by £1.8m.
- An increase in Trust NI contributions of £4.9m due to staff who are members of the NHS Pension scheme no longer having 'contracted out' status from the state pension from April 2016.

### **Other Issues (£0.7m)**

The other main issues included in the plan are detailed below:

	<b>£m</b>
Clinical pass through income and costs	
- Income	45.4
- Costs	-45.4
	<b>0.0</b>
Reduction in Scarborough transition support and costs	
- Income	-0.9
- Costs	1.1
	<b>0.2</b>
Reduction in CLRN Service:	
- Income	-1.0
- Costs	1.0
	<b>0.0</b>
Other income changes:	
- Increase in CQUIN	0.4
- Winter Resilience	0.3
- Reduction in Overseas visitor and Private patient income	-0.1
- Loss of SLA for the provision of Estates services to another provider	-0.7
- Additional NMET income	0.4
- Various other Direct Credit Income	0.3
	<b>0.6</b>
Other Costs:	
- Investment in training Advanced Care Practitioners	-0.2
- Reduction in the cost of leasing equipment	0.2
- Reduction in the cost of leasing equipment	-0.1
	<b>-0.1</b>
<b>Total</b>	<b>0.7</b>

## Sustainability & Transformation Fund (£13.6m)

The Trust has included its notional allocation of £13.6m from the general element of the Sustainability & Transformation fund 2016/17, as notified in the joint TDA/Monitor letter of 15<sup>th</sup> January 2016. No assumption has been made of any allocation from the targeted element of the fund at this stage.

## PFI & Non-EBITDA items (-£0.7m)

The Trust has assessed an increase in non-EBITDA items of £0.7m, primarily in connection with increases in PDC, and Depreciation & Amortisation.

## CIPs (£26.4m)

A CIP requirement of £26.4m (5.5%) has been built into the plan for which current plans exist to meet £18.9m, with the balance of £7.5m identified as non-recurrent due to absence of firm plans at this stage. Further detail is provided in the 'Efficiency Savings 2016/17' section below.

## Summary Financial Forecasts 2016/17

### Income & Expenditure Summary

The summary I&E position for 2016/17 is shown in the table below. The plan for 2016/17 results in a forecast operating surplus of £10.2m, which after allowing for a technical adjustment regarding impairments and profit on asset disposals, results in a normalised I&E surplus of £10.5m.

	£m
Operating Income included in EBITDA	483.176
Operating Expenses included in EBITDA	-454.432
<b>EBITDA</b>	<b>28.744</b>
Operating Income excluded from EBITDA	0.739
Operating Expenses excluded from EBITDA	-12.300
Non Operating Income	0.100
Non Operating Expenses	-7.115
<b>Surplus</b>	<b>10.168</b>

## Balance Sheet

The summary balance sheet for 2016/17 is shown in the table below.

	£m
<b><u>Non Current Assets</u></b>	249.625
<b><u>Current Assets</u></b>	
Cash and cash equivalents	22.690
Other current assets	24.076
	46.766
<b><u>Current Liabilities</u></b>	
Other borrowings	-2.404
Other current liabilities	-35.802
	-38.206
<b>Net Current Assets</b>	8.560
<b><u>Non-Current Liabilities</u></b>	
Other borrowings	-23.826
Other non-current liabilities	-1.055
	-24.881
<b>Total Assets Employed</b>	233.305
<b>Taxpayers' and Others' Equity</b>	233.305

## Cash Flow

The Trust's cash balance is forecast to increase during 2016/17 rising from an opening balance of £10.3m to a closing balance of £22.7m, reflecting the forecast I&E operating surplus.

## Financial Sustainability Risk Rating (FSRR)

The provisional FSRR for 2016/17 is 4, with the scores for the component elements presented in the table below. The 'I&E margin variance from plan' score automatically defaults to the forecast outturn score for 2015/16 for planning purposes.

<b>Capital Service Cover</b>		
Revenue Available for Capital Service	£m	28.844
Capital Service	£m	-8.731
<b>Capital Service Cover metric</b>	0.0x	3.30
<b>Capital Service Cover rating</b>	Score	4
<b>Liquidity</b>		
Working Capital for FSRR	£m	1.720
Operating Expenses within EBITDA, Total	£m	-454.432
<b>Liquidity metric</b>	Days	1.36
<b>Liquidity rating</b>	Score	4
<b>I&amp;E Margin</b>		
Normalised Surplus/(Deficit)	£m	10.468
Adjusted Total Income	£m	484.015
<b>I&amp;E Margin</b>	%	2.16%
<b>I&amp;E Margin rating</b>	Score	4
<b>I&amp;E Margin Variance From Plan</b>		
I&E Margin - Plan from 15/16 APR	£m	n/a
I&E Margin - 15/16 Out-turn	£m	n/a
<b>I&amp;E Margin Variance From Plan</b>	%	-1.75%
<b>I&amp;E Margin Variance From Plan rating</b>	Score	2
<b>Financial Sustainability Risk Rating</b>		4

## Efficiency Savings 2016/17

One of the greatest challenges facing the organisation is the delivery of a £88m efficiency programme; over the five financial years to March 2021, this includes £33m potential opportunity over the first 3 years identified by the Lord Carter team. The Trust also has an extremely challenging stretch CIP target for 2016/17 of £26.4m, which is not without a significant level of risk, however we can demonstrate an excellent record of delivering efficiencies; having exceeded its target for the last seven years and which is due to a number of organisational strengths including significant engagement and innovations. All savings targets are devolved to Directorates and the Clinical Director structure ensures a high level of engagement in the process.

A further strengthening of the organisation's approach to a clinically and financially viable organisation has been the introduction of the Turnaround Avoidance Programme (TAP), led by a dedicated Programme Director. TAP is the organisations approach to delivering a sustainable financial future. It ensures that we focus our management effort on the Trusts priorities. The way that TAP does this is by bringing structure, process and discipline to the way we manage our priorities.

The efficiency programme is an evolving process with schemes being updated on a regular basis. At the time of submission high risk and unidentified plans equate to 53% of the £26.4m CIP target based on NHSI categorisation. However, we know from past experience that this risk profile improves rapidly as we enter each new financial year.

The framework and structure summarised below will allow us to monitor delivery effectively and reduce non-delivery of CIPs. The carry forward of non-recurrent delivery from 2015/16 will be a clear focus for the 1<sup>st</sup> quarter of 2016/17.

### **Lord Carter’s Provider Productivity Work Programme**

In the development of our efficiency programme for 2016/17 our absolute goal has been to incorporate the potential opportunities identified by the Lord Carter work into our core work programme, this will ensure full engagement by the organisation and individual directorate teams. Our initial work has involved identification of opportunities both by theme and by directorate team and it is noted that the Lord Carter opportunity is spread over 3 years.

Our initial work has identified the following areas of opportunity, which are incorporated in our current firm identified plans of £18.9m, although it should be noted there is much more work and refinement still to be completed in this area.

<b><u>Themes</u></b>	<b><u>Yr1 – 16/17</u></b>
Workforce	£6.8m
Procurement	£1.0m
Pharmacy	£1.6m
Other (Incl. Estates & Facilities)	£1.5m
<b>Total</b>	<b>£10.9m</b>

### **Procurement**

Procurement (and choice) is controlled through online catalogues. The catalogues are controlled by qualified professionals (MCIPS) and the system controlled by a series of logins, hierarchies and approvals. This means that no individual person can order and approve the same request and many have to seek senior leadership approval before their goods are ordered.

Reports are routinely run for the top 100 items by value and by demand. These lists are worked through as an on-going project (Project 100) looking at ensuring the top 100 items we procure are fit for purpose and offer value for money. This project is managed through the Medical and Surgical Supplies & Equipment (MSSE) Committee who provide oversight, scrutiny and support. Aligned to this is Project 321, which looks at stripping out duplication of products across the Trust so that we don’t use different products for the same task on different sites. As part of the TAP described above we have just introduced a ‘No Purchase Order, No Payment’ policy.

This work is further supplemented by regional collaboration via the Regional Supplies Managers Network and through the participation of the Trust's Head of Procurement on both the NHS Northern Customer Board, and NOECPC Customer Board.

As a NEP Trust, our data is already shared with Monitor (for the Product Price Benchmark Metrics), and through NHSSC back to the BSA, influencing the NHS's Core Range.

## **Capital Planning**

The Head of Capital Projects is working with various stakeholders on the development of a Trust estate strategy that will be published early in 2016-17. This document will firmly align with the Trust's strategic objectives, and the clinical strategies of individual directorates and divisions. It will enable the Head of Capital Projects to demonstrate that the capital project investment plans are consistent with, and support the delivery of the Trust's clinical strategies. It will also serve to improve the safety, suitability, quality and condition of the estate from which the organisation's healthcare services are delivered.

It is also intended to refresh the development control plans for the Trust's main sites to provide further assurance when investment proposals are being assessed that the projects are consistent with the Trust's estate and clinical strategies. For example, one of the Trust's strategic objectives is to separate elective and emergency / non-elective care delivery. The Capital Projects Department is currently finalising the Outline Business Case for a project to create an elective surgical centre of excellence at the Trust's hospital site in Bridlington. This project will also support another of the Trust's strategic objectives: namely, increasing the organisation's market share for elective services. Another scheme that the Capital Projects Department is developing is the project to reconfigure emergency care facilities at Scarborough Hospital, which will support the achievement of the Trust's strategic objective to develop and reform emergency care with less emphasis on admission and greater focus on rapid diagnostics, assessment and ambulatory care. The Capital Projects Department is also working on a cardio-vascular project to support the increase in the Trust's capacity for this important diagnostic and treatment service, which will support the Trust's strategic objective of developing and growing our specialist services.

In 2015-16, the Head of Capital Projects introduced a revised project initiation procedure to increase the level of grip and control over the initiation of new capital schemes. The process now involves a more robust and structured project initiation request form and the information returned is used to assess each request against a range of criteria including strategic support/consistency, financial benefits, patient benefits, staff benefits, statutory compliance / risk mitigation or elimination. This scoring assessment process will produce a prioritised schedule of projects for approval to be developed into feasibility studies. Estate backlog maintenance schemes are

similarly being assessed and prioritised against the outputs of the risk-based 6-facet survey work and on-going estates and facilities compliance work to ensure that the backlog maintenance element of the capital programme is fully aimed at improving the safety, condition and compliance of the Trust's facilities.

The Head of Capital Projects has now assumed responsibility for the Trust's property management function. Through this function, we are focussing on improving space utilisation across the Trust's estate, consolidating the Trust's premises where possible, disposing of surplus properties where possible, and reducing the cost of the space the Trust currently occupies for example by vacating leasehold properties where possible. The Trust now has a Space Management Group that oversees the allocation and use of space across the estate and it is working with the Finance Directorate to facilitate the inclusion of space occupation costs within the service line reporting process that is being applied to the Trust's services. Divisions and directorates will increasingly be incentivised to increase their space utilisation and to reduce their footprint wherever possible.

### **Link to the emerging 'Sustainability and Transformation Plan' (STP)**

The STP footprint has been agreed and consists of Vale of York, Scarborough & Ryedale, East Riding, Lincolnshire and Hull and North East Lincolnshire areas and will be called Humber Coast & Vale. A Senior Responsible Officer (SRO) is being appointed by NHSE and there will also be an overall Programme Director appointed.

The STP will be an 'umbrella plan', containing within it a number of different specific delivery plans, some of which may be on different geographical footprints, but all of which are interdependent and required to deliver the overall sustainability and transformation challenge of the NHS.

There are a number of emerging themes for the trust's area, which are:-

- Sustaining and developing local services at Scarborough Hospital
- Promoting the review and reinvention of the acute and urgent care model at Scarborough Hospital (the subject of a recent small District General Hospital Pioneer application to NHS England)
- Separating elective and acute care activity with a key development of elective services on the Bridlington Hospital site
- Developing an integration plan with local primary care and CCG partners to provide a wider range of community and out of hours services to help prevent unnecessary hospital admissions; working with Local Authorities and the voluntary sector will be fundamental to this.

- Developing and promoting a range of early supported discharge services to facilitate timely, safe and effective resettlement of patients in their home environment after their stay in Hospital
- Improving the internal hospital flow of patients admitted through Emergency Departments
- Sustaining and building on existing secondary, community and primary care alliances with partner organisations for the benefit of the local health care system as a whole.

Key issues discussed at the local interagency STP planning group meeting that need to be addressed as the York/Scarborough elements of the plan are developed include:

- **Financial position.** Understanding the current financial position and pressures across the system is critical in determining the extent to which existing plans will deliver financial sustainability for partner organisations. This overarching system financial position is pivotal to developing understanding of what approaches will be taken as a system and how actions drive sustainability across the system.
- **Key messages and content.** It is anticipated that current plans are the right approach to delivering the transformational changes that make the local system sustainable. This assumption needs to be tested against the refreshed financial positions of each organisation going into 2016-17 and plans will need to be revised accordingly.
- **Consistency** with plans across organisations. It is essential that the content of the Sustainability and Transformation Plan is consistent with existing plans and does not undermine or conflict with existing approaches. It should summarise and draw together the totality of current plans, expressing this as a clear narrative for change across the system.
- **Structure.** The aim is to adopt the clear structure set out in the guidance – with plans expressed under headings of 1. Closing the health and wellbeing gap 2. Driving transformation to close the care and quality gap 3. Closing the finance and efficiency gap. Existing plans will map to these headings. It is envisaged that the Sustainability and Transformation Plan will be a high-level narrative that sits over and is entirely consistent with existing plans including:
  - Ambition for Health (the Scarborough district interagency planning process)
  - Health and wellbeing strategies and plans
  - Financial recovery plans

- System recovery plan (performance)
- Better Care Fund plans
- Previous strategic and operational plans
- Business plans within partner organisations

A Provider Alliance Board has been established as a means of securing provider engagement and driving transformational change. The Provider Alliance Board includes North Yorkshire County Council, City of York Council, SHIELD GP Federation, CAVA GP Federation, NIMBUS GP Federation, York CVS, Selby Voluntary Service, Tees, Esk & Wear Valleys NHS Foundation Trust and this Trust. The Trust will be a key player in the production, delivery and monitoring of the STP and its constituent parts.

## **Membership and Elections**

### **Governor Elections**

The Council of Governors at the Trust currently has 26 governor seats in the constitution:

Public Governors	Sixteen elected seats
Staff Governors	Five elected seats
Stakeholder Governors: Local Authorities Local Universities Voluntary groups	Five appointed: <ul style="list-style-type: none"> <li>● Three seats</li> <li>● One seat</li> <li>● One seat</li> </ul>

Elections were carried out in August 2015 using the Electoral Reform Society. The following appointments were made:

- 4 public governors were reappointed
- 3 new public governors were appointed
- 1 new staff governor for the community was appointed
- 2 new stakeholder governors were appointed
- 2 stakeholder governors appointments were reconfirmed

The next elections will be held during the summer of 2016. The following seats will be included in the elections:

- York constituency – 2 seats
- Selby constituency - 1 seat
- Ryedale and East Yorkshire constituency – 1 seat
- Hambleton constituency – 1 seat
- Staff - 1 seat

The elections process will begin at the end of June 2016 and the election results will be announced at the end of September 2016.

## **Governor Recruitment, Training and Development**

The following are examples of governor development and governor/membership engagement

- Prospective governor drop in sessions
- Governor induction
- Recruitment training
- Training for PLACE Assessments
- Annual General Meeting
- Open Day
- Council of Governor meetings
- Board of Director meetings
- Meet your governor session held in January 2016

## **Membership Strategy**

As part of the preparation for the completion of the transaction for the acquisition of Scarborough & North East Yorkshire Healthcare NHS Trust, the Trust developed a strategy for membership to increase membership at the East Coast.

A new strategy is been drafted, which sets out the Trust's commitment to building a representative membership to support public accountability and will set out a series of objectives to maintain, grow and engage its membership. Any campaigns to grow membership will be targeted at any under-represented demographic and geographic areas.