York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors – Public

Wednesday 22nd February 2023
Time: 9:00am – 12.00noon

York and Scarborough Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS MEETING

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

On: Wednesday 22nd February 2023

TIME	MEETING	ATTENDEES
9:00 – 12:00	**Board of Directors meeting held in public**	**Board of Directors Members of the Public**
12:30 – 1:30	Board of Directors - Private	Board of Directors
1:45 – 3.45	Draft 2023/24 Operational Plan - Development Session	Board of Directors

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors Public Agenda

All items listed in blue text, are to be received for information/ assurance and no discussion time has been allocated within the agenda. These items can be viewed in a separate supporting information pack (Blue Box).

Item	Subject	Lead	Report/ Verbal	Page No	Time
1.	**Welcome and Introductions**	Chair	Verbal	-	9.00
2.	**Apologies for Absence** To receive any apologies for absence.	Chair	Verbal	-	
3.	**Declarations of Interest** To receive any changes to the register of Directors' interests or consider any conflicts of interest arising from the agenda.	Chair	Verbal	-	
4.	**Minutes of the meeting held on 25 January 2023** To be agreed as an accurate record.	Chair	Report	09	
5.	**Matters Arising / Action Log** To discuss any matters or actions arising from the minutes or action log.	Chair	Report	23	
6.	**Staff Story** Matthew Miller-Swain to share personal story about reasonable adjustments.	Chief Nurse	Verbal	-	9.05

Item	Subject	Lead	Report/ Verbal	Page No	Time
7.	**Chief Executive's Report** To receive the: 7.1 • Chief Executive's Update 7.2 • The February 2022-23 Trust Priorities Report	Chief Executive	 Report Report	 25 29	9.25
8.	**Risk Management Update - Corporate Risk Register** To receive the latest Corporate Risk Register.	Associate Director of Corporate Governance	Report	67	9.45
Trust Priority: Our People					
9.	**Trust Priorities Report: Our People** To receive an update on the Our People priority of the Trust Priorities Report (TPR) (Item 7.2). To include: 9.1 • People Recovery Plan update	Director of Workforce & OD	Item 7.2 Report	- (To follow)	9.55
10.	**Nurse Staffing Report** To receive the report.	Chief Nurse	Report	(To follow)	10.05
Trust Priority: Quality and Safety					
11.	**Trust Priorities Report: Quality & Safety** To receive an update on the Quality and Safety priority of the Trust Priorities Report (TPR) (Item 7.2).	Medical Director/ Chief Nurse	Item 7.2	-	10.10
12.	**CQC Update** To receive an update on the CQC actions.	Chief Nurse	Report	75	10.15

Item	Subject	Lead	Report/ Verbal	Page No	Time
13.	**Ockenden Report Update** To receive the report.	Care Group Director of Midwifery	Report	89	10.25
14.	**Equality Delivery System (EDS) Report** To receive the report.	Patient Equality, Diversity and Inclusion Lead	Report	(To follow)	10.35
15.	**Q3 Mortality Report** To receive the report.	Medical Director	Report	97	10.45
16. 16.1 16.2	**Quality & Safety Assurance Committee** To receive the: • January meeting minutes • February meeting exception report	Chair of Committee	Report Report Verbal	 117 -	10.50
Trust Priority: Elective Recovery & Acute Flow					
17.	**Elective Care position and year-end planning** To discuss the current elective care status and plans until year-end.	Interim Chief Operating Officer	Presentation	-	10.55
18.	**Trust Priorities Report: Elective Recovery and Acute Flow** To receive an update on the Elective Recovery and Acute Flow priorities of the Trust Priorities Report (TPR) (Item 7.2).	Interim Chief Operating Officer	Report	125	11.25

Item	Subject	Lead	Report/ Verbal	Page No	Time
19.	**Digital, Performance and Finance Assurance Committee** To receive the:	Chair of Committee			11.30
19.1 19.2	• January meeting minutes; and • February meeting exception report		Report Report	137 143	
Governance					
20.	**Finance Update** To receive the Trust's financial position from the Trust Priorities Report (TPR) (Item 7.2).	Finance Director	Item 7.2	-	11.35
21.	**H&NY Procurement Collaborative Business Case** To approve the business case for the establishment of a shared procurement collaborative.	H&NY Director of Procurement	Report	147	11.45
22.	**Items for Information**	All			-
22.1 22.2 22.3	• Executive Committee Minutes • Star Award nominations • TPR Mandatory Reporting			306 315 (To follow)	
23.	**Any other business including questions from the public**	Chair	Verbal	-	11.55
24.	**Summary of Actions Agreed**	Chair	Verbal	-	
25.	**Time and Date of next meeting** The next meeting held in public will be on 29 March 2023 9:00am.				
26.	**Exclusion of the Press and Public** 'That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1(2), Public Bodies (Admission to Meetings) Act 1960.				

Item	Subject	Lead	Report/ Verbal	Page No	Time
27.	**Close**				12.00

Minutes
Board of Directors Meeting (Public)
25 January 2023

Minutes of the Public Board of Directors meeting held on Wednesday 25 January 2023 in the Boardroom, Trust Headquarters, 2nd Floor Admin Block, York Hospital. The meeting commenced at 9:45am and concluded at 12:47am.

Members present:

Non-executive Directors
- Alan Downey (Chair)
- Lynne Mellor
- Jim Dillon
- Denise McConnell
- Lorraine Boyd
- Steve Holmberg
- Jenny McAleese (virtual)

Stakeholder Non-Executive Director
- Matt Morgan

Associate Non-executive Director
- Ashley Clay

Executive Directors
- Simon Morritt, Chief Executive
- Andrew Bertram, Deputy Chief Executive/Finance Director
- Heather McNair, Chief Nurse
- Melanie Liley, Interim Chief Operating Officer
- Polly McMeekin, Director of Workforce and Organisational Development
- James Hawkins, Chief Digital Information Officer
- Karen Stone, Medical Director

Corporate Directors
- Lucy Brown, Director of Communications

In Attendance:
- Mike Taylor, Associate Director of Corporate Governance
- Cheryl Gaynor, Corporate Governance Manager

Observers:
There were no observers at the meeting

The Chair welcomed everyone to the meeting.

115 22/23 Apologies for absence

There were no apologies for absence received.

116 22/23 Declaration of Interests

There were no declarations of interest to note.

117 22/23 Minutes of the meeting held on 30 November 2022

The Board approved the minutes of the meeting held on 30 November 2022 as an accurate record of the meeting.

The Board:

- **Approved the minutes of the meeting held on 30 November 2022.**

118 22/23 Matters arising from the minutes

The Board discussed the following actions:

Action 67 – on agenda. Item closed.

Action 73 – Action overtaken by events. This item is now closed.

Action 99 – A Board session on organisational culture and behaviours is planned for February.

Action 101 – Scheduled for inclusion on the agenda for the August Board.

119 22/23 Chief Executive's Update

The Chief Executive presented his report to the Board and highlighted some key areas:

Industrial action – The Royal College of Nursing (RCN) carried out its second round of industrial action over NHS pay on 18 and 19 January. The RCN had also announced two further dates for action (6 and 7 February), which were to involve the Trust and would coincide with GMB ambulance staff strike action planned for 6 February. Simon highlighted that in the previous strike (15 and 20 December) a lot of planned activity was cancelled. Following learning and working closely with the RCN, the intention was to maintain more planned work this time.

Acute flow – There have been several days when pressure in both York and Scarborough has reduced compared with recent months: we have reached Opel 2 on both the York and Scarborough sites. It was believed this was due to a series of contributory factors discussed later in the meeting. There were ongoing difficulties in securing the discharge of patients on pathways 1, 2 and 3. There was known to be funding available in the system to now begin conversations with local authority partners about supporting discharges.

Elective Recovery – Delivery of the elective recovery programme remained a challenge for the Trust. NHS England had deployed a checklist tool in a bid to tackle the elective and cancer backlog. The Trust was in Tier One for elective and cancer performance, meaning it was one of the trusts most at risk of missing key targets. As the Trust had been able to give only limited assurance in relation to the 62-day (cancer) and 78 week targets, the Trust had now moved into weekly meetings with the Intensive Support Team. Despite there being an improvement in trajectory (currently at 397) and confidence that this will

continue to drop, the Trust was not expecting to be reach the target of zero by the deadline. Non-executive Director Steve Holmberg asked about the consequences of not achieving this for the Trust. Simon replied that the target was unlikely to be achieved nationally and that the Trust might avoid undue scrutiny if it could get close to the target. Steve asked whether there was a sense that a number of patients were no longer pursuing their treatment, having waited a significant length of time. Interim Chief Operating Officer Melanie Liley advised that the Trust had written to all patients and 4% of those had replied to confirm that they no longer wished to be included and to forgo their treatment. Further discussions with patients were taking place to establish whether any would be willing to have treatment elsewhere (Bridlington or Harrogate, for example), but so far only a small number of those had agreed. The Board were assured, however, that through clinical validation there were no patients being removed from the lists who required treatment. Wait time would be published by specialty so that patients and GPs could see them. As part of the revalidation and communication exercise, Non-executive Director Lorraine Boyd asked whether the Trust was using this opportunity to reassess the risk that sat within the waiting list with urgent patients becoming even more urgent. As part of the revalidation process, priority can change according to clinical validation and the Board were assured that this was being managed.

NHS England Planning Guidance published – Simon highlighted that NHS England's Priorities and Operational Planning Guidance for 2023-24 was published at the end of the year which set out actions to support delivery of national objectives, focusing on three priority areas. Of particular note was the Urgent and Emergency Care objective to improve A&E waiting times so that no less than 76% of patients are seen within for hours by March 2024 with further improvement in 2024/25.

Simon went on to report that interviews for the Chief Operating Officer were held earlier in the month, but the decision was taken not to appoint any of the candidates. The Trust was continuing its search and Melanie Liley was to continue in the role on an interim basis until an appointment has been made. The Deputy Chief Operating Officer was also appointed in December: Kim Hinton, currently ACOO for Cancer and Support Services, was the successful candidate. Kim was to start in the role in February.

Looking at the long term plan, Non-executive Director Lynne Mellor suggested reviewing the Trust priorities. Simon advised that he intended to present to the Board an explanation of how national expectations align with the Trust priorities.

120 22/23 Trust Priorities Report: Our People

The Director of Workforce and Organisational Development, Polly McMeekin, presented the report and provided an update on the actions developed to support the workforce recovery. Polly described that many of the measures to "fix the basics" were complete or on the verge of completion.

Jim Dillon, Non-executive Director, commented on the challenge of delivering against the Trust's priorities when there was insufficient funding. Polly confirmed that the Trust's charity was providing funding in support of the priorities. She pointed out that there are limiting factors other than funding, such as capacity within the capital planning team. The Finance Director, Andrew Bertram, noted that material asks and planning concerns for the coming year would be considered as part of the capital prioritisation process. The Chief Executive, Simon Morritt, stressed the importance of the hospital charity and its role in supporting patient and staff welfare and wellbeing.

Non-Executive Director Lorraine Boyd commented on the shortage of funds for initiatives to improve staff wellbeing: this issue should be included in the corporate risk register.

The Board discussed the action concerning increased executive visibility across the Trust. Non-Executive Director Jenny McAleese asked whether staff feedback on this point had improved. Polly commented that visibility could be via social media as well as face to face. It was difficult to assess whether attempts to increase visibility had landed well with staff, but positive feedback had been received during the recent industrial action: a number of staff members had commented on the visibility of executives during that time. Simon referred to the annual staff survey which provides feedback on this point, albeit only once a year.

121 22/23 Nurse Workforce Report

The Chief Nurse, Heather McNair presented the report which was also presented to the Boards People & Culture Assurance Committee. The report provided the Board with information and assurance on how the Trust had responded in providing the safest and most effective nurse staffing levels during October and November 2022.

Heather highlighted that the report and data had been presented differently following feedback from Non-executive Director Matt Morgan, in particular around planned verses actual. Recruitment continued but vacancy levels for Healthcare Assistants (HCA's) continued to be high. There was immense work ongoing around retention and it was acknowledged that the Trust was struggling with staff who are were leaving very quickly. In response to this there were plans to provide some HCA support at recruitment events in February where they will share aspects of the role in much more detail to try and let people know what modern healthcare is like today. In terms of the attrition for HCA recruitment, the Chair, Alan Downey questioned whether there was any feedback on the recent attritions about why people may want to leave. Despite the support provided, Heather advised that the general census was that the role was not what they anticipated with shifts and long days, the nature and intensity can be surprising.

In terms of the nursing vacancies and the actual leavers figures included, Non-executive Director Denise McConnell said that it would be beneficial for the Board to see a trend so to illustrate figures going back as well as forwards. There was a further discussion around staff establishment levels. The Board wanted to see actual staff levels compared with an accurate assessment of safe staffing levels as well as against the establishment level the Trust could afford. This issue was remitted to the Quality and Safety Assurance Committee for further discussion.

Heather gave some context and explained that the original nurse staffing establishment review was carried out pre-covid and around 1/3 of the gap between the old and new establishment was funded. The second review was to revisit and refresh it because there had been quite a gap and recognising that some services had evolved or had not been there before and were consequently not captured in the first review. This context was given in response to Non-executive Director Steve Holmberg questioning where the target establishment derives from and suggesting if the only reason for not filling any gap was due to funding constraints, the Trust should challenge what was really required and consider more achievable and efficient ways to meet the staffing levels such as taking into account a whole clinical staffing review. Medical Director Karen Stone assured the Board that the Trust would also look into medical establishment as well as other roles and resources that contribute to the functioning of a ward or service. Steve highlighted that the Board were yet to have sight of any assurance around doctors' activity and effective job planning which would be an integral part of any review to ensure the best direction of any resources. Non-executive Director Ashley Clay also added not wanting to lose sight of attrition issues.

The Board:

- **received and noted the report.**

122 22/23 Public Sector Equality Duty Report

Workforce

Head of Equality, Diversity and Inclusion (EDI), Virginia Golding attended the meeting to present the Public Sector Equality Duty (PSED) Workforce Annual Review Report 2022 and gave an account of where the Trust was in terms of its 2020-2024 objectives which were previously approved by the Trust in 2020 and covered Patients, Buildings Environment and Workforce. It was previously decided upon that the Patient and Workforce agendas would be reported upon separately. Therefore, the PSED Patient Annual Review Report was presented by the Patient EDI Lead, Helen Ketcher at the meeting. The Board noted that a combined PSED report would be received in future to provide a more holistic overview of progress against the objectives as normal practice. The Board were informed that this would coincide with the finalisation of the current equality objectives.

Overall, there was good progress on objectives, Virginia described that she had created an EDI action plan to address the recommendations of the external review conducted in 2022. This action plan incorporated elements of the PSED Objectives as did the Gender Pay Gap (GPG), Workforce Race and Disability Equality Standards (WRES) and (WDES) WRES action plans. Next steps were to look at disseminating within the Trust and filter this information down and hold individuals responsible for some of the actions. Another suite of training for staff had been arranged to update their knowledge and awareness.

The Board discussed the culture in terms of behaviours around EDI across the organisation and Non-executive Director Denise McConnell described her interest in understanding whether in terms of culture the Trust was changing and improving in relation to inclusion and behaviours. She reminded the Board that at a previous meeting there was an example given that suggested the Trust faced significant challenges in this area. Virginia acknowledged that culture takes time to change and that the Trust is on a journey, moving beyond compliance. She added that the EDI workstreams would be a good way to effect culture in a positive way. Non-executive Director Matt Morgan added that there had been previous discussions at the Board around staff being able to challenge when they see anything inappropriate. He commented on the lack of assurance that the Trust's policies were being actively put into practice: it was not clear from the report where the Trust was in terms of progress. He gave an example of a staff member who witnesses behaviours that were of concern: would they feel able to challenge in a safe way and be confident that their concerns would be followed up? Virginia assured the Board that she was working through this in collaboration with the Freedom to Speak Up Guardian and delivering workshops on EDI, while also ensuring that staff members are able to engage with the Fairness Champions. Patient EDI Lead Helen Ketcher mentioned Disability History month (16 November to 16 December) where the Trust raised awareness, in particular for front line staff, around accessibility including how to get an interpreter and when to remove mask. This was a starting point to try and understand training needs. Helen stressed the importance of empowering staff to ask questions and advocate for their colleagues and patients in order to get what they need. She went on to say that there was something about having further conversations and developing care groups awareness, capability and capacity to take things in that direction. Matt observed that some staff members clearly lack the confidence to speak up through internal processes and asked what more could be done to address this. Helen commented that there are a number of approaches for reporting concerns, including the Freedom to Speak up route. Better reporting would result in the impact on patient care becoming become more visible and identifiable.

Non-executive Director Lynne Mellor asked what the biggest risk was, in terms of implementation of the plan, and what steps could be taken to mitigate that risk. Virginia was clear that not being able to provide patient centred care was a risk at all times. She particularly mentioned trans as an area where more work was needed. Transgender awareness training was available to staff to increase their knowledge. Issues around transgender were acknowledged as complex.

Patient

The Patient EDI Lead, Helen Ketcher, presented the PSED Patient Equality, Diversity and Inclusion annual report. Helen highlighted the key objectives noted in the report around listening and engaging with community, communicating internally with staff and teams and Trust compliance with the Accessibility Information Standard 2016.

Helen commented that the workstreams included in the reports would help to formalise EDI and in terms of leadership, staff behaviours and the impact on patient care.

Non-executive Director, Matt Morgan asked whether the Trust was making progress in relation to accessibility, bearing in mind that the report included work only until June 2022. Helen advised that there had been discussion at the Fairness Forum (now known as the Inclusion Forum), and there had been a number of improvements around accessibility. The report described a number of references to deaf awareness and Helen added that David Biggins, Inclusive Built Environment Lead, had secured some charitable funding to supply some additional portable hearing loops which were distributed during the disability history month and the discussions with reception staff. There was also progress at Care Group level with further discussions through the Inclusion Forum around what was within their power to action and essentially what could be done through central programmes or funding streams available. There are some issues given the age of many Trust buildings and the maintenance backlog. Helen asked that the Board consider the equality impact on not acting on some of those maintenance requirements and in balancing the risks. Going forwards there were also new developments in the Trust estate, and Helen stressed the importance of including equality impact assessments into the planning phase of projects, as well as ensuring that plans were consistently run through the Inclusive Built Environment Lead. Virginia clarified that the current Equality Impact Assessment process was to be reviewed.

Matt asked whether charitable funds could be used to support patients who face particular difficulties in accessing services. The Chief Executive, Simon Morritt, stressed the importance of ensuring that the accessibility plan was aligned to the capital plan for 2023-24 and included in the prioritisation process. Simon also suggested that the 'Inclusion Plan' that was discussed at the last Fairness Forum meeting should be shared with the Board.

The Board:
Noted the reports and requested an update on progress in six months' time.

123 22/23 People & Culture Assurance Committee

The Board noted the minutes of the latest People & Culture Assurance Committee.

Chair of the People & Culture Assurance Committee highlighted a key discussion at a meeting in relation to long term sustainability plans for occupational health and given the

delays, the committee had challenged whether the internal provision needed to be reviewed.

124 22/23 Trust Priorities Report: Quality & Safety

The Chief Nurse, Heather McNair, presented the quality and safety element of the Trust Priorities Report. She highlighted that there was a continued focus on performance around complaints and response rates, in particular waiting times and patient access. Turnaround times were generally good. She acknowledged that the complaints process needed further work as it was not being as responsive as it could be and needed to be understood better. Heather also highlighted that there was no reference currently to safeguarding in the data of the report and suggested that this would be included going forwards as a key matrix for the Board's oversight.

125 22/23 CQC Update

The Chief Nurse, Heather McNair, presented the report and provided the Board with an updated position in relation to the action being taken to address the CQC regulatory conditions.

Heather gave an update on progress, as follows:

Section 29A Warning Notice

- Scarborough Hospital Emergency Department – This post was now filled and a request for approval to remove will be submitted in due course
- York Hospital Medicine – Assessment & management of patients' nutrition & hydration needs. (May 2022)
- York Hospital Medicine – Recording of patient risk assessment and subsequent management of risks. (May 2022)
- York Hospital Medicine – Adherence to the Mental Capacity Act. (May 2022)

Section 31 Conditions of Registration

- York Hospital Emergency Department – Mental Health Risk Assessments. (Jan 2020)
- Scarborough Hospital Emergency Department – Mental Health Risk Assessments. (Jan 2020)
- Maternity and Midwifery Services (Nov 2022)

Much of the work was on track with only a couple of 'must do's' remained outstanding. In terms of the Should do actions, the report described one action that was in place to address the action '*The trust should ensure that persons employed receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform'.* It was noted that this action was to establish the Trust training sub-group, which did not completely address the action required. Non-executive Directors Matt Morgan pointed out that Ttable 8 in the report contradicted this statement in that it noted the action as completed but may have been the incorrect action. Heather agreed to pick this up and report back to Matt.

The Board touched further on the completion of actions, and Non-executive Director Steve Holmberg asked whether there was a mechanism of triangulation that described what had changed as a consequence when something is closed. Heather assured the Board that

whenever an action is closed, evidence is required to be provided which should describe the reasons for closure. The challenge was sustainability. The Board suggested that sustainability was something that could be measured on an ongoing basis through the Quality & Safety Assurance Committee.

126 22/23 Ockenden Report Update

Care Group Director of Maternity Sue Glendenning attended the meeting to present the report and highlighted the following points:

- Maternity services unannounced Care Quality commission 3 day visit in October and follow up visit in November 2022 – no feedback had been received on the submission of the first monthly report
- Maternity services supported by the National and Regional maternity Teams as part of the Maternity Safety Support Programme and a Strategic Improvement Director
- Maternity Incentive Scheme (MIS) (included in the report as appendix D) report presented to the ICB as non-compliant for the reporting period
- Ockenden and MIS were key workstreams alongside the 5 Key
- Lines of Enquiry and plans need to incorporate the embedding as key workstreams in
- conjunction with the Maternity Improvement Plan and be monitored via the Maternity
- Transformation Committee.
- Review of the midwifery structure was on-going

The Board discussed the suggested senior team on-call and the risks associated with the escalation of divert and closure decisions. Non-executive Director Lorraine Boyd felt that there was clarity needed around how the Trust was mitigating the risk identified by the CQC. Sue assured the Board that the diverts and closures had dramatically reduced recently and there had been ongoing work in developing the escalation policy, in particular in understanding the expectations around roles and responsibilities of individuals in that process.

The Board touched on communication of the work being done in maternity and Lorraine asked whether the work that had been done was being effectively communicated. Sue suggested that there was significant progress in terms of communication and engagement and it was felt that the right mix of individuals and roles were present. Sue provided examples of assurance around some of the communication and engagement activities in the department through continuing a Tune-in Tuesday weekly staff briefing, the way in which handovers were structure continued to evolve and improve, safety briefings were now included as part of the handovers. A specific area of improvement was around increased senior visibility across both sites with sharing good practice.

There was a discussion around staff training compliance which remained low. Non-executive Director Matt Morgan questioned whether this was a consequence of staff not being engaged. Non-executive Director Steve Holmberg highlighted that a factor may be the number of temporary staff.

The Board:

- **received and noted the report**

127 22/23 Q3 Guardian of Safer Working Report

The Medical Director, Karen Stone, presented the report and highlighted:

- Outstanding £15,000 national funding provided to enhance junior doctor rest facilities on the York site was yet to be spent – deadline to be spent by end of March 2023
- There were Education Supervisors who are not supportive of the exception reporting process. This is currently being addressed through increased education but highlighted that escalation may become necessary
- Requests for locums (bank and agency) fell compared to Q2

The Board discussed the junior doctor training and Non-executive Director Lorraine Boyd asked about the impact of the current operational pressures on the delivery of doctors' training. Karen assured the Board that to date there had been no concerns and that work was in hand to understand what opportunities for training were being used and also what were available.

The Board:
- **received and noted the report**

128 22/23 Quality and Safety Assurance Committee

Chair of the Quality and Safety Assurance Committee, Steve Holmberg presented the minutes of November and December meeting and the escalation report from the January meeting highlighting the following escalations to the Board:

- 8 Maternity Services (Ockenden) - To inform the Board of on-going work to address concerns by CQC and to achieve compliance with Ockenden standards
- 10 CQC Compliance Report - To inform the Board of on-going work to address regulatory action imposed by CQC and to address additional recommendations for improvement in the Trust
- 11,12,15 Digital Improvements – Care Group 6 reported safety concerns relating to delays in digital developments associated with outpatient transformation. Additional concerns were raised in relation to delays in developing new dashboards associated with projects including Nucleus

Chief Digital Information Officer, James Hawkins assured the Board that the Digital team were working hard to tackle some administration issues highlighted and were hoping to speed up that resource

129 22/23 Trust Acute Flow Current Pressures

The Board received the report and noted the following points highlighted by the Interim Chief Operating Officer, Mel Liley:

- No surprise it was busy
- Normally have a high discharging period before Christmas but we didn't see that this year
- Mindful that attendances were fairly flatline but an increase in numbers of patients who do not have a right to reside. Proportionally higher number of admissions than normal
- Normally see a flu spike in January and also in covid
- All of the above were contributing factors of the pressures
- Normal winter plan funding allocation was different and through Place this year
- Because of Tier 1 status we would normally stand down activity and were not in a place to be able to do that.
- Full detailed learning exercise being undertaken

- Some of the measures that were taken to try to remedy the situation in the moment (list on page 228 of measures that evidently had an impact) recognising that a lot required longer term
- Risk point of view – standing up some additional capacity – still trying to reduce bed capacity as part of a CQC action but at that moment it felt like a risk that needed to take. Some immediate benefits were seen and particular around:
    - Flu ward had more timely senior reviews as well as the outliers
    - Improvement in pathway 0 discharge
    - Increased speciality input in emergency departments (much like the new operating models that were hoped to be introduced)
    - Challenges around the elective programme, over the winter period and because of pressures a number of elective patients were cancelled
    - Workforce challenges
- Looking to sustain the impact - Some of the actions were to be explored further to sustain the impact, in particular around areas in relation to IPC, complex discharge and the processes we have in place as well as the partnership working and specialty reviews. Medical Director Karen Stone also discussing an ongoing clinical review and internal professional standards setting

Will take the learning once completed in its full and consider how the Trust could enhance its Opel 4 actions to have some additional associated actions that can be initiated by Gold Command in the event of a similar position and under that level of extreme operational pressure. It was stressed that such learning be incorporated into the future Winter Plans and the results from the review be shared with the Board once available, which would look to describe the actions against their level of impact and equally include reviewing the build up to the situation an any red flags that became apparent along the way.

Mel further reported a significantly improved position with both sites reporting Opel 2 at the time of the meeting.

The Board were keen to share their acknowledgement of the circumstances and share that lessons would be learnt to avoid in future. **The Director of Communications, Lucy Brown was asked to take that action to consider a communication method to support the Board request.**

They also discussed a thank you for staff similar to the 'big Thank You' campaign around the pandemic. Non-executive Director Lynne Mellor suggested a further board discussion on developing something similar in the summer to not only thank staff for this incident but work achieved over time. Lynne also suggested to project the voice of the patients to describe and understand what it felt like to them throughout the extreme pressures and as a consequence of the Gold Command, appreciating the difficulties around this so perhaps on this occasions some mechanisms rather than the patients themselves. Karen extended this to also include staff experience (to include partners i.e. ambulance, local authorities etc.). Mel agreed to take this back and incorporate where possible as part of the review.

The Board:

- **received and noted the report**

130 22/23 Trust Priorities Report: Elective Recovery and Acute Flow

The Interim Chief Operating Officer, Mel Liley, presented the report and highlighted the following key messages:

- Covid and flu numbers today have reduced and are seeing a downward trend - flu 23 and covid 78 and 4 patients with both flu and covid (105 total)
- Acute flow – reenergised the Urgent and emergency Care Programme with 7 key workstreams. Four of which were highlighted:
  - virtual ward and SDEC – this week had agreement from the Urgent Emergency Improvement Support Team (NHS England) had agreed to support the Trust with extending the virtual ward capability and included looking and clinical ambition to extend that into different areas and specialties.
  - Dr Matthew Cooke (previous Chair of the Royal College of Emergency Medicine) visit in December – received a comprehensive report from his visit. Key highlights noted in the report including clarity around the Trust 5-year vision for integrated urgent and emergency care. This reflected the work around the operating model for the new build. Overall was a reassuring report.
  - Looking further at discharge processes and the Medical Director support in terms of development and implementation of the discharge framework which built on some of the lessons learnt through enhanced Opel actions. Will report further information on this back to the Board in due course.
  - Scope to provide support around provision of a domiciliary care service. The decision to focus on effort and resources around the community response team – the team were working way over their capacity at the moment and was a key focus around elective work for the Trust.
- Elective position – in particular 78-week position which is the focus of NHS England and a key focus of the ICB. 2 key elements of support from fruition of coming into Tier 1 – is bringing some positive actions. Have the Elective Intensive Support Team in addition with Ernst and Young (funded through NHS England) and now finalised the contractual requirements. Some of the work included governance processes and some further forensic work around trajectories for recovery including sensitivity analysis and also some detailed work with operational and administrative teams around processes. Looking to hold a detailed session with the Board in February.

131 22/23 Digital, Performance and Finance Assurance Committee

Chair of the Digital, Performance and Finance Assurance Committee, Lynne Mellor presented the Board with the minutes of the November and December meetings and the Board acknowledged the following key escalations from the January meeting:

- Committee suggested a Board deep dive addressing both short term and longer-term issues/needs particularly on how the Trust can mitigate the risk of elective backlogs rising by almost 50% and to include a deep dive on cancer (suggested to have a deep dive review session following the Elective Intensive Support team visit in December)
- The Board to ensure that the Trust reiterates the mandate from the Executive Committee that patients need to be informed of the outcome of their Cancer review outcome within 48 hours
- Cyber desktop exercise and areas of potential concern

132 22/23 Finance Report

The Finance Director, Andrew Bertram presented the report to the Board and described the month 9 Trust finance position with an actual adjusted deficit of £6.4m against a planned deficit of £0.4m for December. The Trust was consequently £6.0m adversely adrift of plan and represented a deterioration of the position reported in prior months. Andrew clarified that of the £6.0m adverse variance, the unfunded pay award and the additional

CT scanner accounted for a pressure of £2.65m for which recompense has been confirmed for the pay award (to be received in February and January report would reflect this), and some still expected for the CT scanner. The scanner was a fully serviced scanner at a cost of £1.4m for the full financial year and was currently impacting the Trust position by £1.05m. This left a balance of £3.35m created through other pressure for which additional income was not expected.

In terms of confidence levels in the requirement of delivering the balanced position feeding through up to the ICB, Non-executive Director, Denise McConnell had previously asked on this assurance from Andrew. He shared that he had concerns around the £2m move up to £6m from month 8 to month 9 but given the movement on some of the funding issues and the progress that care groups had made in relation to their recovery action, there was a continued effort to work towards and deliver a balanced position.

The Board sought further clarity on the utilities impact and the expectation that the Trust covered the gap. Associate Non-executive Director, Ashley Clay questioned if there was exposure on the forecast until the end of year on the utilities and Andrew confirmed that the forecast picked up on the latest projections for which the Trust were accountable.

The Board:

- **noted the report and the Trust financial position.**

133 22/23 Risk Management Update – Board Assurance Framework and Corporate Risk Register

Associate Director of Corporate Governance Mike Taylor presented the report which illustrated the latest iteration of the Board Assurance Framework and Corporate Risk Register for January – Quarter 3 following their presentation to the relevant sub-committees.

Looking at Equality, Diversity and Inclusion, Non-executive Director Lynne Mellor reminded the Board of the risk highlighted earlier in the meeting around transgender and gender diversity and suggested that another glance be considered from the EDI perspective. Lynne went on to question how the Trust was capturing this subject and whether the Board had done enough around the BAF to look at the risks and mitigation related to EDI.

The Board:

- **approved the Q3 Board Assurance Framework and noted the current Corporate Risk Register.**

134 22/23 Corporate Governance Framework Review

The Associate Director of Corporate Governance, Mike Taylor, presented the report and acknowledged the Corporate Governance Framework review as part of an annual review with some minor amends noted in the report. The review had subsequently been presented to the Group Audit Committee in December where it was recommended for approval.

The Board:

- **approved the amended Trust Reservation of Powers and Scheme of Delegation and Standing Financial Instructions.**

135 22/23 Group Audit Committee

Chair of the Group Audit Committee, Jenny McAleese, presented the report and highlighted the following points:

- Risks facing the Trust and the Board Assurance Framework (BAF): Jenny described that the committee remained concerned that Board and Sub-Committee agendas do not focus sufficient time and attention on identifying risks and managing these to the lowest possible level. The Committee suggested that representatives of the Board look at how progress with this could be made.
- Process of Escalation – The Committee recognised that Sub-Committees were routinely escalating items to the Board but that this didn't always result in action by the Board. The Committee requested that the Board reviews the system of escalation with a view to ensuring that action is agreed as a result of an issue being escalated.

Jenny suggested and it was agreed that she work through the escalations collectively with the Chair and Associate Director of Corporate Governance with a view to recommend how to address them. In the meantime, the Chair, Alan Downey agreed to move the BAF up on the Board's agenda going forwards.

Jenny took the opportunity to inform the Board that a refresher session had taken place which covered the role of the Audit Committee and internal audit, there was also a session due to be planned with the Board to understand expectations.

The Board:

- **received and noted the report**

136 22/23 Any Other Business

The Associate Director or Corporate Governance, Mike Taylor requested Board approval for the use of the Trust Seal in relation to a new lease of property (Holgate Park) for International Nursing Training.

The Board

- **approved the use of the Trust Seal for the new lease as described.**

137 22/23 Time and Date of next meeting

The next public meeting of the Board of Directors will be held on 22 February 2023.

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Item 05

Action Log – Board of Directors (Public)

Action No.	Date of Meeting	Meeting	Minute Number Reference	Title	Action (from Minute)	Executive Lead/Owner	Update / comments	Due Date	Status
101	02 November 2022	Public Board of Directors	84 - 22/23	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Report and Action Plan	Head of Equality, Diversity and Inclusion invited to report on Progress in 6 months.	Associate Director of Corporate Governance	25.01.23 - scheduled for August (September due to no Board in August) Board meeting	Apr-23	Green

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	22 February 2023
Subject:	Chief Executive's Report
Director Sponsor:	Simon Morritt, Chief Executive
Author:	Simon Morritt, Chief Executive

Status of the Report (please click on the appropriate box)

Approve ☐ Discuss ☒ Assurance ☐ Information ☒ A Regulatory Requirement ☐

Trust Priorities	Board Assurance Framework
☒ Our People	☒ Quality Standards
☒ Quality and Safety	☒ Workforce
☒ Elective Recovery	☒ Safety Standards
☒ Acute Flow	☐ Financial
	☒ Performance Targets
	☐ DIS Service Standards
	☒ Integrated Care System

Summary of Report and Key Points to highlight:

To provide an update to the Board of Directors from the Chief Executive in relation to the Trust priorities. Key areas include: Industrial action, Urgent and emergency care recovery plan, update on capital schemes (Scarborough urgent and emergency care centre and York emergency department), Annual planning 2023-24.

Recommendation:

For the Board of Directors to note the report.

Report Exempt from Public Disclosure

No ☒ Yes ☐

(If yes, please detail the specific grounds for exemption)

Report History

Board of Directors only

Meeting	Date	Outcome/Recommendation
Board of Directors	22 February 2023	

Chief Executive's Report

1. Our People

1.1 Industrial action

We continue to experience periods of industrial action by the unions representing NHS staff in the ongoing dispute about pay.

The RCN has announced further action affecting our Trust on Wednesday 1 March, Thursday 2 March and Friday 3 March 2023.

This time the industrial action will commence at the beginning of the day shift on Wednesday 1 March 2023 and will last until the start of the day shift on Friday 3 March 2023.

As before, this will be managed through our command and control structure, coordinated via silver and bronze leads.

In addition, further ballots from the BMA (British Medical Association) and BDA (British Dietetic Association) are currently ongoing. The BMA has already confirmed that junior doctors will undertake 72 hours of continuous action in March, should they reach the numbers needed.

Members of the CSP (Chartered Society of Physiotherapists) have voted to take action short of strike, however no dates for this have been provided for our Trust.

Upcoming action is as follows:

- 20 February - ambulance workers who are members of GMB and Unite
- 22 February - ambulance workers who are members of Unite
- 1,2,3 March – staff who are members of the RCN
- 6 March - ambulance workers who are members of GMB and Unite
- 20 March - ambulance workers who are members of GMB and Unite

2. Acute Flow

2.1 Urgent and emergency care recovery plan

The national Urgent and emergency care recovery plan was published on 30 January, with the aim of recovering urgent and emergency care services, reducing waiting times, and improving patient experience.

Frontline capacity will be boosted with additional ambulances (including specialist mental health vehicles), and around 5,000 more hospital beds, supported by £1 billion of funding.

Urgent care in the community will also be expanded to allow patients to be treated at home and avoid a hospital admission. These services will operate 12 hours a day and ensure patients who fall or injured at home are seen within two hours, while same day emergency care units, staffed by emergency consultants and nurses, will open in every major A&E.
Pilots of NHS step down care will be rolled out across the country, where patients will receive rehabilitation and physiotherapy in dedicated centres or at home. Virtual wards are also set to be expanded.

We have undertaken an initial assessment of the national plan to ensure the key actions are covered by our trust's refreshed Urgent and Emergency Care Programme. A more detailed analysis is taking place this month, and the programme will be updated if required.

2.2 Update on capital schemes

Scarborough Urgent and Emergency Care Centre

The project remains on track for completion and occupation by Spring 2024.

The current focus is on work to complete the floor slab, stair/lift cores and the structure of the building. Work has also commenced on the external envelope as well as the electrical infrastructure element of the project.

In the next couple of months there will be considerable work ongoing to complete the external envelope of the building (roof, brickwork, and cladding), which will allow the internal work to fit-out the building to commence in earnest.

A lot of work is taking place regarding the scheduling of new equipment that needs to be procured in addition to identifying existing equipment that can be transferred to the new facilities.

York Emergency Department extension

The project is on track for construction completion this Spring.

The current focus is on internal fit-out, completion of the external cladding and completion of the engineering installation. This work will continue for the next quarter until construction is complete. At this point, the remaining testing and commissioning of all the engineering infrastructure, systems and components can be undertaken prior to the new facilities being thoroughly cleaned ready for occupation and use.

Testing the new models of care

Both of these capital developments will not only provide larger and vastly-improved facilities, they will more importantly support our staff to work differently to deliver acute care.

New models of care are being developed for both sites, and are being tested and refined in readiness for moving into the new buildings and working differently from the start. To support this, we have been working with colleagues in the Army Medical Services Training Centre to plan a live exercise to test and validate the proposed models.

The exercises will replicate the layout of the new floor plans in the training facility and staff will be faced with a number of scenarios using 'casualty actors' to provide realistic challenges for the staff.

The York team will undertake their training exercise in early March, with Scarborough to follow later in the year.

4. Governance

4.1. Annual operational and financial planning for 2023-24

As briefed at last month's Board meeting, NHS England's Priorities and Operational Planning Guidance for 2023-24 was published in December setting out actions to support delivery of national objectives under three priority areas:

- Recovering our core services and productivity
- As we recover, make progress in delivering the key ambitions in the Long-Term Plan
- Continue transforming the NHS for the future

The technical guidance has also been released, and we are in the process of developing both the trust's plan and the ICB's plan, in partnership with the other organisations in our ICS.

We will be discussing the draft plan in the private session of the Board meeting, with final submission to NHS England due at the end of March.

Date: 22 February 2023

York and Scarborough Teaching Hospitals
NHS Foundation Trust

TRUST PRIORITIES REPORT

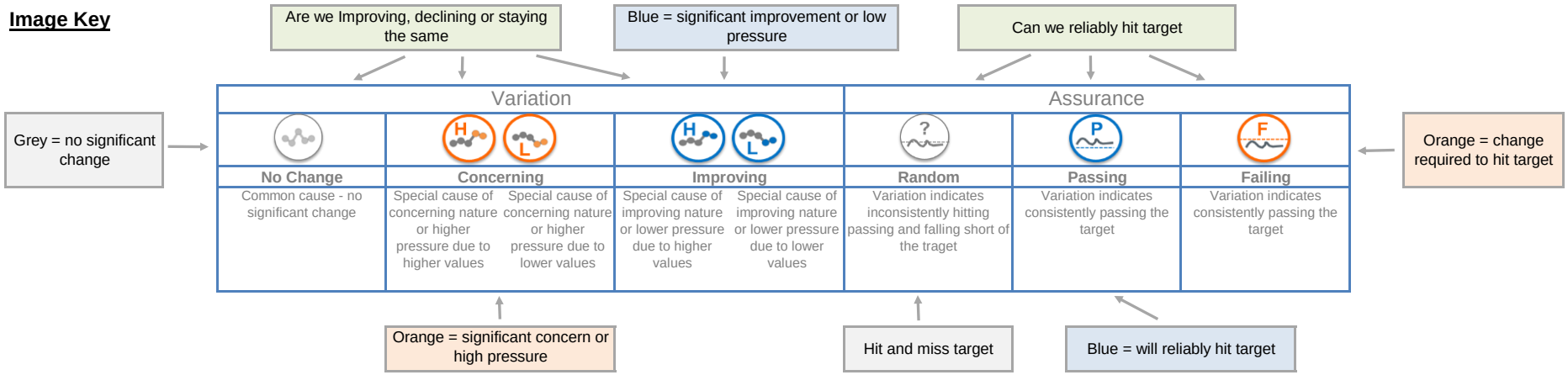
January 2023

Board Assurance Framework supporting information for:
PR1 Quality Standards, PR2 Safety Standards,
PR3 Performance Targets, PR4 Workforce, PR5 Finance,
PR6 DIS Service Standards, PR7 Integrated Care System (identified risk interdependencies)

KEYS

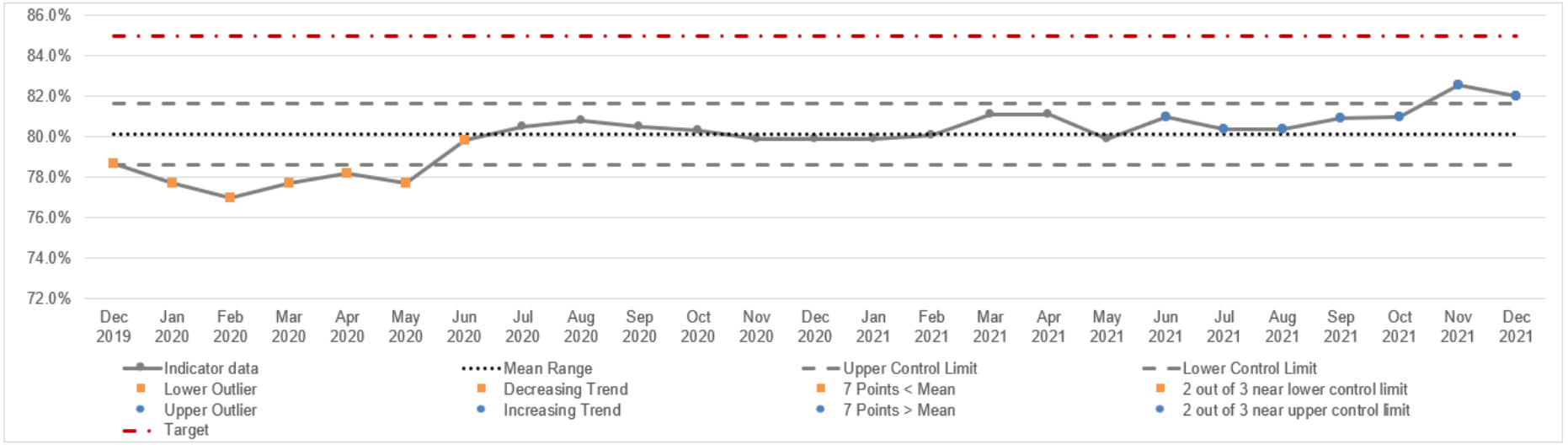
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Image Key



Note: 'Action Required' is stated on the Scorecard when either the Variation is showing special cause concern or the Assurance is indicating failing the target (where applicable). This is only applicable where there is sufficient data to present as a Statistical Process Control Chart (SPC).

SPC Key - example SPC chart



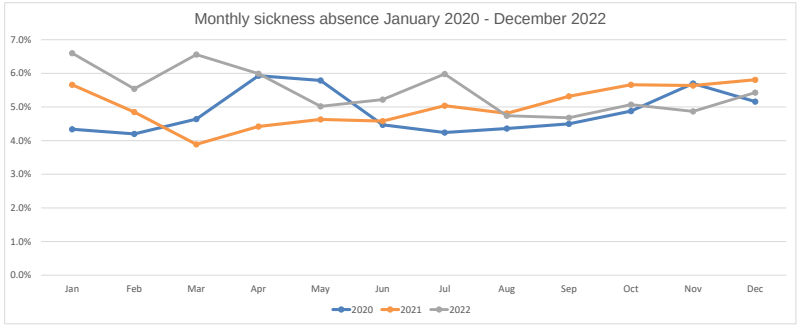
Orange Squares = significant concern or high pressure

Blue Circles = significant improvement or low pressure

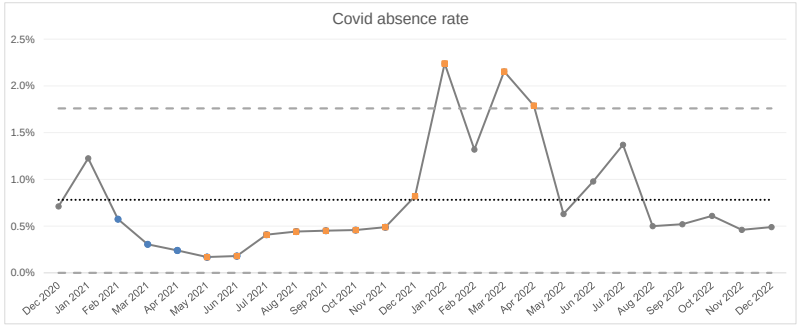
OUR PEOPLE - Sickness Absence

York and Scarborough Teaching Hospitals NHS Foundation Trust

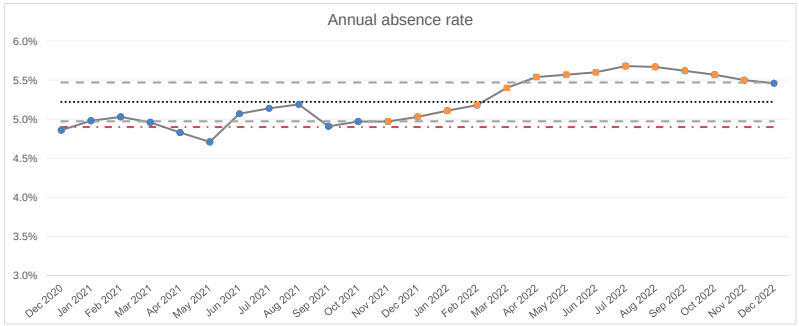
REPORTING MONTH : JANUARY 2023



Dec 2022
5.43%
Target
No Target
Variance
Assurance



Dec 2022
0.49%
Target
No Target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



Dec 2022
5.46%
Target
4.9%
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Variation indicates consistently falling short of the target

This space is left intentionally blank

Data Analysis:

Monthly sickness absence rate: This indicator is not presented as a statistical process control chart (SPC) so that the comparison of monthly sickness can be seen month on month for the past 3 years, and to allow for seasonal variation. The sickness rate for Dec 2022 (5.43%) is lower than that seen last year (5.81%).
Covid absence rate: The indicator is currently showing common cause variation since May 2022, with special cause concern seen in January, March and April 2022 with both data points above the upper control limit. There was also a peak in Jul 2022.
Annual absence rate: The indicator was showing special cause concern since November 2021, with an increasing trend. The data points were above the upper control limit from April to November 2022. For December 2022 improvement is shown after a consistent decreasing trend, and is slightly below the upper control limit. The target is slightly below the lower control limit, so is showing as consistently failing target.

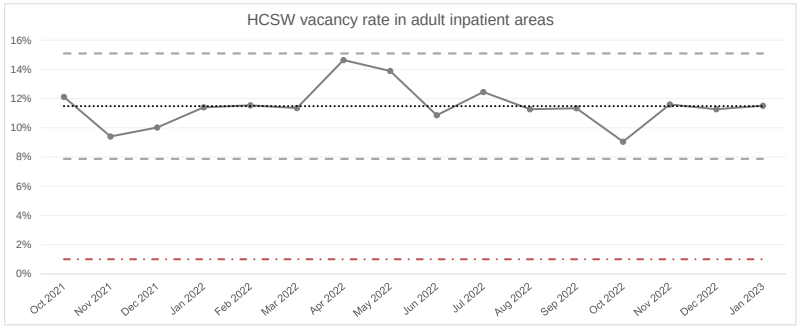
Operational Update

The annual absence rate has reduced in each of the last five months but it is still higher than it was at the same point last year and above 5%. We did see an increase in the monthly rate for December. High absence rates are indicative of low levels of engagement within the workforce. The embargo for the staff survey reuslts from the 2022 survey will be lifted on 9th March 2023 and a Trust action plan will follow.

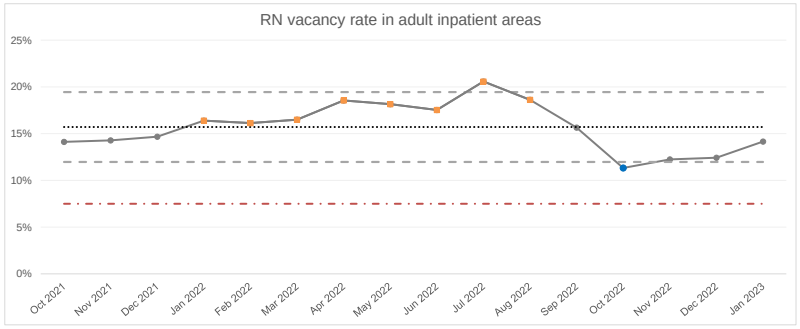
OUR PEOPLE - Vacancy Rate

REPORTING MONTH : JANUARY 2023

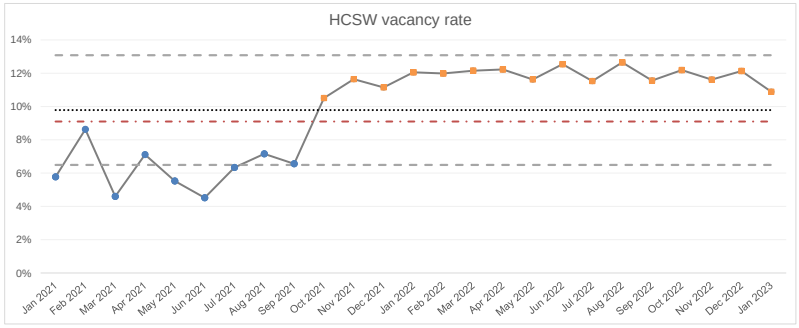
York and Scarborough Teaching Hospitals NHS Foundation Trust



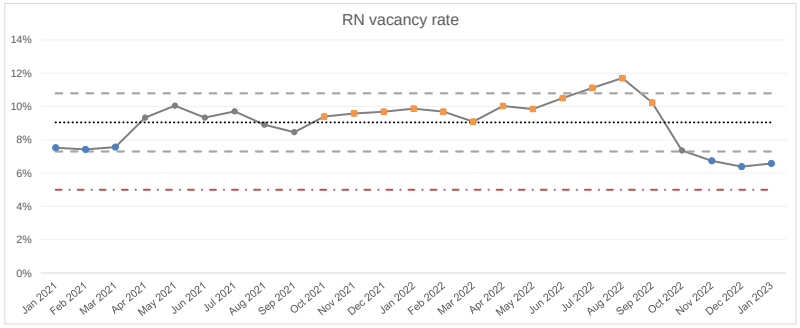
Jan 2023	Target	Variance	Assurance
11.51%	1%	Common cause - no significant change	Variation indicates consistently falling short of the target



Jan 2023	Target	Variance	Assurance
14.15%	7.5%	Common cause - no significant change	Variation indicates consistently falling short of the target



Jan 2023	Target	Variance	Assurance
10.89%	9.10%	Special cause of concerning nature or higher pressure due to higher values	Variation indicates inconsistently hitting passing and falling short of the target



Jan 2023	Target	Variance	Assurance
6.58%	5%	Special cause of improving nature or lower pressure due to lower values	Variation indicates consistently falling short of the target

Data Analysis:

HCSW vacancy rate in adult inpatient areas: The indicator is showing common cause variation, however please note the vacancy rate is shown from Oct 2021 only and has been re-calculated on this month's report. The target is consistently not being met.
RN vacancy rate in adult inpatient areas: The indicator is showing common cause variation with Oct 2022 being below the lower control limit, please note the vacancy rate is shown from Oct 2021 only and has been re-calculated on this month's report. July 2022 was above the upper control limit. The target is consistently not being met.
HCSW vacancy rate: The indicator is showing special cause concern, above the mean but below the upper control limit, from Oct 2021. The target is just below the mean and has not been met since Sep 2021.
RN vacancy rate: The indicator is showing special cause improvement, below the lower control limit in Nov 2022 to Jan 2023. The months of Jul and Aug 2022 were above the upper control limit. The target is consistently not being met.

Operational Update

Following the recruitment trip to Kerala, India, the Trust has made offers to 97 RN's and 10 AHP's. Work is underway to process applications and support candidates with their English to enable cohorts to be drafted so we can plan commencement dates across 2023/24.

The Trust has started the process to bid for NHSE funding to support international nursing recruitment between April – November 2023 and has indicated a target of 90 international nurses which could generate £450k in funding.

NHSE has confirmed that we have met our target of international nursing recruitment in 2022/23, with 134 nurses recruited. The Trust is on track to deliver our international AHP recruitment target of 18 and has been recognised as the organisation with the highest level of international AHP's on-boarded in the region.

A HCSW recruitment event is planned for 15 February. Recruitment events held in September and October for HCSWs and PSOs, resulted in over 80 HCSW new starters and over 40 PSO new starters to date, with a small number of successful applicants for both roles still in the pipeline with start dates to be confirmed.

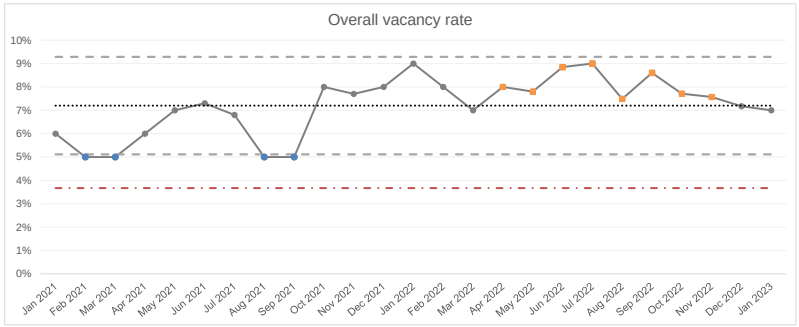
A recruitment workshop facilitated by NHSE has been scheduled for 20 February. It will consider the Trust approach to recruitment and explore new ways of working to improve engagement and time to hire.

The figures shown in the graph above for vacancy rates on adult inpatient wards does not account for those international nurses who have recently joined us but are still completing their OSCE training or awaiting their PIN. When these numbers are taken into the account the vacancy rate on adult inpatient wards across the Trust is reduced to 7.68%.

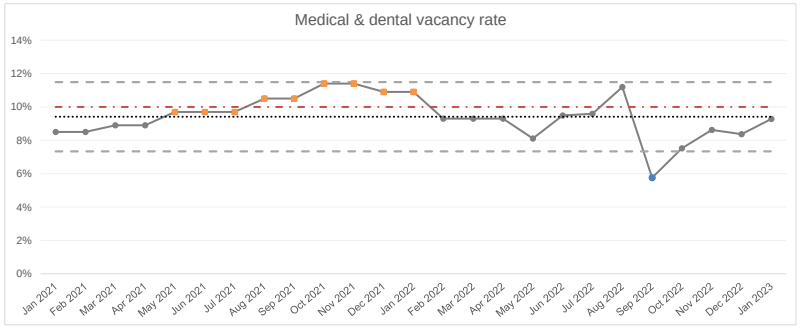
OUR PEOPLE - Vacancy Rate and Turnover Rate

York and Scarborough Teaching Hospitals NHS Foundation Trust

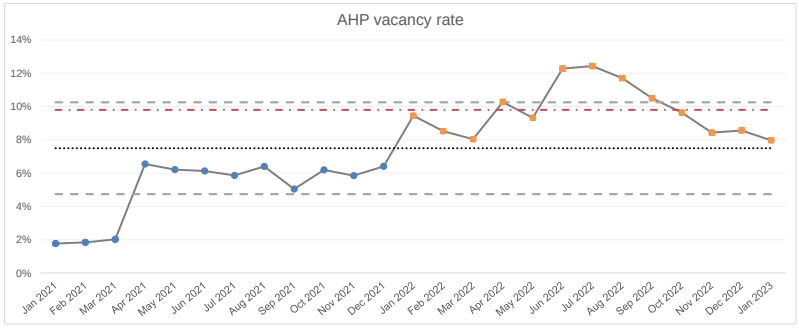
REPORTING MONTH : JANUARY 2023



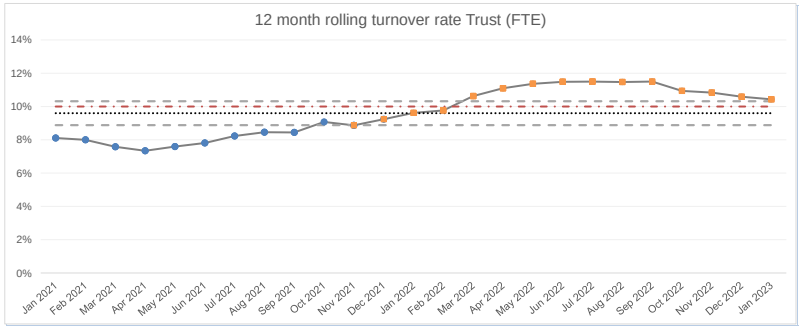
Jan 2023	Target	Variance	Assurance
7.00%	3.67%	Common cause - no significant change	Variation indicates consistently falling short of the target



Jan 2023	Target	Variance	Assurance
9.3%	10%	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the target



Jan 2023	Target	Variance	Assurance
8.0%	9.80%	Special cause of concerning nature or higher pressure due to higher values	Variation indicates inconsistently hitting passing and falling short of the target



Jan 2023	Target	Variance	Assurance
10.43%	10%	Special cause of concerning nature or higher pressure due to higher values	Variation indicates inconsistently hitting passing and falling short of the target

Data Analysis:

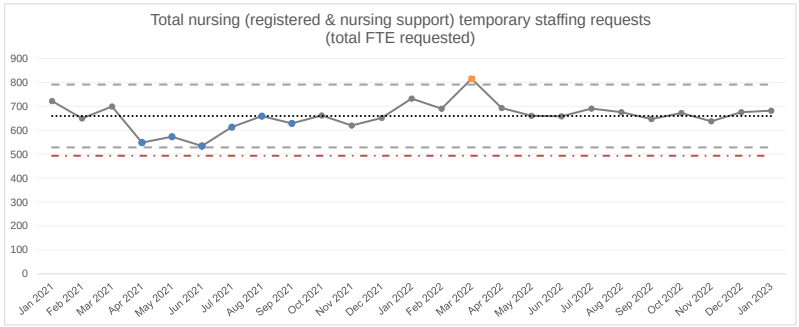
Overall vacancy rate: The indicator was showing special cause concern from April 2022 with a run of points above the mean, but is now showing common cause variation. The indicator is consistently failing target.
Medical & dental vacancy rate: The indicator is showing a period of nine points above the mean from May 2021 to Jan 2022, for Sep 2022 this was showing special cause improvement below the lower control limit, but has since returned nearer to the mean. The target is showing above the mean.
AHP vacancy rate: The indicator is showing special cause concern with a period of points above the mean since Jan 2022 and points above the upper control limit in Apr 2022 and Jun-Sep 2022. There are signs of a decreasing trend back towards the mean from Jul 2022. The target is showing as consistently passing.
12 month rolling turnover rate - Trust (FTE): The indicator is showing special cause concern since November 2021, with data points above the mean. The data points have been above the upper control limit from Mar 2022. The target is slightly below the upper control limit.

Operational Update

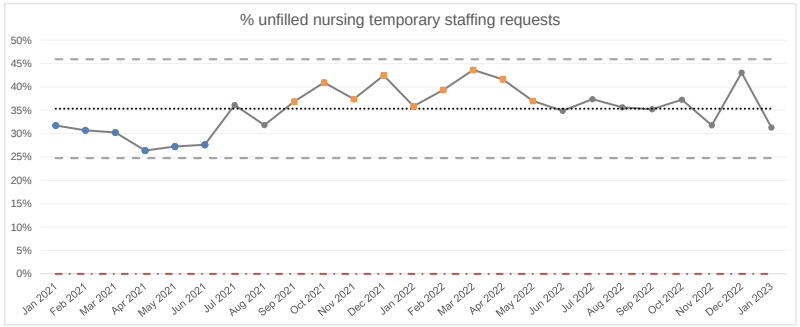
OUR PEOPLE - Temporary Staffing

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

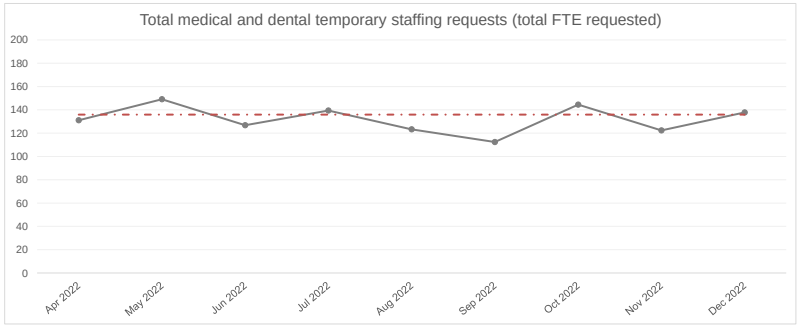
REPORTING MONTH : JANUARY 2023



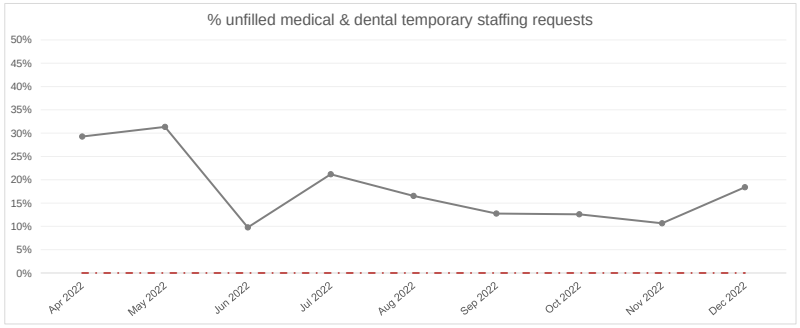
Jan 2023
681.42
Target
493.33
Variance
Common cause - no significant change
Assurance
Variation indicates consistently falling short of the target



Jan 2023
31.31%
Target
0%
Variance
Common cause - no significant change
Assurance
Variation indicates consistently falling short of the target



Dec 2022
137.79
Target
135.93
Variance
There is currently insufficient data, therefore variance and target assurance are not relevant
Assurance
There is currently insufficient data, therefore variance and target assurance are not relevant



Dec 2022
18.39%
Target
0%
Variance
There is currently insufficient data, therefore variance and target assurance are not relevant
Assurance
There is currently insufficient data, therefore variance and target assurance are not relevant

Data Analysis:

Total nursing (registered & nursing support) temporary staffing requests (total FTE requested): The indicator is showing special cause concern above the upper control limit in March 2022. It is showing common cause variation for most recent month, and is consistently failing target with the target just below the lower control limit.
% unfilled nursing temporary staffing requests: The indicator is showing nine points above the mean from Sep 2021 to May 2022 but is currently showing common cause variation. It is consistently failing the target of 0%.
Total medical and dental (registered & nursing support) temporary staffing requests (total FTE requested): This indicator is not currently shown as an SPC chart due to insufficient data points, but the available data points are a combination of above and below target, with the latest month above target.
% unfilled medical & dental temporary staffing requests: This indicator is not currently shown as an SPC chart due to insufficient data points. For the available data points, it is consistently failing the target of 0%.

Operational Update

Feedback has been that the Winter incentives introduced in December continue to work well to support operational pressures, of note is that more than 2,000 bank shifts were filled during January for Allocation on Arrival at double time pay rate.

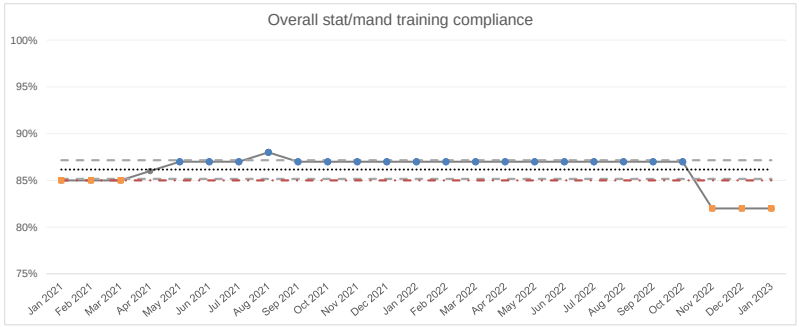
From 1st November, a flexibility payment was available to substantive staff who moved specialty during their shift. As these payments are made in arrears they are reported retrospectively, with the most recent reports showing that in December 2022, the flexibility payment was used 219 times, which was similar to usage of this incentive in the previous month.

Despite a significant reduction of Thornbury use in December, this has increased again in January with the number of shifts covered almost doubling in the space of a month, at an estimated cost of over £420k due to significant operational pressures. NHS England continue to scrutinise the Trust's off framework agency use and are working with us to develop action plans to remove the reliance on off framework supply.

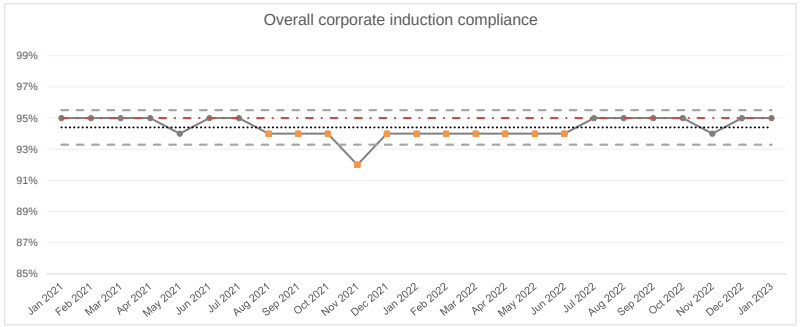
OUR PEOPLE - Training / Induction

York and Scarborough Teaching Hospitals NHS Foundation Trust

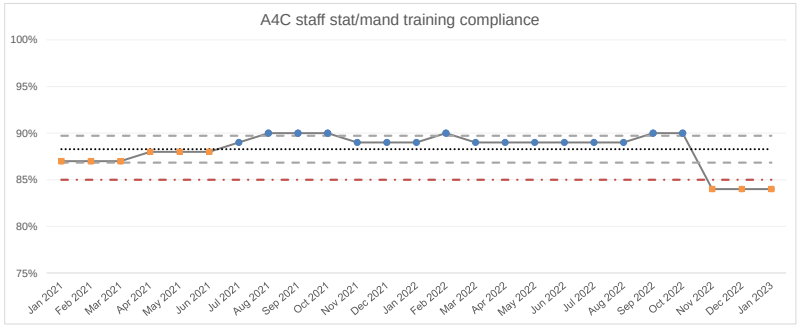
REPORTING MONTH : JANUARY 2023



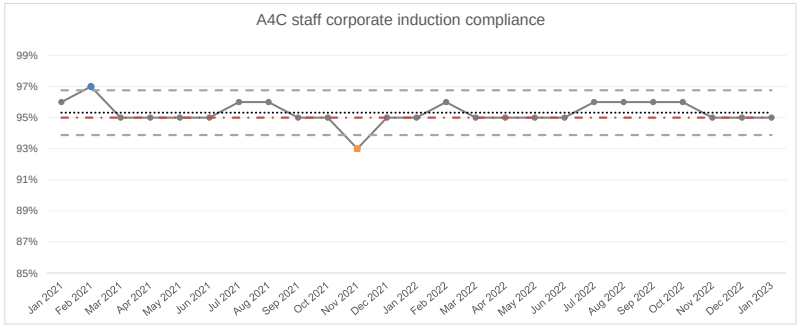
Jan 2023	82%
Target	85%
Variance	Special cause of concerning nature or higher pressure due to lower values
Assurance	Variation indicates consistently passing the target



Jan 2023	95%
Target	95%
Variance	Common cause - no significant change
Assurance	Variation indicates inconsistently hitting passing and falling short of the target



Jan 2023	84%
Target	85%
Variance	Special cause of concerning nature or higher pressure due to lower values
Assurance	Variation indicates consistently passing the target



Jan 2023	95%
Target	95%
Variance	Common cause - no significant change
Assurance	Variation indicates inconsistently hitting passing and falling short of the target

Data Analysis:

Overall staff stat/mand training compliance: This indicator was showing special cause improvement since May 2021 with all data points above the mean and Aug 2021 being above the upper control limit. The target is consistently being met, however Nov 2022 to Jan 2023 are below the lower control limit and target.
Overall staff corporate induction compliance: The indicator was showing special cause concern with a run of data points below the mean from Aug 2021 to Jun 2022, with Nov 2021 being below the upper control limit. The indicator is currently showing common cause variation, however the target was not met in Nov 2022.
A4C staff stat/mand training compliance: This indicator was showing special cause improvement since Jul 2021 with all data points above the mean. The target is consistently being met, however Nov 2022 to Jan 2023 are below the lower control limit and target.
A4C staff corporate induction compliance: The indicator is currently showing common cause variation with special cause concern seen in Nov 2021 below the lower control limit. The target has been met since Nov 2022.

Operational Update

Statutory and Mandatory training compliance rates for all staff groups remain below target at 82%. Compliance increased steadily during the pandemic (85% in February 2020 compared with 87% in October 2022) due to increased provision through elearning and adoption of the Core Skills Training Framework (CSTF) standards which reduced requirements; however, the addition of Equality, Diversity and Human Rights (ED&HR) training to the programme in November has pulled compliance down.

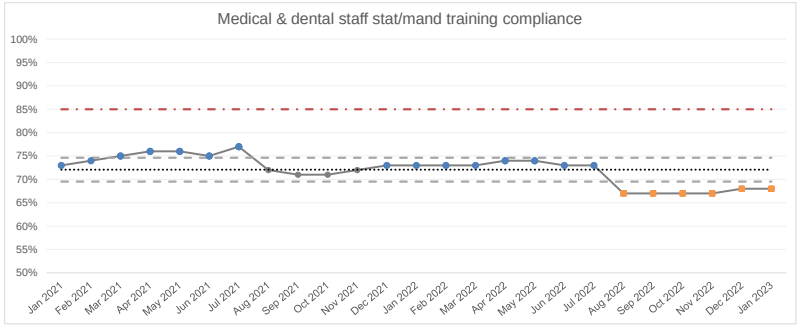
There has been good progress on Equality, Diversity and Human Rights (ED&HR) completions (34% of Trust staff have now completed this; up by 15% over the past month); however, this has had no effect on the bottom-line compliance rate for Statutory and Mandatory training because of the roll-out to YTHFM staff in January (this follows development of an offline version). ED&HR training will remain a key focus in February, which marks the end of the grace period for completion. We aim to embed this programme and recover overall compliance rates by the end of May 2023.

Outside of this programme, the Trust is continuing to track below the 85% target across a number of programmes, most significantly for Resus (compliance with specific programmes ranges from 53% for Paediatrics Advanced Life to 76% for Basic Life Support), Deprivation of Liberty Safeguards (DOLs L1 – compliance is 73%) and Safeguarding Children training (core training compliance for Level 3 at 79%). Resus and DOLS training rates did show nominal improvement across some subjects; however, this was stunted by the cancellation of 12 sessions in January due to industrial action. A further eight sessions were been cancelled in February because of industrial action. Going forward mandatory training will be ringfenced and retained during periods of industrial action to protect complaince levels.

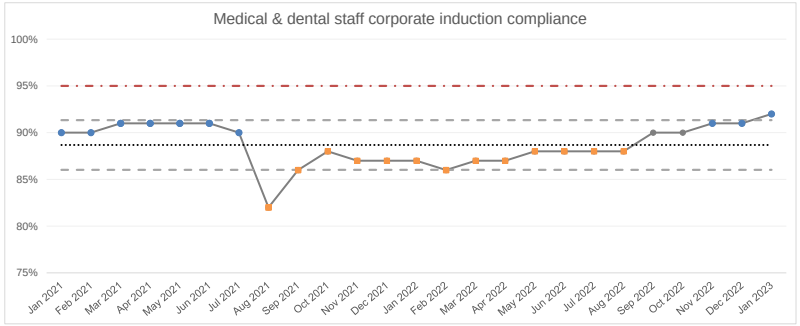
OUR PEOPLE - Training / Induction (cont.)

York and Scarborough Teaching Hospitals NHS Foundation Trust

REPORTING MONTH : JANUARY 2023



Jan 2023
68%
Target
85%
Variance
Special cause of concerning nature or higher pressure due to lower values
Assurance
Variation indicates consistently falling short of the target



Jan 2023
92%
Target
95%
Variance
Special cause of improving nature or lower pressure due to higher values
Assurance
Variation indicates consistently falling short of the target

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Data Analysis:

Medical & dental staff stat/mand training compliance: The indicator is consistently failing target. Compliance from Aug 2022 is below the lower control limit and therefore is showing special cause concern.
Medical & dental staff corporate induction compliance: The indicator was showing special cause concern with a run of points below the mean from Aug 2021 to Aug 2022. The last time the target was met was July 2020. The indicator is currently showing special cause improvement with Nov and Dec 2022 close to the upper control limit and Jan 2023 above the upper control limit.

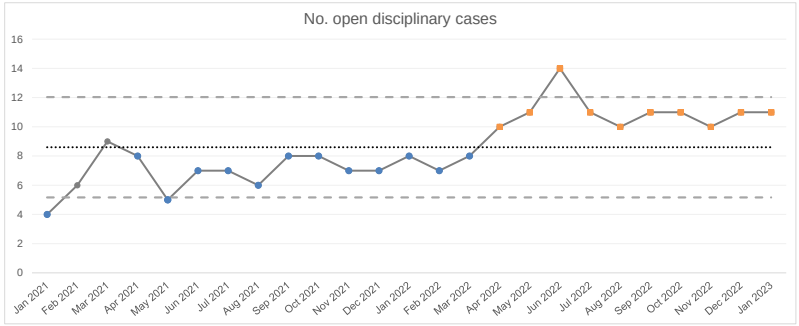
Operational Update

At the end of December, Corporate Induction compliance returned to 95% in line with the Trust's target (and remainded at this level in January 2023). Compliance rates in the medical and dental staff group, where there is greater movement of staff, is continuing to sit below target. There are plans for some bespoke induction sessions targeted in particular at doctors in Trust and Careers Grade roles to improve performance in this area. More generally, work continues to develop the content and delivery of induction with a focus on strengthening the quality of new staff members' early experiences. New Starters' Fairs were launched in November 2022 and a new Welcome Booklet launched in December. Further options to provide opportunities to increase people's understanding of and sense of belonging to the organisation on joining are being explored, including development of video content and options for virtual or face-to-face sessions.

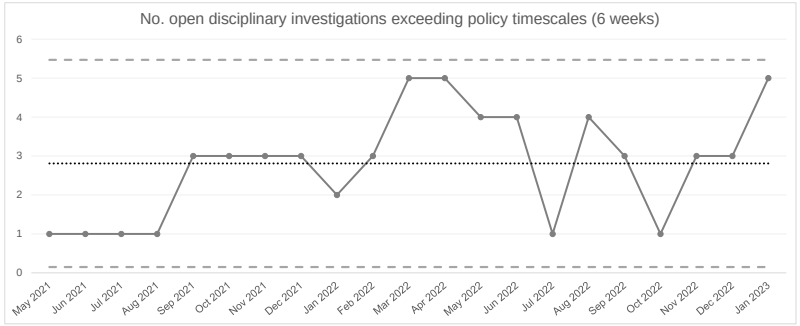
OUR PEOPLE - Employee Relations Activity

NHS York and Scarborough Teaching Hospitals NHS Foundation Trust

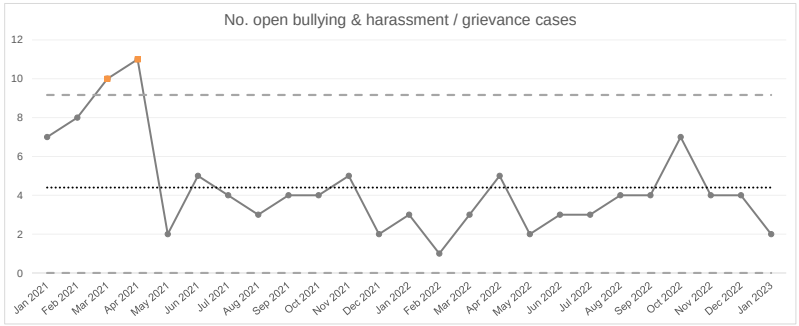
REPORTING MONTH : JANUARY 2023



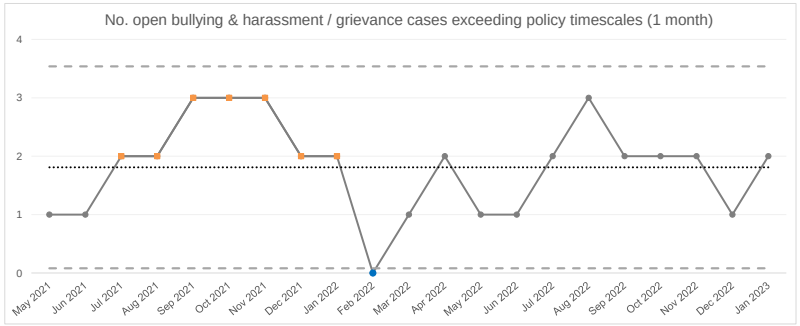
Jan 2023	Target	Variance	Assurance
11	No Target	Special cause of concerning nature or higher pressure due to higher values	There is no target, therefore target assurance is not relevant



Jan 2023	Target	Variance	Assurance
5	No Target	Common cause - no significant change	There is no target, therefore target assurance is not relevant



Jan 2023	Target	Variance	Assurance
2	No Target	Common cause - no significant change	There is no target, therefore target assurance is not relevant



Jan 2023	Target	Variance	Assurance
2	No Target	Common cause - no significant change	There is no target, therefore target assurance is not relevant

Data Analysis:

No. open disciplinary cases: The indicator is showing over seven points above the mean from Mar 2022 and special cause concern above the upper control limit in Jun 2022.
No. open disciplinary investigations exceeding policy timescales (6 weeks): The indicator is currently showing common cause variation, although please note the figures are shown from May 2021 only.
No. open bullying & harassment / grievance cases: The indicator is currently showing common cause variation with recent months mostly falling below the mean.
No. open bullying & harassment / grievance cases exceeding policy timescales (1 month): The indicator is currently showing common cause variation after a run above the mean from Jul 2021 to Jan 2022, although please note the figures are shown from May 2021 only.

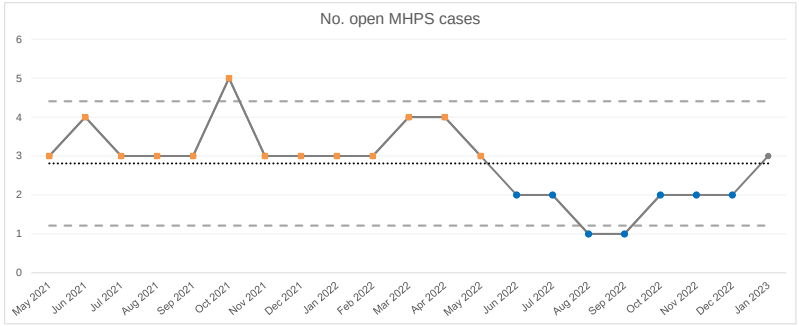
Operational Update

Whilst we have seen a reduction in the number of formal grievance and bullying & harassment cases the number of informal concerns being raised remains high; the HR team continue to work with managers to try and resolve these cases informally in line with a Just and Learning approach to cases.

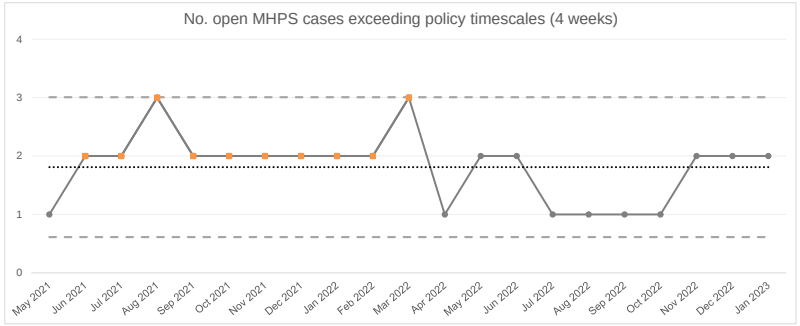
OUR PEOPLE - Employee Relations Activity (cont.)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

REPORTING MONTH : JANUARY 2023



Jan 2023
3
Target
No Target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



Jan 2023
2
Target
No Target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

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Data Analysis:

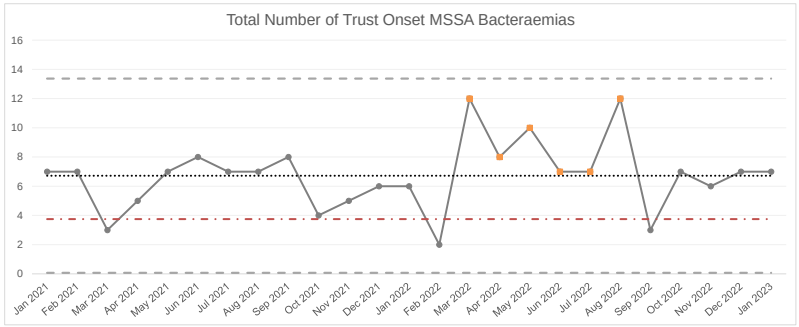
No. open MHPS cases: The indicator is showing common cause variation after a seven-month period of special cause improvement, with Aug and Sep 2022 below the lower control limit. Prior to that the data points were all above the mean. Please note the figures are shown from May 2021 only.
No. open MHPS cases exceeding policy timescales (4 weeks): The indicator is currently showing common cause variation, after a period of data points above the mean from Jun 2021 to Mar 2022. Please note the figures are shown from May 2021 only.

Operational Update

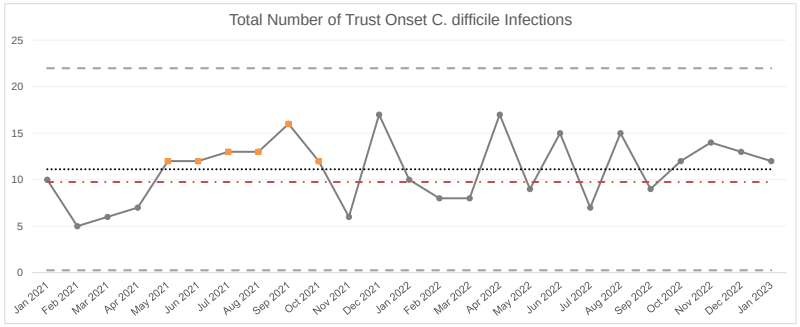
QUALITY AND SAFETY - Priority Metrics

York and Scarborough Teaching Hospitals NHS Foundation Trust

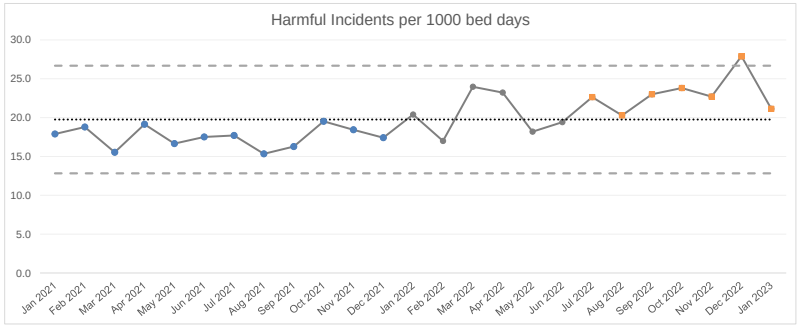
REPORTING MONTH : JANUARY 2023



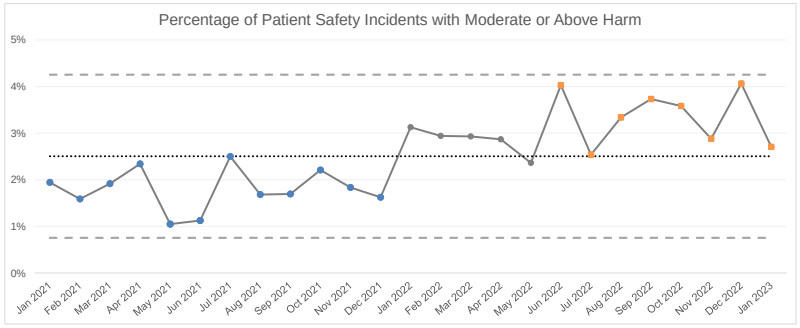
Jan 2023	Cumulative 12-month Target	Variance	Assurance
7	45	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the target



Jan 2023	Cumulative 12-month Target	Variance	Assurance
12	117	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the target



Jan 2023	Target	Variance	Assurance
21.1	No Target	Special cause of concerning nature or higher pressure due to higher values	There is no target, therefore target assurance is not relevant



Jan 2023	Target	Variance	Assurance
2.7%	No Target	Special cause of concerning nature or higher pressure due to higher values	There is no target, therefore target assurance is not relevant

Data Analysis:

Total Number of Trust Onset MSSA Bacteraemias: The number of infections of patients with MSSA has shown a trend above the mean from Mar to Aug 2022, however is now showing common cause variation around the mean.
Total Number of Trust Onset C. difficile infections: The number of infections of patients with C.difficile is currently showing common cause variation, with some degree of variation around the mean.
Harmful Incidents per 1000 bed days: The number of harmful incidents per 1000 bed days is showing special cause concern due to the data points above the mean from Jul 2022, with Dec 2022 being above the upper control limit.
Percentage of Patient Safety Incidents with Moderate or Above Harm: The percentage of patient safety incidents with moderate or above harm is showing special cause concern, this is due to a trend above the mean from Jun 2022 with Dec 2022 being close to the upper control limit.

Operational Updates:

Total Number of Trust Onset MSSA Bacteraemias
The internal agreed target for 2022/23 for combined HOHAs and COHAs MSSA bacteraemia is 59. The trust is above trajectory for MSSA bacteraemia by 24 cases to the end of January 2023. There were 7 trust apportioned cases of MSSA bacteraemia in January 2023. To target Staphylococcus aureus bacteraemia reduction, QI work will focus on improving Aseptic Non-Touch Technique (ANTT) training compliance, Visual Infusion Phlebitis (VIP) scoring, education around prompt removal of cannula and reintroduction of cannulation trollies. The MSSA PIR process roll out has commenced, utilising the Datix system. Staphylococcus aureus bacteraemia risk remains whilst this work is still developing.

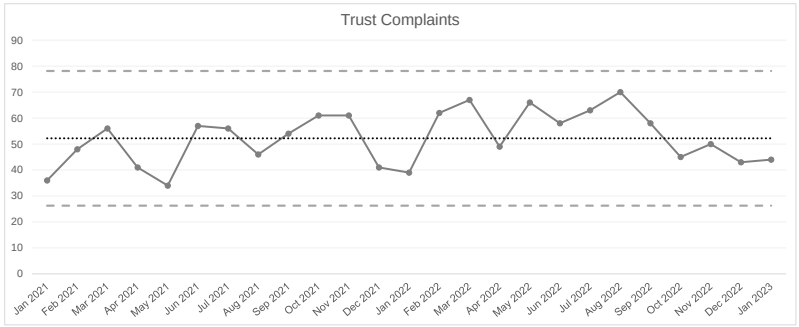
Total Number of Trust Onset C. difficile infections
There were 12 cases of hospital attributed cases of C.difficile in January 2023. There has been a total of 123 hospital attributed cases to the end of January 2023 against a trajectory of 117 for 2022/23. The trust is over trajectory by 24 cases to the end of January 2023. The C.difficile high incidence in the trust could be associated with the environmental contamination whilst there's no decant space particularly in Scarborough.
A decant and minor refurbishment of the wards at York continued in January 2023 as part of the window replacement project. In Scarborough the proactive HPV program of all the wards including the Emergency Department was completed in January 2023.

Harmful Incidents per 1000 bed days / Percentage of Patient Safety Incidents with Moderate or Above Harm
There are ongoing pressures, especially on emergency and urgent care impacting on quality of care and capacity of clinical teams. The pressure on services is especially severe at present with an enhanced level of OPEL 4 in place in January. There is a clear association between pressure on services / staffing issues and patient harms / quality of care. Improvement groups continue to progress initiatives in relation to falls and pressure ulcers. Key risks include pressures on services and capacity and national issues with staff shortages, recruitment and retention. Staffing challenges are recognised and various measure in place to mitigate risks as much as possible. Improvement in the availability of nursing staff has been seen in the last few months on Datix. A discrepancy with IPC new positive incidents at York means that over-reporting is likely to have caused skew in the data. This is currently being investigated to ensure consistency with reporting across sites.

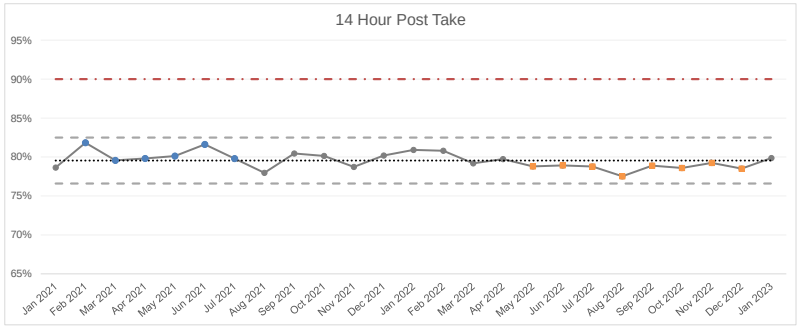
QUALITY AND SAFETY - Priority Metrics (cont.)

York and Scarborough Teaching Hospitals NHS Foundation Trust

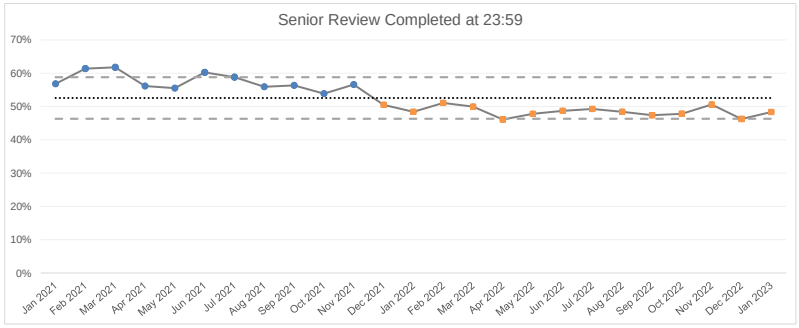
REPORTING MONTH : JANUARY 2023



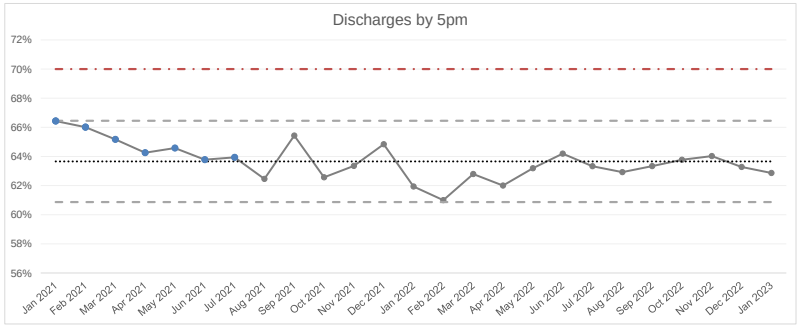
Jan 2023	Target	Variance	Assurance
44	No Target	Common cause - no significant change	There is no target, therefore target assurance is not relevant



Jan 2023	Target	Variance	Assurance
79.9%	90%	Common cause - no significant change	Variation indicates consistently falling short of the target



Jan 2023	Target	Variance	Assurance
48.4%	No Target	Special cause of concerning nature or higher pressure due to lower values	There is no target, therefore target assurance is not relevant



Jan 2023	Target	Variance	Assurance
62.9%	70%	Common cause - no significant change	Variation indicates consistently falling short of the target

Data Analysis:

Trust Complaints: The number of Trust complaints is currently showing common cause variation.
14 Hour Post Take: This indicator is consistently failing target, with the upper control limit falling beneath the target. This indicator requires process re-design in order to meet target. A run below the mean has been seen since May 2022 to Dec 2022 but is currently showing common cause variation.
Senior Review Completed at 23:59: Special cause concern is showing with a run below the mean since Dec 2021. April and Dec 2022 were slightly below the lower control limit.
Discharges by 5pm: This indicator is consistently failing target, with the upper control limit falling beneath the target. This indicator requires process re-design in order to meet target. The indicator is currently showing common cause variation.

Operational Updates:

Trust Complaints
Challenges: CG5 currently has 28 open cases (34% of all Trust cases).
Key Risks: Care groups still struggling to address complaints in timely way, with the exception of CG2.
Actions: Patient Experience Improvement Plan developed to address main themes - monitored by Patient Experience Steering Group

7 Day Standards
The challenges which are affecting performance against these measures:
- The performance for 14-hour post-take review remains consistently below expected performance with Scarborough showing a better level of performance than York.
- Daily Senior review is also below performance target and has been drifting around and below the lower control limit for nearly a year. Compliance is significantly lower at the weekend in both York and Scarborough.
- Challenges relate to consistent recording of reviews, medical engagement and medical capacity across the 7-day period.
- Acuity of patients, requiring more medical input

These factors present a risk of patient harm due to delays in appropriate treatment or diagnosis. The 7 Day standards group is undertaking analysis of the 7-Day standards to support Board discussions regarding the resources required to achieve performance over the 7-day period. NEWS2 compliance has been escalated to QPAS. The effects are being mitigated through the wider Trust response to current and anticipated service pressures.

TPR: Icon Summary Matrix (Priority)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Filters:

METRIC

All

METRIC GROUP

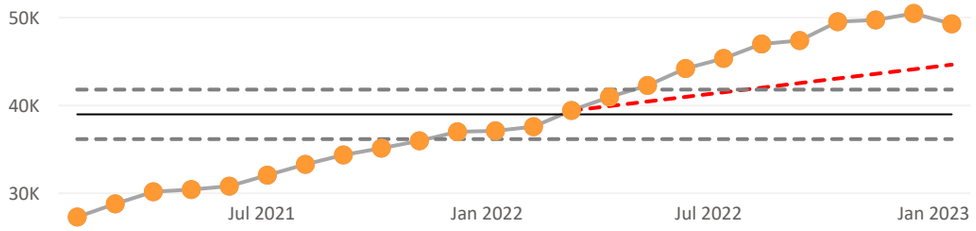
All

VariationIcon	P	?	F	◌	Total
Improvement			1		1
H					
L			1		1
Common Cause		2	2		4
		2	2		4
Concern	1	1	1		3
H	1	1	1		3
L					
Neither					
↗					
↘					
Empty					
◌					
Total	1	3	4		8

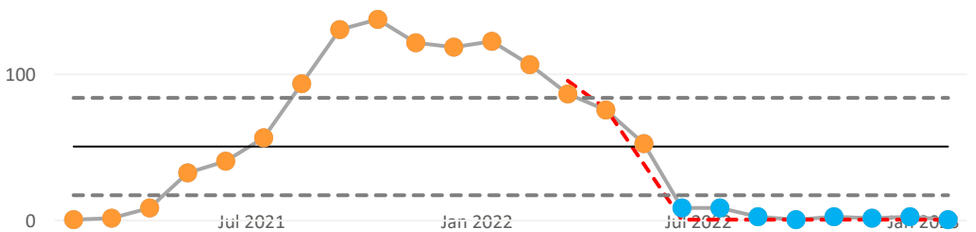
MetricName	Date	Variation	Assurance	Target	Latest Value
Ambulance handovers waiting >60 minutes (%)	2023-01		?	10	16
ED - Total waiting 12+hours - % of all type 1 attendances	2023-01	H	F	8	17
ED: Median Time to Initial Assessment (Minutes)	2023-01		?	18	13
Number of patients waiting 63 or more days after referral from cancer PTL	2023-01	H	?	133	335
Proportion of patients discharged before 5pm (70%)	2023-01		F	70	63
RTT Total Waiting List	2023-01	H	P	44541	49186
RTT Waits over 104 weeks for incomplete pathways	2023-01	L	F	0	0
RTT Waits over 78 weeks for incomplete pathways	2023-01		F	63	529

TPR: Elective Recovery Priority Metrics

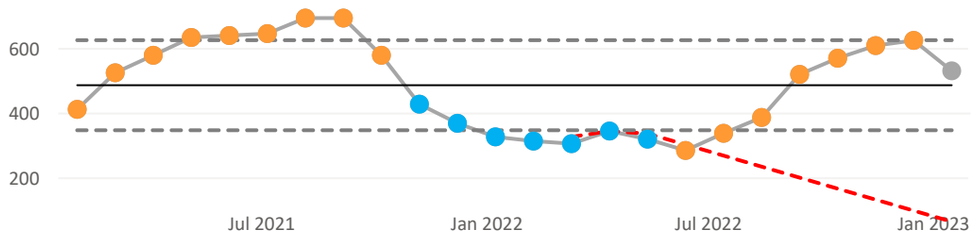
MetricName	Assurance	Variation	LATEST MONTH	Target
RTT Total Waiting List	P	H	49K	44.5K



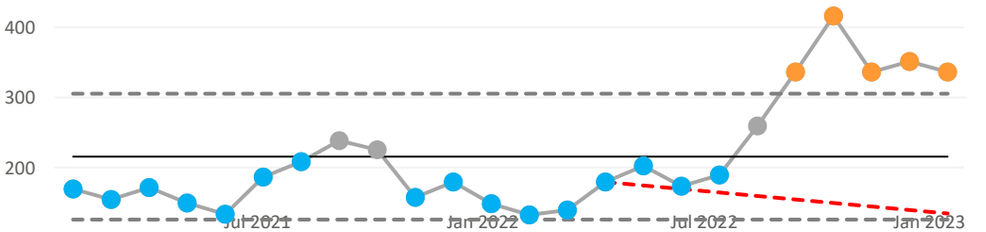
MetricName	Assurance	Variation	LATEST MONTH	Target
RTT Waits over 104 weeks for incomplete pathways	F	L	0	0



MetricName	Assurance	Variation	LATEST MONTH	Target
RTT Waits over 78 weeks for incomplete pathways	F		529	63



MetricName	Assurance	Variation	LATEST MONTH	Target
Number of patients waiting 63 or more days after referral from cancer PTL	?	H	335	133



DATA ANALYSIS:

- **RTT Total Waiting List:** The indicator is showing deteriorating performance, with a series of points above the mean since Mar 2022. The target is consistently not being reached.
- **RTT Waits over 104 weeks for incomplete pathways:** The indicator has been improving since Nov 2021 and for Sep 2022 and Jan 2023 there were 0 waiters at Priority 6. The target was to reduce the number of 104+ week waiters to 0 by June 2022.
- **RTT Waits over 78 weeks for incomplete pathways:** The indicator was improving from Oct 2021, but the value is now back above the target and the mean. The national target is to reduce the number of 78+ week waiters to zero by March 2023. Since Jul 2022, we have generally seen the trend deteriorating in performance with some improvement for Jan 2023.
- **Number of patients waiting 63 or more days after referral from cancer PTL:** The indicator has been showing variation within the upper and lower control limit since Sep 2020 to Aug 2022. The value is now above the upper control limit.

TPR:

Narrative for Elective Recovery Priority Metrics

York and Scarborough Teaching Hospitals NHS Foundation Trust

BI&IREF : 10042

Challenges & Risks	Actions & Mitigations
Challenges: The Trust is in Tier 1 Elective Recovery support (national intervention). Delivery of 78 week trajectory is challenged. The Trust is off trajectory for the number of patients waiting over 62 days on a Cancer pathway, at 335 against a target of 133 for January. Insufficient established workforce in MRI to meet demands on service. Gynaecology Nursing capacity to support delivery of planned care. Extended times to first appointment resulting in delays for patients and reduction in clock stop activity. The 50 week theatre SLA has been agreed, however is not yet mobilised due to job planning arrangements and the reduction in the Trust SLA. Mutual aid arrangements are in place but as yet have not been able to offer significant support for the Trust.	Actions: 1. The Intensive Support Team and EY Consultancy have commenced on site at York Hospital at the end of January. The teams are working to support the Trust on a range of issues including governance, speciality recovery planning, skills and development of the teams and data to support operational teams. 2. The Tier 1 regime has refocussed to a weekly meeting with the Chief Executive and Chief Operating Officer as the end of March target approaches. The Trust is currently forecasting to be below the planned trajectory of 397 at the end of March. Additional support had been offered through the national Digital Mutual Aid System (DMAS) and NHSE expertise to Humber and North Yorkshire. The focus of the Tier 1 meetings is ensuring all 78 week patients have booked appointments or TCI dates for surgery, ensuring chronological booking of patients and validation of all long waiters. 3. The 50 week theatre SLA has been agreed, however is not yet mobilised due to job planning arrangements and the reduction in the Trust SLA. Planned to go live at the beginning of April 2023. 4. The Short Form Business Case for additional theatre and outpatient procedures facilities (TIF2) has been approved by the national team. 5. Waiting List Harms Task and Finish Group established. 6. The Trust is reviewing the theatre productivity approach and data quality. 7. Insourcing is in place, with a contract extension to March 2023 for theatres. Potential additional insourcing and outsourcing has been scoped by Care Groups. 8. Electronic platform for patients to access guidance on keeping ‘fit for surgery’; ‘My Planned Care’ platform live with review of options for patient specific information underway. 9. The Outpatients Transformation Programme is in place with PIFU moving to business as usual and pilot work for Room Booker. REI launched in October. 10. The Executive approved additional capacity to support patient pathways, including use of Clinical Assessment Services, booking processes and improved PTL management. Work is ongoing to recruit to these positions. 11. Training Programme for operational managers to commence in February, with pre-requisite training on RTT, Cancer and Waiting List management.

TPR:

Narrative for Elective Recovery Priority Metrics

York and Scarborough Teaching Hospitals NHS Foundation Trust

BI&IREF : 10042

Challenges & Risks	Actions & Mitigations
Risks: Potential further COVID-19 variants and/or waves. Ongoing management of high levels of acute activity and delayed discharge impacting ordinary elective work. Elective activity impacted in early January by Urgent and Emergency Care pressures. Growth in the non-admitted waiting list. Theatre staffing vacancy, retention, and high sickness rates. Industrial action throughout February.	Mitigations: Tier 1 weekly meetings with National Team on elective recovery. Trust is seeking to utilise the nationally provided Digital Mutual Aid System (DMAS) to offer long waiting patients who are willing to travel an alternative provider. Weekly Elective Recovery Meetings in place for long wait RTT patients and outpatient performance. Use of IS capacity to support delivery of diagnostic activity (currently MRI and CT). Additional mobile capacity to be supported by the ICS. Plans in place to mitigate impact of industrial action. COVID surge plan in place and our RVI Flu plan has been published.

TPR: Health Inequalities (RTT)

RTT PTL by Ethnic Group
At end of January 2023

Ethnic Group	Average RTT Weeks Waiting	Number of Clocks	Proportion on RTT PTL*	Trust Catchment
White	22	33370	98.24%	94.34%
Black, Black British, Caribbean or African	27	61	0.18%	0.94%
Mixed or multiple ethnic groups	22	157	0.46%	1.26%
Asian or Asian British	22	259	0.76%	2.97%
Other ethnic group	22	122	0.36%	0.49%
Unknown	22	11977	-	-
Not Stated	21	3279	-	-
Grand Total	**22**	**49225**	**-**	**-**

Data source for trust catchment area: Public Health England NHS Acute Catchment Areas.
*Proportion on waiting list excluding not stated and unknown.

RTT PTL by Indices of Multiple Deprivation (IMD) Quintile
At end of January 2023

IMD Quintile	Average RTT Weeks Waiting	Number of Clocks	Proportion on RTT PTL*	Trust Catchment
1	22	5842	12.20%	8.88%
2	22	6638	13.86%	13.59%
3	22	10032	20.95%	20.94%
4	23	10402	21.73%	20.68%
5	23	14962	31.25%	35.90%
Unknown	18	1349	-	-
Grand Total	**22**	**49225**	**-**	**-**

Data source for trust catchment area: Public Health England NHS Acute Catchment Areas.
*Proportion on waiting list excluding unknown.

Highlights For Board To Note:

As per the 2022-23 national planning mandate, RTT Waiting List data has, in order to identify any potential health inequalities, been split to view Ethnic Groups and IMD Quintile.

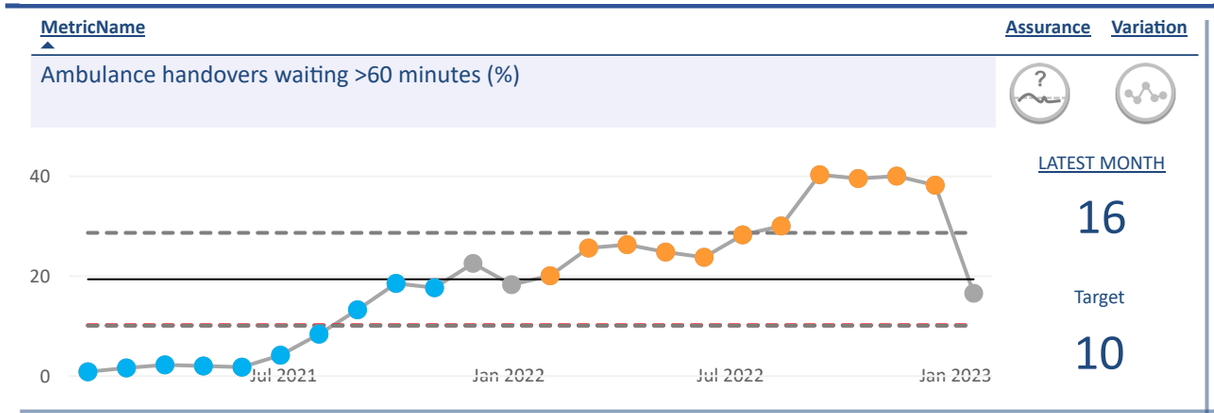
The Index of Multiple Deprivation (IMD) is the official measure of relative deprivation. IMD is a combined measure of deprivation based on a total of thirty seven separate indicators that are grouped into seven domains, each of which reflects a different aspect of deprivation experienced by individuals living in an area.

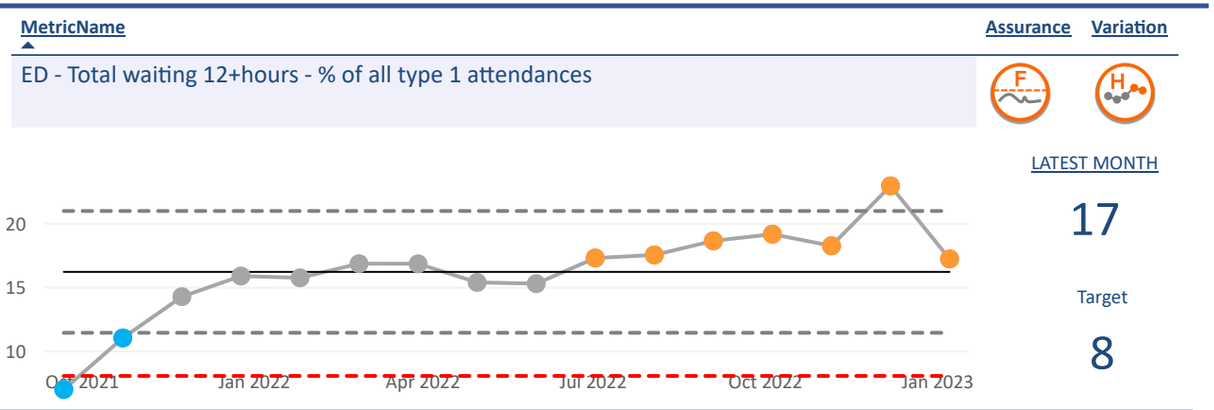
IMD quintiles range from one to five, where one is the most deprived. Please note that IMD quintiles are not available where we have no record of a patient postcode, the postcode is not an English postcode or is an unmatched postcode.

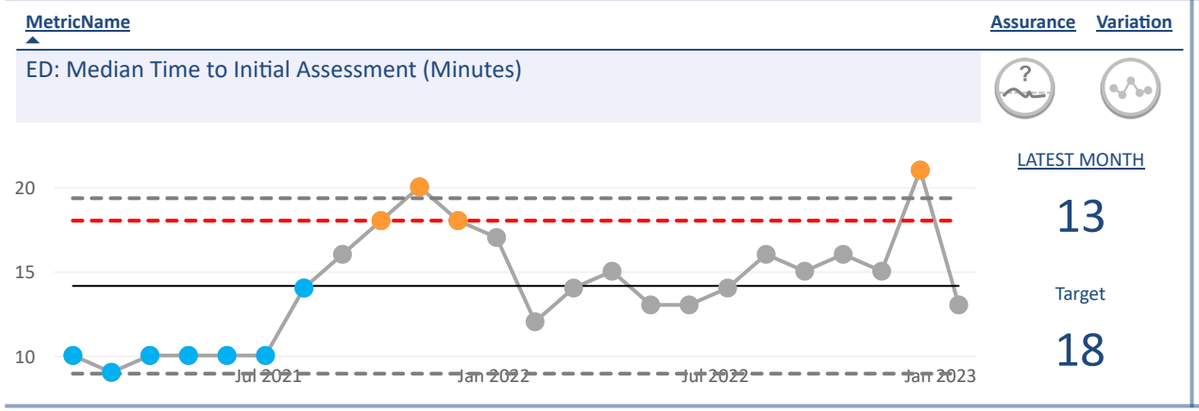
Ethnic codes have been grouped as per the 2021 census. Any patient where Ethnic Group is either 'Unknown' or 'Not Stated' is excluded from the PTL proportions. Areas to take into consideration when interpreting the data include the lack of available site split for Trust Catchment, and the variation that Clinical Prioritisation can bring to weeks waiting.

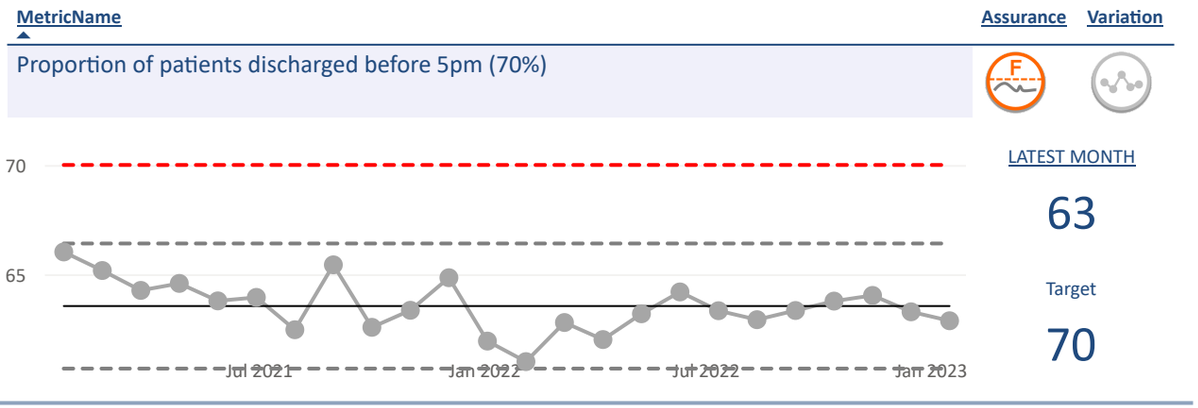
The next steps for this work will be to understand any differentials between the population base and the waiting list. Further analysis will be undertaken in coming months, and this piece of work will also be expanded to include Urgent Care, Cancer, Learning Disabilities and Military Veterans.

TPR: Acute Flow Priority Metrics









DATA ANALYSIS:

- **Ambulance handovers waiting >60 minutes (%):** The indicator is generally showing deteriorating performance over the last year with a series of points above the mean since Feb 2022 to Dec 2022. The target has not been reached since Aug 2021. There has been a significant improvement for Jan 2023 coming below the mean.
- **ED - Total waiting 12+hours - % of all type 1 attendances:** The indicator is showing deteriorating performance with a series of points above the mean since Jul 2022. The target has not been reached since Oct 2021.
- **ED - Median time to initial assessment (minutes):** The indicator is showing a trend above the mean in recent months, with Dec 2022 going above the upper control limit. There has been a significant improvement for Jan 2023 coming below the mean.
- **Proportion of patients discharged before 5pm:** The indicator is showing common cause variation, with Jan, Feb and Apr 22 being close to the lower control limit. The target will not be met without redesign (the closest data point to 70% was in Mar 2020).

TPR:

Narrative for Acute Flow Priority Metrics

York and Scarborough Teaching Hospitals NHS Foundation Trust

BI&IREF : 10042

Challenges & Risks	Actions & Mitigations
Challenges: The ED Capital Build at York which commenced at the beginning of November 2021 has meant that York Emergency Department continues to operate out of a smaller footprint. The development has been delayed with a completion date of May 2023 rather than March 2023 anticipated. High number of patients without a 'Right to Reside' in inpatient beds affecting flow and ability to admit patients from ED in a timely manner. Staffing constraints (sickness, vacancies, use of agency and bank staff).	Actions: 1. Trust participated in an ICB led Winter Pressures tabletop exercise entitled 'Arctic Willow'. Best practice and lessons learnt have been shared across the ICB. 2. Work continues to support direct admission from ambulance to assessment units by extending the range of clinical criteria for Paediatrics, Gynaecology and Medicine by March 2023. 3. Emergency Assessment Units now open 24/7, work ongoing to extend the clinical criteria and pathways. 4. Project on track to extend the range of specialities operating through a Surgical Assessment Unit E.g. Orthopaedics and Gynaecology. 5. Work continues on the new ED build at Scarborough due for completion in 2024, with project resource identified to support the development of the revised acute care clinical model with all specialities. 6. The refreshed Urgent and Emergency Care Programme key aim is: To deliver high quality, safe, urgent and emergency care, for our communities, with our partners, delivered in the right place, at the right time, appropriate to our patient's needs. The focus of the programme in the last month has been on expanding the Programme Team's resource. The Programme Lead has now been appointed on a permanent basis and two Programme Managers and two Project Managers will be joining the team on a permanent basis from 1st April. External support has also been sought to further build the capacity and strengthen the team. An Improvement Manager from ECIST has joined the team at the end of January for 2 days a week and a Senior Manager from NHS England is joining the team for 1 day a week from February. The national UEC Recovery Plan was published on 30th January and an initial assessment has taken place to ensure key actions are covered by the programme. In February a more detailed analysis will take place and the programme updated if required to ensure the plan will be fully addressed. Each workstream has continued to be developed with key updates PTO for further details

Narrative for Acute Flow Priority Metrics

Challenges & Risks	Actions & Mitigations
	6.1 Urgent Care: The first workshop is being scheduled in February to bring together Place teams, commissioners and clinical teams to further build upon the discussions to co-produce the new Integrated model of Urgent Care. 6.2 Children and Young people Integrated Care and Assessment: The initial focus has been on understanding children and their family's behaviour around accessing healthcare. The partnership group will be reviewing this in February and starting to discuss options for integrated models of care which can be tested ahead of next winter. The CAT hub continues as the initial test of an integrated model of care with recurrent funding options being discussed with the Place team this month. 6.3 Virtual Ward: Virtual Wards are specifically identified in the national recovery plan with a requirement to expand capacity. Clinical leaders are to be identified in February, with a clinical workshop being scheduled for March, to review learning from other organisations and identify the requirements for implementation here. 6.4 SDEC: The actions identified in the December UEC Programme Board continue to be progressed alongside developing the improvement support from ECIST. A missed opportunity audit will take place to clinically identify opportunity to maximise SDEC services across the organisation. Additionally, the Acute Provider collaborative has prioritised SDEC, and the Trust is taking part in an assessment and associated development work with The Collaborative. 6.5 Discharge: The January Programme Board focused on the development of a pan trust discharge framework. The proposal will be further developed at the February board and will cover the full patient pathway from admission. The ECIST Improvement Manager and Clinical Lead will also support this work initially with a criteria to admit audit in March which will be carried out in both hospitals with the clinical teams. The framework will set standards for consistency across the organisation and build upon existing work in this area. It will provide a refreshed focus especially for patients on Pathway 0 (no additional support required on discharge). 6.6 7 day standards: Work is continuing towards the four priority standards in relation to post take, diagnostics and review of patients. Standard 6 is achieved by the organisation and an internal audit has been completed which provides clearer assessment of performance against standards 2 (post take) and standard 8 (daily senior review). The audit is now being reviewed with the Medical Director and Care Group Directors to agree actions. 6.7 Access to post hospital care: In relation to Transfer of Care a commitment has been made with the York Place Director to progress work in relation to developing integrated intermediate care. The system plan continues to be developed with partners covering all three areas of pre hospital, in hospital and transfer of care. A monthly partnership session is now being established to support further development and delivery of the plan alongside the weekly action meetings. 7. Continued focus on the 100-day Discharge Challenge to optimise discharge planning and flow. Ongoing engagement with system partners. A pan-Trust discharge framework is being developed as part of the wider system plan. 8. Exploration of the development of a domiciliary social care service to support the discharge of patients who do not have the right to reside. 9. NY and York place have agreed to fund CIPHER at Scarborough (ambulance clinical handover and PTS discharge) and York (ambulance clinical handover working with VCS-PTS) through to the end of March 2023. This commenced in December 2022.

TPR:

Narrative for Acute Flow Priority Metrics

York and Scarborough Teaching Hospitals NHS Foundation Trust

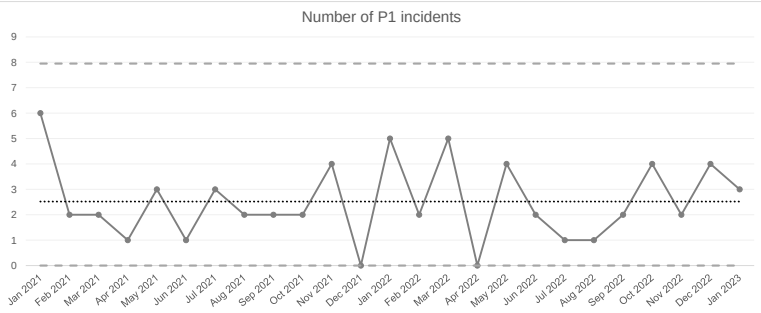
BI&IREF : 10042

Challenges & Risks	Actions & Mitigations
Risks: Staffing gaps in both medical and nursing reducing the ability to open all bed capacity at York Site and requirement to reduce existing capacity to support safe staffing levels. Inability to achieve Ambulance Handover targets due to patient flow within the hospital. Inability to meet patient waiting times in ED due to flow constraints at both sites Staff fatigue. Risk of COVID-19 new variant or surge in respiratory virus Industrial action in February following the Unison, GMB and Royal College of Nursing ballot action	Mitigations: Daily review of medical and nursing staffing to ensure appropriate skill mix – ongoing. Weekly meeting to progress the Rapid Quality Review Action Plan. Urgent Care System Programme Board established across the Integrated Care System. Ambulance Handover Plan in place and updated SOP for escalations, cohorting and diversion requests. Plans in place to mitigate impact of industrial action. COVID surge plan in place and RVI Flu plan has been published.

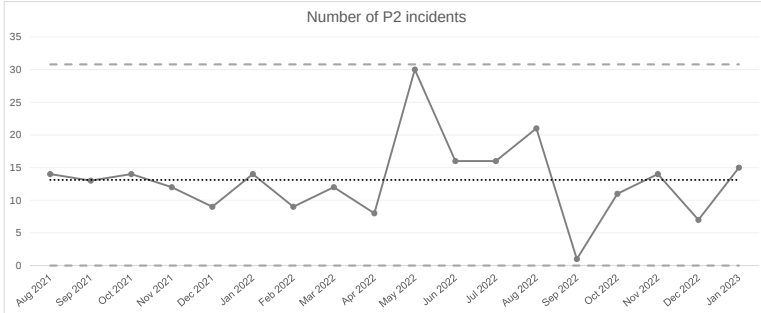
DIGITAL - Digital Indicators

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

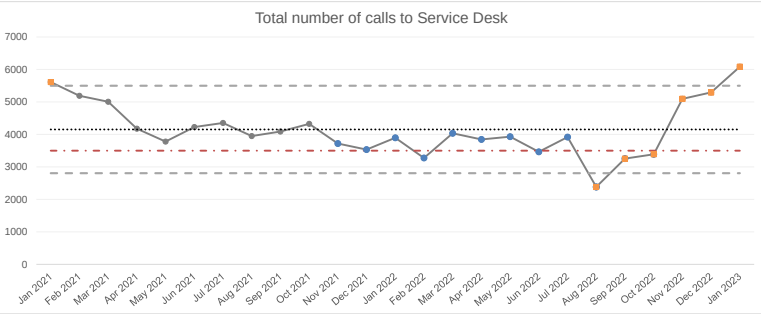
REPORTING MONTH : JANUARY 2023



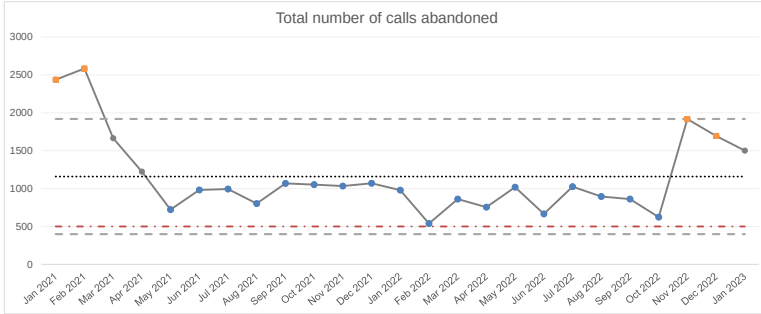
Jan 2023	3
Target	No Target
Variance	Common cause - no significant change
Assurance	There is no target, therefore target assurance is not relevant



Jan 2023	15
Target	No Target
Variance	Common cause - no significant change
Assurance	There is no target, therefore target assurance is not relevant



Jan 2023	6083
Target	3500
Variance	Special cause of concerning nature or higher pressure due to higher values
Assurance	Variation indicates inconsistently hitting passing and falling short of the target



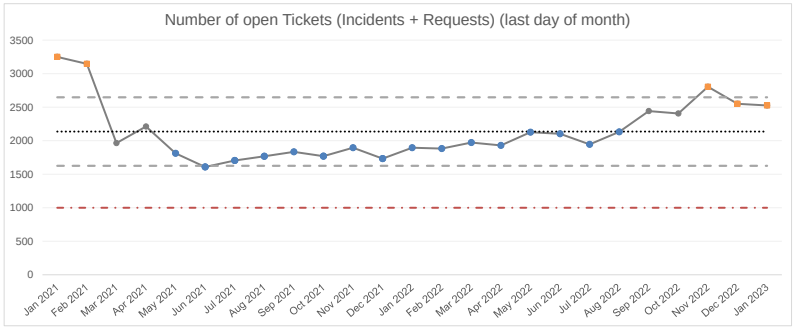
Jan 2023	1501
Target	500
Variance	Common cause - no significant change
Assurance	Variation indicates inconsistently hitting passing and falling short of the target

Data Analysis:

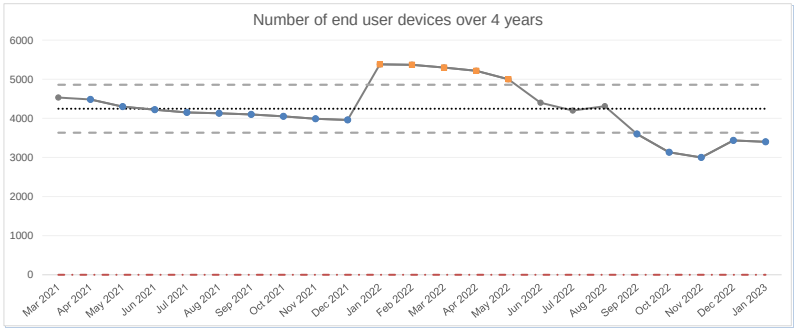
Number of P1 incidents: The indicator is currently showing common cause variation, with a wider degree of variation around the mean seen in the last 12 months.
Number of P2 incidents: The indicator is currently showing common cause variation, with a sharp increase in P2 calls in May 2022, and only one P2 call showing in Sep 2022. A wider degree of variation around the mean has been seen in the last nine months.
Total number of calls to Service Desk: The indicator is showing a run of points below the mean from Nov 2021 to Oct 2022, with a sharp rise in Nov and Dec 2022 close to the upper control limit. January 2023 is now above the upper control limit. Please note that the Sep 2022 figure is an estimation based on an average of the previous three months. The months from Nov 2022 to Jan 2023 have not met the target, and the target is not being met consistently.
Total number of abandoned calls: The indicator is showing a run of points below the mean from May 2021 to Oct 2022, with a sharp rise in Nov 2022 close to the upper control limit. Please note that the Sep 2022 figure is an estimation based on an average of the previous three months. The target is not being met consistently, but the target line is above the lower control limit.

Operational Update:
P1 incidents:
- 4/1 - CPD performance incident affecting users across all sites and modules, including EPMA and Nucleus
- 4/1 - eRS server offline affecting eReferrals bookings. Network connection issue resolved
CPD performance problems are being investigated and tuning/optimisation actions taken where opportunities arise. Ongoing actions to monitor and review for root causes
16/1 - Inbound telephone lines to York Hospital affected overnight due to fault with BT ISDN services.

Total number of calls / number of abandoned calls
- Continued high demand arising from rollout of Office 365 / NHSmail, and CPD performance incident on 4/1
- Staffing situation improving and new recruits start in March



Jan 2023
2525
Target
1000
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
Variation indicates consistently falling short of the target



Jan 2023
3400
Target
0
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Variation indicates consistently falling short of the target

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Data Analysis:

Number of open calls (last day of month): The indicator was showing a run of points below the mean since April 2021, however Sep to Dec 2022 were all above the mean. Nov 2022 rose above the upper control limit, with Dec 2022 and Jan 2023 just below it. The indicator is consistently failing the target.
Number of end user devices over 4 years: In Jan 2022 the indicator moved above the upper lower control limit for five months. The number of end user assets (laptops, desktops) over 4 years old rose in Jan 2022 by circa 1500. This was due to a batch of devices triggering their anniversary and moving from 3 year plus to 4. The number of devices has fallen below the lower control limit from Sep 2022 to Jan 2023, with 3400 devices now over 4 years old.

Operational Update:

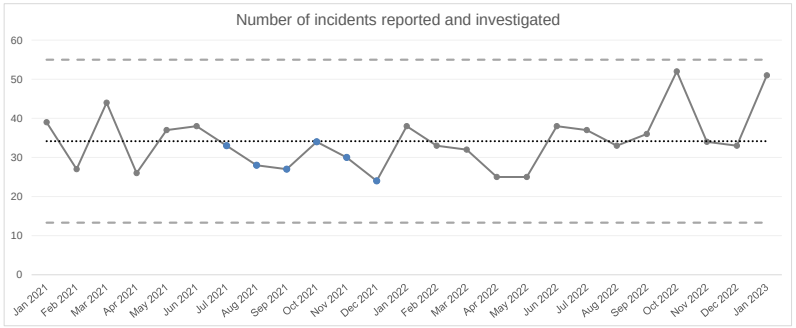
Number of open calls (last day of the month)
- Number of open calls remains high, although it should be noted that **917 / 2551 (36%)** are deferred and awaiting replies/action by users, or delivery of equipment.
- Service Desk capacity will increase in March and focus on review/closure of deferred tickets
- Continued elevated demand for support relating to NHSmail and Office 365 project

Number of End User Devices over 4 years
An increase of 436 devices from first January and small % increase in growth in the last year with more proactive management of our estate. Multiple pieces of work, we have identified 237 machines that had not touched our physical network (onsite) for 90 days we have engaged the users who have provided assurances this piece is still on going. The next steps are for us to introduce a policy that remote IT equipment (i.e. laptops) to come onsite once every 30 days. There are multiple benefits in doing this.

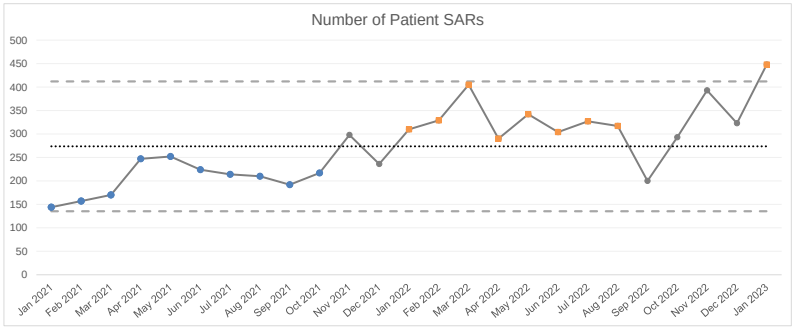
DIGITAL - Information Governance Indicators

York and Scarborough Teaching Hospitals NHS Foundation Trust

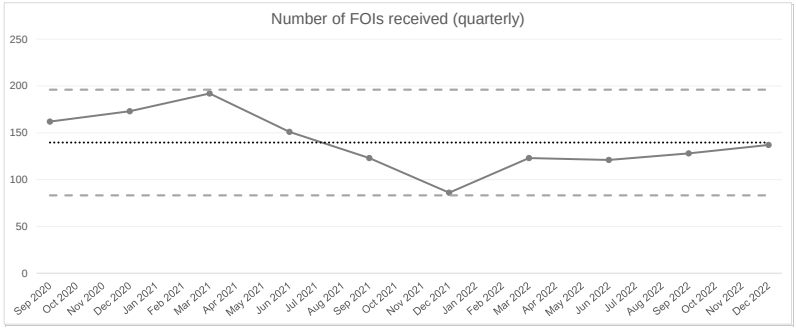
REPORTING MONTH : JANUARY 2023



Jan 2023
51
Target
No Target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



Jan 2023
448
Target
No Target
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
There is no target, therefore target assurance is not relevant



Dec 2022
137
Target
No Target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

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Data Analysis:

Number of incidents reported and investigated: This indicator is showing common cause variation, however Oct 2022 and Jan 2023 saw an increase closer to the upper control limit.
Number of Patient SARS: This indicator is currently showing special cause variation with Jan 2023 above the upper control limit (448 SARs), after a run of eight points above the mean from Jan to Aug 2022.
Number of FOIs received (quarterly): This indicator is showing common cause variation, with the latest trend moving back towards the mean.

Operational Update:

FoIs:
Challenges faced are sufficient resources to manage FoIs, chasing responses alongside other IG priorities, engagement and sufficient resources within the service areas to provide FoI responses alongside other priorities.

Actions are to develop FoI handbook to speed process of applying exemptions and developing providing response templates. Establish key contacts within service areas that can support with responses. Explore the need for additional resource within the IG team to support the FoI process.

Key Risks are not meeting statutory responsibilities and intervention from the regulator (ICO)

Finance Performance Report : Jan-2023

Executive Summary

Trust Strategic Goals:

- [x] to deliver safe and high quality patient care as part of an integrated system
- [x] to support an engaged, healthy and resilient workforce
- [x] to ensure financial sustainability

Purpose of the Report:

To provide the Board with an integrated overview of Finance Performance within the Trust

Executive Summary:

Key discussion points for the Board are:

Financial Position – January 2023 (Month 10)

1. Summary Plan Position

At its June 2022 meeting the Board of Directors approved the final I&E balanced annual financial plan, which formalised the e-mail acceptance of the plan previously received by the Finance Director from Board members. The final plan replaced the draft £11.8m I&E deficit annual financial plan previously approved by the Board. The final plan is now set into the ledger and is being used to monitor current performance. Operational budgets have been set on this basis.

2. Income and Expenditure Position

The I&E table below confirms an actual adjusted deficit of £5.1m against a planned deficit of £0.2m for January. The Trust is £4.9m adversely adrift of plan. This represents a slight deterioration of the position reported in prior months.

The largest adverse variance relates to pay at £12.2m. Premium rate pressures linked to vacancies and high sickness levels are continuing to contribute to the adverse position. As reported last month, funding has been confirmed for the unfunded pay award and this is now factored into the reported position.

The position also remains impacted by the cost of the unfunded mobile CT scanner that the Board agreed to continue to support because of the safety impact associated with our diagnostic waiting times. Although discussions have continued through NHSE to access national Community Diagnostic funding, we have just been informed that no funding will be possible through this route. The scanner is a fully serviced scanner at a cost of £1.4m for the full financial year; at month 10 this is adversely impacting our position by £1.17m.

Of the £4.9m total reported adverse variance, after discounting the financial impact of the additional CT scanner accounts of £1.17m, this leaves a balance of £3.73m created through other pressure for which additional income is not expected.

Following the CQC visits the Trust has responded to identified improvement requirements to its maternity and emergency services at additional cost. To date this amount to £262k and is contributing to the overall adverse financial position.

On top of the locum and agency pay pressure noted above other notable variances include drugs overspend of £3.4m (£2.3m relating to out of tariff drugs with compensating additional income from NHSE), an overspend on other costs of £3.0m (including particularly a pressure on utilities of £1.9m due to the further price increases seen last autumn) and a CIP shortfall of £2.0m with some compensation from an underspend on clinical supplies and services of £5.7m.

Also of note is that we spent £8.0m for the year to date on covid costs compared to a plan of £6.2m; therefore we are £1.8m adversely adrift of our covid plan.

Income and Expenditure Account

	Annual Plan £000's	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's	FOT £000's
NHS England	75,290	62,977	66,899	3,922	80,279
Clinical commissioning groups	528,607	440,533	442,668	2,135	533,000
Local authorities	4,793	3,990	4,012	22	4,815
Non-NHS: private patients	514	428	355	-73	426
Non-NHS: other	1,185	989	1,240	251	1,799
Operating Income from Patient Care Activities	**610,389**	**508,917**	**515,174**	**6,257**	**620,319**
Research and development	1,765	1,471	2,131	660	2,557
Education and training	24,231	20,133	21,466	1,333	25,812
Other income	49,084	40,854	41,567	713	49,521
Other Operating Income	**75,080**	**62,458**	**65,164**	**2,706**	**77,890**
Employee Expenses	-446,037	-371,224	-383,400	-12,176	-457,048
Drugs Costs	-61,987	-51,686	-55,044	-3,358	-66,083
Supplies and Services - Clinical	-74,868	-61,914	-56,248	5,666	-65,958
Depreciation	-18,291	-15,243	-14,544	699	-17,456
Amortisation	-1,521	-1,268	-1,268	0	-1,521
CIP	3,776	2,007	0	-2,007	0
Other Costs	-68,455	-57,225	-60,177	-2,952	-72,647
Total Operating Expenditure	**-667,383**	**-556,552**	**-570,680**	**-14,128**	**-680,713**
OPERATING SURPLUS/(DEFICIT)	**18,086**	**14,823**	**9,658**	**-5,165**	**17,496**
Finance income	30	25	701	676	621
Finance expense	-975	-813	-726	87	-976
PDC dividends payable/refundable	-8,014	-6,678	-6,625	53	-8,014
NET FINANCE COSTS	**9,127**	**7,357**	**3,008**	**-4,349**	**9,127**
Other gains/(losses) including disposal of assets	0	0	0	0	0
Share of profit/ (loss) of associates/ joint ventures	0	0	0	0	0
Gains/(losses) from transfers by absorption	0	0	0	0	0
Movements in fair value of investments and liabilitie	0	0	0	0	0
Corporation tax expense	0	0	0	0	0
Surplus/(Deficit) for the Period	**9,127**	**7,357**	**3,008**	**-4,349**	**9,127**
Remove Donated Asset Income	-9,607	-8,006	-8,510	-504	-9,607
Remove Donated Asset Depreciation	452	377	377	0	452
Remove Donated Asset Amortisation	28	23	23	0	28
Remove net impact of DHSC centrally procured invento	0	0	0	0	0
Remove Impairments	0	0	0	0	0
Remove Gains/(losses) from transfers by absorption	0	0	0	0	0
NHSI Adjusted Financial Performance Surplus/(Deficit)	**0**	**-249**	**-5,102**	**-4853**	**0**

3. Cost Improvement programme

The core efficiency programme requirement for 2022/23 is £15.7m. This is the core value to be removed from operational budgets as we progress through the financial year and deliver cash-releasing savings.

The Board will be aware through the financial plan presentations that NHSE required technical efficiencies, covid spend reductions and estimated productivity gains to be expressed as CIPs. These total a further £16.9m (shown against Corporate CIP below) and increase the full programme value to £32.4m. These requirements have been fully delivered and transacted. The table below details the full programme.

2022/23 Cost Improvement Programme - January									
		January Position			Planning Position		Planning Risk		
Care Group	Full Year CIP Target	Target	Delivery	Variance	Total Plans	Planning Gap	Low	Medium	High
	£000	£000	£000	£000	£000	£000	£000	£000	£000
1. Acute, Emergency and Elderly Medicine (York)	£3,015	£2,394	£1,239	£1,155	£1,601	£1,413	£1,519	£82	£0
2. Acute, Emergency and Elderly Medicine (Scarborough)	£1,404	£1,115	£1,115	£0	£1,404	£0	£1,404	£0	£0
3. Surgery	£3,008	£2,389	£1,450	£939	£2,309	£699	£2,225	£84	£0
4. Cancer and Support Services	£2,552	£2,027	£1,319	£708	£1,843	£709	£1,843	£0	£0
5. Family Health	£1,595	£1,266	£1,140	£126	£1,394	£201	£1,394	£0	£0
6. Specialised Medicine	£1,639	£1,301	£1,487	-£186	£1,902	-£264	£1,902	£0	£0
7. Corporate Functions									
Chief Exec	£65	£52	£76	-£24	£77	-£11	£77	£0	£0
Chief Nurse Team	£164	£130	£128	£2	£134	£29	£134	£0	£0
Finance	£184	£146	£648	-£502	£683	-£499	£683	£0	£0
Medical Governance	£15	£12	£125	-£113	£125	-£110	£125	£0	£0
Ops Management	£101	£80	£50	£30	£50	£51	£50	£0	£0
Corporate CIP	£16,890	£14,075	£14,160	-£85	£18,547	-£1,657	£18,547	£0	£0
DIS	£289	£229	£234	-£5	£319	-£30	£319	£0	£0
Workforce & OD	£314	£250	£605	-£355	£800	-£485	£800	£0	£0
				£0					
Sub total	**£31,234**	**£25,466**	**£23,775**	**£1,691**	**£31,188**	**£46**	**£31,022**	**£166**	**£0**
YTHFM LLP	£1,123	£892	£576	£316	£1,169	-£46	£1,073	£95	£0
Group Total	**£32,357**	**£26,358**	**£24,351**	**£2,007**	**£32,357**	**£0**	**£32,096**	**£261**	**£0**

Delivery in month 10 remains £2m behind plan in terms of the core programme delivery. Plans have been identified to deliver the total programme of £32.4m, and of this sum £32m (99%) is identified as low risk.

Recurrent delivery is 35.4% of the year-to-date target and remains a key risk to the programme.

Productivity and Efficiency Review Sessions

Review sessions are to be chaired by the Chief Executive with attendance from Care Groups and Finance colleagues.

Format of sessions

The sessions will form 2 parts:

- Part 1 will be a summary of the planning and delivery position for 2022/23 and plans for 2023/24. A review of the **Matrix of Opportunity**, potential opportunities, and results of deep dives relevant to the individual Care Group.

- Part 2 will be an opportunity for the Care Group to discuss current and future challenges in terms of meeting the efficiency ask.

Ongoing Developments

- **Robotic Process Automation**

  Work is under-way with Robotic Process Automation (RPA) with a 'proof of concept' project in Accounts payable. This has the potential to be rolled out into other areas within Finance and across the Trust where appropriate and was approved at the Finance and Procurement Transformation Board. This is also being looked at across the ICS. Currently awaiting a DPIA (Data Protection Impact Assessment) to be complete.

- **Collaborative Programme of Work**

  We are working with the North Yorkshire and York Place Finance Director Forum (NY&YPFDF) to pull together a programme of work that will support delivery of System savings. The table below identifies some of the schemes that have been discussed and will be worked up and prioritised. Work is ongoing with regular progress meetings in place.

Scheme no	Care Group/Trustwide/System	Benefits	Next Steps
1	Inventory Management within Community – CG1	Improved stock control Improved pricing through purchasing of products via Supply Chain Gain/Share savings circa £40k recurrent FY 22/23. Further opportunity to make savings through roll-out to other community sites – circa £80k recurrent.	Direction of travel: scanning of 'product to patient'; all about patient safety, better governance and compliance Part 2: Trial at Tang Hall HC (BC attached) eventually roll out to other Health Centres in York area. Review formulary with TVN's once switch to Supply Chain Possibility of rolling out across ICS. NHS Supply Chain Key Stakeholder in process.
2	Pharmacy - Excluded Drugs : Set Target for Pharmacy	Regional Collaboration. Improved pricing.	MH System Top Ten Drugs/Biosimilars. Drugs Spend Provider/Community/Place Agree appropriate Task and Finish group. DoF Place Group to agree & Assign Target
3	Pharmacy: Prescribing	Improved prescribing Reduction in Waste Reduce number of products prescribed Cash reduction £TBA	Review current practice, delivery, spend & volume. Review across ICS and Health sectors. Identify existing Pharmacy collaborative forum across ICS S Parkes, Chief Pharmacist Y&S happy to talk to group Identify opportunity and timescale. Agree appropriate Task and Finish Group DoF Place Group to agree and priortise.
4	Pharmacy & CG1 - Nebulised Drugs	CF Drugs, High Cost Nebulised Medications	Share CG1's paper identify saving and evidence from other Trusts. Savings opportunity reflects Hull and York activity (York are commisioned to provide both). CG1 are leading on this. Is there opportunity for Harrogate.
5	Pharmacy - Formulary Review	Rationalisation of products. Improve patient outcomes. Reduction in Cost.	Formulary review and rationalization of products across ICS and health sectors Agree appropriate Task and Finish Group. DoF Place Group to agree and prioritise.
6	Community - Stoma Care	Improved prescribing	Approach as New scheme. Review current practice, delivery, spend & volume across ICS
10	Community Loan Equipment	Improved stock control. Rationalisation of equipment	Decision maker (prescriber) separate from budget responsibilitiy. Undertake review to scope aligning funding with decision maker. Project manager funded through £500m fund to support

Getting It Right First Time (GIRFT) Update

Work is ongoing in relation to Gynaecology. The national Team will benchmark this service against the GIRFT recommendations.

4. Unfunded Revenue Schemes

There are a small number of revenue schemes running that do not currently have funding. These are outside of our plan. The table below confirms the schemes and the current position in terms of action being taken.

Scheme	Annual Cost	Comments	Funding Action	Timeline for Resolution	Update
Mobile CT	£1,400,000	This relates to a fully staffed and fully utilised mobile CT facility. This is key to our diagnostic recovery work. The scanner has previously been funded through the national diagnostic programme and more latterly the community diagnostic programme. No funding has been agreed but we continue with the hire of the scanner.	NHSE are involved, along with the ICS, in seeking to secure funding as a pre-commitment from this year's community diagnostic hub. No further action is required from the Trust at this time. At present this is reported as a gross cost in our position.	Confirmation of no funding now received.	Continuing in operation. NHSE and ICS aware. Causing £1.17m pressure on our plan. ICS have now confirmed that no funding is available to support this.
CG1 Discharge Command	£115,000	This initiative was funded last year through Hospital Discharge Programme funding. We have been requested to cease all HDP funded schemes, but this is deemed a priority to continue to support discharge at a time of such significant operational pressure. This is not funded within our plan.	There is no additional financial support available for this scheme. The CG, Ops Team and Finance Team are working through a prioritisation process to identify funds that can be diverted to support this.	End of May 22	Agreement reached with CG1 for covering expenditure non-recurrently using temporary vacancies elsewhere in the CG.
CG2 Weekend Therapy Service	£93,000	This initiative was funded last year through additional winter funding. This has now been withdrawn. The service provides a weekend therapy team to continue therapy intervention and to support discharge.	There is no additional financial support available for this scheme. The CG, Ops Team and Finance Team are working through a prioritisation process in order to identify funds that can be diverted to support this.	End of May 22	Agreement reached with CG2 for covering expenditure non-recurrently using temporary vacancies elsewhere in the CG.
CIPHER Ambulance Cohort Service	£1,000,000	This is a new service, deployed to respond to the requirement to release ambulance crews in a timely way given the significant operational pressure on the York site and the significant number of delayed ambulance handovers. CIPHER provide a nurse/paramedic and a care assistant to provide cohorted care for ambulance patients pending ED capacity becoming available. Data shows a marked improvement in ambulance release times when deployed.	The service has been used at peak times and over bank holiday weekends and is expected to cost more than £50k through to the Jubilee weekend. Requests to deploy are increasing and full 24/7 cover would equate to £1m in full year terms. This is not included in our plan and is a new service development. Discussions are underway with the ICS and NHSE/I as to where the liability lies for the cost and how best the service can be provided. At present this is reported as a gross cost in our position.	End of June 22	Confirmation received from ICS that there is no external funding to support this cost at the Trust. Discussions continue between ICS and YAS as to the future arrangements. The Trust has ceased general use after the Jubilee bank holiday weekend to limit expenditure but has occasionally deployed when under real exceptional pressure.

5. ERF

ERF has been confirmed as not recoverable i.e. there we be no clawback by NHSE for under performance, for quarters one and two. This secures ERF income in plan through to September. We have heard informally that the arrangements for the first half of the year may be extended to the second half of the year, but we still await formal confirmation. This assumption is fully reflected in the reported position for the period to date.

6. Current Cash Position

January cash balance showed a £3.5m adverse variance to plan; this is mainly due to the payment of outstanding capital invoices. £11.5m of PDC funding has been drawn down in February in readiness for payment of additional capital invoices. The table below shows our current planned month end cash balances.

Month	Mth 1 £000s	Mth 2 £000s	Mth 3 £000s	Mth 4 £000s	Mth 5 £000s	Mth 6 £000s	Mth 7 £000s	Mth 8 £000s	Mth 9 £000s	Mth10 £000s	Mth11 £000s	Mth12 £000s
Plan	64,116	51,724	46,473	49,160	41,182	34,713	36,376	33,648	33,599	36,273	39,964	53,435
Actual	51,793	45,722	39,382	40,651	45,200	48,410	48,796	35,012	30,711	32,745		

With NHSE confirming that no ERF will be clawed back for quarters one and two we have been able to forecast income with greater certainty over the first half of the year, but we await confirmation of how ERF will operate for the second half of the year. At this stage we are not predicting cash problems will emerge in the next 12 months, but this is conditional on managing all aspects of the income and expenditure plan.

7. Current Capital Position

The total capital programme for 2022/23 is £86.5m; this includes £22.8m of lease budget that has transferred to capital under the new lease accounting standard and £50m of external funding that the Trust has secured via Public Dividend Capital funding (nationally funded schemes) and charitable funding.

Capital Plan 2022-23 £000s	Mth 10 Planned Spend £000s	Mth 10 Actual Spend £000s	Variance £000s
86,513	63,047	35,074	(27,973)

The capital programme at month 10 is £27.9m behind plan. £9.6m of this relates to IFRS 16 leases; Community Stadium lease of £8m not being finalised and £1.6m due to delays in equipment leases running behind plan.

If we remove the impact of IFRS 16 figures the capital programme is £18.3m (39%) behind plan. The 3 main schemes contributing to this adverse variance are Scarborough UEC scheme (£11.0m), Decarbonisation Salix Scheme (£3.4m) and York Cardiology VIU (£3.2m).

Prioritisation of the discretionary element of the capital programme has now concluded and was approved by the Board at its June meeting.

All capital schemes are now progressing.

8. Risk Overview

The financial plan includes significant risk, discussed and acknowledged at the time of Board approval. The table below summarises the risks, the mitigation and the latest update.

Risk Issue	Comments	Mitigation/Management	Current Update
Delivery of the efficiency requirement	At 2.4% the cost out efficiency programme is arguably manageable in comparison to previous years, but the programme has been halted for the last 2 years and clinical teams are focused elsewhere in terms of workforce issues and elective recovery.	The Corporate Efficiency Team has restarted its full support programme. The BBC programme is linked to efficiency delivery opportunities. Full CIP reporting has recommenced. CIP panel meetings have been reconvened with the CEO.	Work with Care Groups and Corporate Teams has identified plans equal to the full value of the required programme. Notably most of the plans are categorised as low risk. Best practice would suggest plans should exceed target to hold contingency against delivery shortfall.
Retention of ERF Funding through delivery of 104% activity levels	ERF is lost at the rate of 75% of tariff value for under recovery of the 104% required activity level.	A full 104% activity plan has been devised. Full monitoring of delivery will be implemented. The BBC programme picks up elective recovery as a specific work stream.	ERF has been confirmed as non-refundable for the first half of the financial year. This has significantly reduced the risk in this regard. We have heard informally that the arrangements in the first half of the year may be extended into the second half of the year, but formal confirmation of this position is still awaited.
Managing the Covid spend reduction	The plan proposed with the ICB requires a £3.5m reduction on covid spend linked to reducing IPC requirements and the national covid expenditure reduction programme.	Work is underway with the CGs and YTHFM to look for opportunities. If necessary, a formal task and finish group will be required to work alongside IPC and the Care Groups to manage covid expenditure down. Formal monitoring in now in place.	This review work is progressing with the Care Groups and is looking to specifically step down spend later in the year to coincide with expected continued downward patient trends. Currently £1.8m has been identified against the £3.5m target
Managing the investment reduction programme	£2m of the required £4.3m investment reduction programme had been identified at the original time of planning. The remaining reduction will require management through the release of activity pressure funding into operational budgets.	Formal monitoring will be required to track progress. This has been implemented.	This review work has been completed and all the £4.3m reduction requirement has been identified.
Expenditure Control	Formal budgets identified through this planning process will require careful management to ensure expenditure compliance and to ensure that any investments made are matched with identified funding sources.	Finance reporting will require enhanced variance analysis and assurance processes. Reporting into the Exec Committee and Board of Directors will be refined to provide greater assurance and transparency. Compliance with the scheme of delegation regarding expenditure approval will be monitored.	This report identifies unfunded expenditure along with details of action being taken regarding funding. There are no control issues at this stage to highlight.

Risk Issue	Comments	Mitigation/Management	Current Update
Winter funding pressures	The plan removes the Trust's typical winter contingency that would normally allow further investments to be made at peak activity times.	Full knowledge has been shared to ensure that the ICB and regional teams are aware that providers are not holding winter contingencies on the grounds of affordability. Additional funding would need to be sought in the evet of material pressures. Our approach is consistent with other providers.	Early information has been shared that suggests £250m will be released nationally for additional winter capacity. We expect to be working with ICS colleagues on this programme in the coming month. The Trust has now been notified that it will receive up to £2.1m from this fund.
The ICB may seek to further reduce expenditure to manage with overall resources.	We will be required to work with the ICB should this prove to be the case. Clinical teams would be required to work alongside the Exec Team and the ICB.	Formal monitoring would be required alongside a quality impact assessment programme in the event of real service expenditure reductions being required.	This risk is receding, and we do not expect material clawback or further savings requirements from the ICB.
Management of the Capital Programme	The 2022/23 capital programme is the largest programme the Trust has ever undertaken. There is significant risk in managing to approved CDEL limits; both in terms of pressure on the programme for additional spend but also difficulty in spending due to construction industry difficulties associated with Brexit, the pandemic, and the Ukraine conflict.	The programme is managed by CEPG. Monitoring provided at Board level. Prioritisation exercise has now concluded to agree the final discretionary elements of the programme for 22/23.	The key risk of the York ED scheme overspend is now clear and the programme has been adjusted accordingly. This has placed significant pressure on the Trust's capital programme.

9. Income and Expenditure Forecast

As the financial year progresses, we continue to review and update our I&E forecast tool to assess our likely year end outcome. The tool takes current trends, adjusted for non-recurrent issues and new expected issues, and extrapolates forward to March 2023.

The current assessment is summarised in the table below.

	Forecast Outturn 22/23 (£000)
Clinical Income	618,146
Non-Clinical Income	80,063
Expenditure	-689,082
Surplus/(deficit)	9,127
NHSE Adjustments	-9,127
NHSE Adjusted Position	0

Key assumptions that been made in the forecast include:

- All ERF income is received.
- Covid in the envelope expenditure returns to plan for the final two months of the year.
- The remaining CIP left to achieve will have a 36% impact on run rate.
- Utilities expenditure does not exceed the £2.2m pressure currently forecast.
- The financial recovery plan discussed at the last Board is developed and is successful in reducing predicted spending by £2.9m.
- Support from the ICB is assumed at £2m based in part on conversations in light of no support being forthcoming from NHSE for the CT scanner.

This forecast has formed the basis of our forecast submission to NHSE/ICB for M10.

Within the overall Trust forecast are differing forecast variances across the Care Groups. Linked to the recovery plan agreed by the Board at its last meeting, the Care Groups have been asked to develop their own recovery plan using the initiatives identified in the Board paper, and to report on their assessed impact on the Care Groups forecast outturn position as at M7.

The table below illustrates the Care Groups respective forecast net expenditure positions at M7, and how their identified recovery actions improve on these positions. Overall the table shows that of the £2.9m target for the financial recovery plan £2.1m of low to medium risk initiatives have been identified to date. Work continues with the Care Groups to reach the target and on lowering the overall delivery risk.

Care Group etc.	Budget	Actual Forecast	Forecast Expenditure Variance	Offset by income	Underlying expenditure variance	Sum of Recovery Actions	Revised Forecast Outturn
Acute Elderly Emergency General Medicine and Community Services - York	105,243,917	109,324,147	-4,080,230	-992,417	-3,087,813	-236,000	-2,851,813
Acute Emergency and Elderly Medicine-Scarborough	53,495,453	58,470,342	-4,974,889	-811,472	-4,163,417	-97,000	-4,066,417
Surgery	100,407,767	104,350,540	-3,942,773	-1,359,741	-2,583,032	-236,113	-2,346,919
Cancer and Support Services	119,305,973	120,548,156	-1,242,183	-709,172	-533,011	-221,000	-312,011
Family Health & Sexual Health	49,970,411	50,668,590	-698,179	0	-698,179	-308,490	-389,689
Specialised Medicine & Outpatients Services	86,648,645	85,596,359	1,052,286	0	1,052,286	-165,000	1,217,286
Other	0	0	0	0	0	-874,000	874,000
TOTAL	**515,072,166**	**528,958,134**	**-13,885,968**	**-3,872,802**	**-10,013,166**	**-2,137,603**	**-7,875,563**

Using the deficit position with the Care Groups reported above, after recovery actions, and after considering the full corporate reported position and YTHFM position we remain targeting a balanced outturn position for the wider group.

Recommendation:

The Board of Directors is asked to discuss and note the January 2023 financial position for the Trust.

Author(s): Graham Lamb, Deputy Finance Director

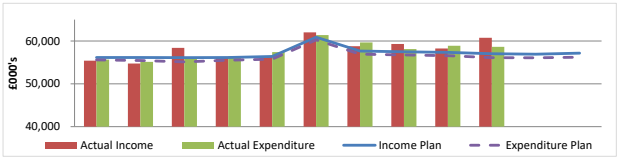
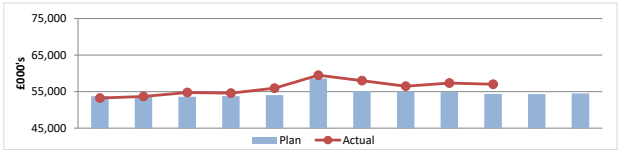
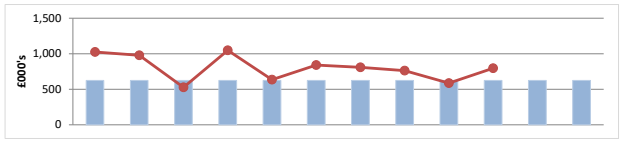
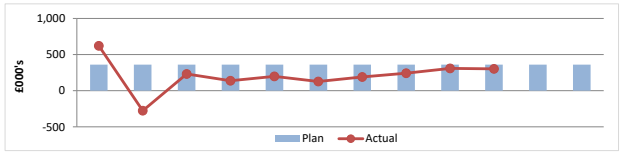
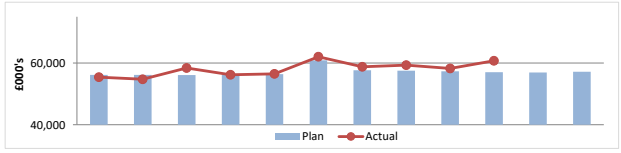
Director Sponsor: Andrew Bertram, Finance Director

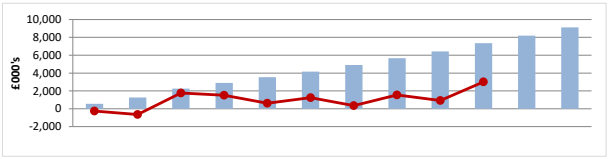
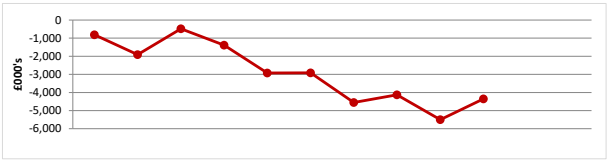
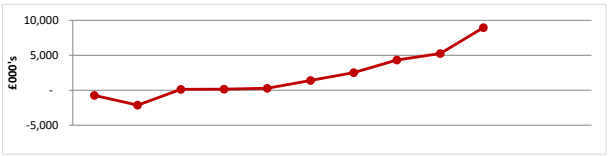
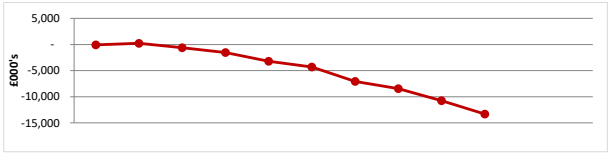
Date: Feb-2023

TRUST PRIORITIES REPORT : January-2023

SUMMARY INCOME AND EXPENDITURE POSITION

STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY

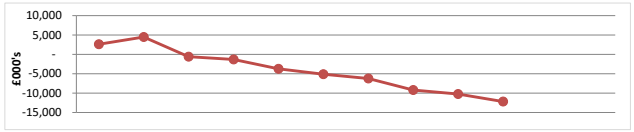
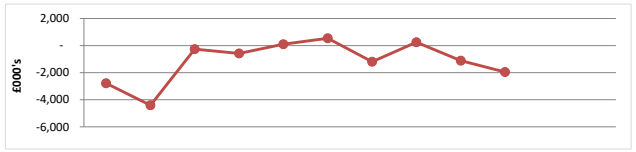
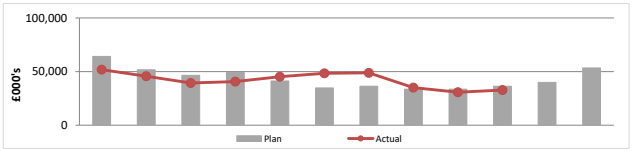
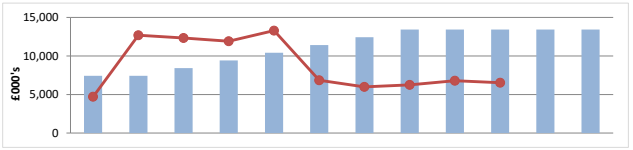
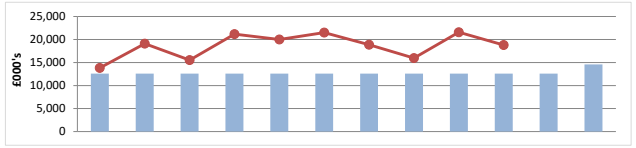
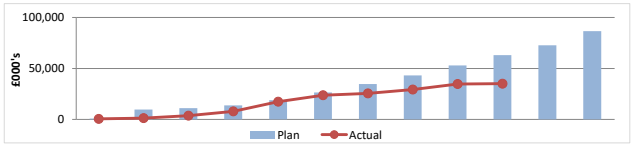
Jan-23	METRIC:	PLAN:	
£3,008	6.01 Income and Expenditure	£7,357	
£57,034	6.02 Operational Expenditure against Plan (exc. COVID)	£54,373	
£796	6.03 COVID-19 'Inside the Envelope' Expenditure	£624	
	Monthly % Covid Spend of Operational Spend:	1.4%	
£303	6.04 COVID-19 'Outside the Envelope' Expenditure	£360	
£60,738	6.05 Income against plan	£57,036	

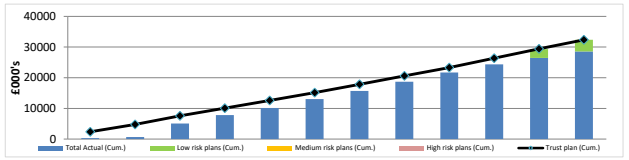
	METRIC:	PLAN:	
£3,008	6.06 Cumulative net actual Income and Expenditure surplus/(deficit)	£7,357	
-£4,349	6.07 Cumulative net Income and Expenditure surplus/(deficit) variance to plan	£0	
£8,963	6.08 Cumulative Income Variance to Plan	£0	
-£13,312	6.09 Cumulative Expenditure Variance to Plan	£0	

TRUST PRIORITIES REPORT : January-2023

SUMMARY INCOME AND EXPENDITURE POSITION

STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY

Jan-23	METRIC:	PLAN:	
-£12,176	6.10 Cumulative Pay Expenditure Variance to Plan	£0	
-£1,952	6.11 Cumulative Non-pay Expenditure Variance to Plan	£0	
£32,745	6.12 Cash Position	£36,273	
£6,521	6.13 Debtors	£13,424	
£18,794	6.14 Creditors	£12,605	
£35,074	6.15 Capital	£63,047	

	METRIC:	PLAN:	
£24,352	6.16 Efficiency programme - delivery against plan and forecast delivery	£26,359	
Delivery ytd:			
Recurrent	£12,863	2,007	
Non Recurrent	£11,489		
£32,357	6.17 Efficiency programme - planning position full year	£32,357	

Planning (Gap)/Surplus

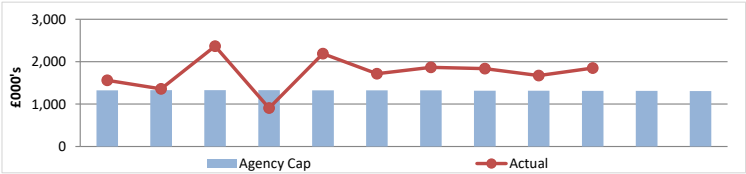
	January £'000	EOY £'000	Comments
Target	**26,359**	**32,357**	
PLANS			
Low Risk	26,291	32,357	
Medium Risk		0	Medium Risk Plans being reviewed re risk status and if deliverable in-year.
High Risk		0	No High Risk plans in 2022/23
Total Plans	26,291	32,357	
Planning (Gap)/Surplus	**-68**	**0**	
Actions			**New Plans** - continue to work with CG's to identify u/spends; opportunities presented in Model Health System (more likely medium/longer term)

TRUST PRIORITIES REPORT : January-2023

SUMMARY INCOME AND EXPENDITURE POSITION

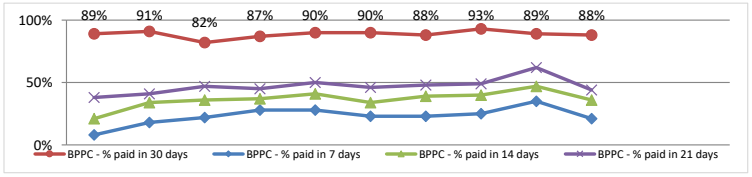
STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY

Jan-23	METRIC:	PLAN:
£0	6.2 Capital Service Cover	£0
£0	6.21 Liquid Ratio	£0
£0	6.22 I&E Margin	£0
£0	6.23 I&E Margin Variance from Plan	£0
£1,850	6.24 Agency Spend against Agency Cap	£1,312



BPPC Performance

Within 30 days		Within 7 days
88%	6.25 BPPC - % paid in 30 days	21%
	6.26 BPPC - % paid in 7 days	
Within 14 days	6.27 BPPC - % paid in 14 days	Within 21 days
36%		44%
	6.28 BPPC - % paid in 21 days	



Highlights for the Board to Note:

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

Other Financial Issues:

Metrics 6.2 through 6.23 are not being actively reviewed by NHSE/I following the operation of the emergency financial regime. When normal operation resumes it is expected these will remain key assessment metrics. 6.24 showing our agency spend against plan remains a live assessment metric and, for the year to date we have used more agency staff than planned.

6.24 showing our agency spend against the announced NHSEI target for 22/23, which remains a live assessment metric and, for the year to date we have used more agency staff than target.

The Trust's compliance with the Better Payments Practice Code (BPPC) is currently averaging around 88% of suppliers being paid within 30 days.

Research & Development Performance Report : Jan-2023

Executive Summary

Trust Strategic Goals:

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

Purpose of the Report:

To provide the Board with an integrated overview of Research Development Performance within the Trust

Executive Summary:

Key discussion points for the Board are:

Our key outcomes in the last month are as follows:

- We have recruited 3555 patients into clinical trials so far this financial year, against a target of 3506, so we have exceeded our accrual target with two months to go!
- We are exploring the possibility of creating some joint clinical and academic posts within Dermatology, including the possibility of a Clinical Lectureship post. Our first meeting with HYMS/UoY was very encouraging with a second meeting planned soon
- We have submitted to HYMS (with Care Group Manager support) 10 staff who would like to have a HYMS funded research PA within their job plans, These are currently being reviewed by HYMS and we remain hopeful!
- We have advertised for new Care Group Research Leads in CG1 and CG5 (Due to Professor James Turvill being promoted to Clinical Director of Research & Innovation and the stepping down of Dr Adrian Evans)
- We are having exciting conversations regarding joint support within the new Institute of Health at the University of York St John, under Professor Garry Tew.
- Our bid to the Clinical Research Network to add some additional staff to the Scarborough MLTC Hub for the next 12 months has unfortunately been unsuccessful. We are now considering what do to with the MLTC Hub going forward.
- We are working on several grants for applications currently, all due for submission in the next two months
- Members of the Team supported the Learning & Development away day that has come up with some exiting ideas we hope to support going forward
- We are also supporting the New Starter Fairs and Careers Days in schools
- Head of R&D and Director of Research and Innovation are currently exchanging ideas on how we can create a better Care Group research infrastructure and the future of the Trusts research Committee

Recommendation:

The Board is asked to receive the report and note any actions being taken.

Author(s): Lydia Harris Head of R&D

Director Sponsor: Polly McMeekin Director of WOD

Date: Feb-2023

TRUST PRIORITIES REPORT : January 2023

CLINICAL RESEARCH PERFORMANCE REPORT

Recruitment

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2022-23	494	570	225	237	217	362	774	221	223	232			3555
2021-22	77	166	127	1060	648	469	383	411	374	396	179	293	4583
2020-21	615	597	440	461	421	331	259	484	293	513	201	145	4760
2019-20	334	275	284	298	348	220	464	615	477	426	365	166	4272

Breakdown as of end January 2023

Care Groups	Accruals Running Total 22/23
CG1 Total	424
CG2 Total	174
CG3 Total	413
CG4 Total	136
CG5 Total	63
CG6 Total	107
RP's Total	600
Cross Trust Studies Total	1638
ACCRUAL TOTALS	3555

Accruals Still Required	0
Trials Open to Recruitment	94

Non-Commercial Studies 22/23 - Breakdown by Study Design (does not add to 100% as does not include commercial studies)

Study Design	% of all open studies	% of total 22/23 accruals to date	NIHR ABF Weighting
Interventional	33%	13%	*Weighted 11*
Observational	51%	60%	*Weighted 3.5*
Large Interventional	4%	4%	*Variable weighting by study*
Large Observational	5%	16%	*Weighted 1*

Breakdown of Trial Category % - All Open Studies

Commercial	7%
Non Commercial	93%

If you would like a breakdown of Accruals in each CG, please contact Angela.jackson2@york.nhs.uk

APPENDIX : National Benchmarked Centiles

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

REPORTING MONTH : JANUARY 2023

Centiles from the Public View website have been provided where available (these are not available for all indicators in the TPR).

The Centile is calculated from the relative rank of an organisation within the total set of reporting organisations. The number can be used to evaluate the relative standing of an organisation within all reporting organisations. If York and Scarborough Hospitals NHS Foundation Trust's Centile is 96, if there were 100 organisations, then 4 of them would be performing better than the Trust. The colour shading is intended to be a visual representation of ranking of the Trust (red indicates most organisations are performing better, green indicates the Trust is performing better than many organisations. Amber shows that the Trust is in the mid range. Note: Organisations which fail to report data for the period under study are included and are treated as the lowest possible values.

Source: https://publicview.health as at 08/02/2023
* Indicates the benchmarked centiles are from varying time periods to the data presented in the TPR and should be taken as indicative for this reason
^ Indicates the benchmarked centiles use a variation in methodology to the TPR and should be taken as indicative for this reason

			Local Data (TPR)			National Benchmarked Centile		
TPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Acute Flow and Elective Recovery	UEC	Proportion of patients discharged before 5pm (70%)	Jan-23	63.0%	70%	83	21/121	*Dec 22
	UEC	ED: Median Time to Initial Assessment (Minutes)	Jan-23	13	18	21	94/118	*Nov 22
	RTT	RTT Total Waiting List	Jan-23	49186	44541	30	118/168	*Nov 22
	RTT	RTT Waits over 104 weeks for incomplete pathways	Jan-23	0	0	38	105/168	*Nov 22
	RTT	RTT Waits over 78 weeks for incomplete pathways	Jan-23	529	63	13	147/168	*Nov 22
Quality & Safety	Healthcare Associated Infections	Total Number of Trust Onset MSSA Bacteraemias	Jan-23	7	45 (12-month)	3	133/137	*Oct-22
	Healthcare Associated Infections	Total Number of Trust Onset C. difficile Infections	Jan-23	12	117 (12-month)	21	109/137	*Oct-22
	Patient Experience	Trust Complaints	Jan-23	44	No Target	23	162/210	*Q4 21/22

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	22 February 2023
Subject:	Risk Management Update - Corporate Risk Register
Director Sponsor:	Simon Morritt, Chief Executive
Author:	Mike Taylor, Associate Director of Corporate Governance

Status of the Report (please click on the appropriate box)

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ A Regulatory Requirement ☐

Trust Priorities	Board Assurance Framework
☒ Our People	☒ Quality Standards
☒ Quality and Safety	☒ Workforce
☒ Elective Recovery	☒ Safety Standards
☒ Acute Flow	☒ Financial
	☒ Performance Targets
	☒ DIS Service Standards
	☒ Integrated Care System
	☒ Sustainability

Summary of Report and Key Points to highlight:

To note the current Corporate Risk Register that are risks rated 15 or greater following the formal risk assessment process and consideration at the Risk Committee.

Recommendation:

The Board of Directors is asked to note the current risks on the Corporate Risk Register.

Report History
(Where the paper has previously been reported to date, if applicable)

Meeting	Date	Outcome/Recommendation
Risk Committee	Each Month	Approved

Risk Management Update – Corporate Risk Register

1. Introduction and Background

Risk and its assessment are an integral part of the services provided by the York and Scarborough Teaching Hospitals NHS Foundation Trust.

The management and mitigation of risks is essential to safeguard the Trust's staff, assets, finance, and reputation and is fundamental to the provision of high-quality care for patients and staff by creating a control environment centred on continuous improvement.

2. Corporate Risk Register (CRR)

The CRR is a high-level operational risk register which captures trust-wide risks and their controls. Used correctly, it demonstrates that an effective risk management approach is in operation within the Trust. Risks on the CRR are owned by Executive directors.

The CRR is reviewed, and quality assured monthly by the Executive directors and/or their delegates prior to presentation at the Risk Committee, which includes risks escalated from care groups and corporate service functions to be considered for inclusion onto the CRR.

Appendix 1 presents the current Corporate Risk Register.

3. Risk Management Process

The date of meetings of the Trust's Risk Committee are currently being rescheduled to ensure a more effective and timely risk reporting process through the Committee onwards to the Board Subcommittees and subsequently the Board on a monthly basis commencing in March. This will be supplemented by the reporting of the Trust's strategic risks in the Board Assurance Framework (BAF) on a quarterly basis.

Escalations to the Risk Committee will be considered by its members to determine whether a risk that is being proposed for escalation should feature on the CRR or should be de-escalated to its point of origin. For each risk that is escalated, rationale should be provided as to why the risk should be considered for inclusion on the CRR.

Finally, the Trust's Risk Policy is being re-drafted addressing shortfalls in process and addressing care group feedback. This will be reported to the March Audit Committee and subsequently Board for approval.

4. Next Steps

The risks on the Corporate Risk Register and any further risks for escalation will be considered at the 1 March Risk Committee.

Corporate Risk Register February 2023 - Appendix 1

BAF Ref	ID	Title	Opened	Description	Current Mitigation	Manager	Next Review Date	Severity (Current)	Likelihood (current)	Risk level (current)	Actions (Risk)	Severity (Target)	Likelihood (Target)	Risk level
PR1 PR3	368	Failure to manage contagious infection outbreaks	20/08/2018	The risk of ineffective management systems caused by environmental issues, insufficient specialist and standard isolation capacity, reduction of bed base, a lack of adequate facilities at Scarborough Hospital and the recent spike of COVID and non-COVID patients in ICU which impact on separating separate COVID and non-COVID patients in ICU. The Trust has no specialist isolation facilities for patients with airborne infection or potential high-consequence infectious diseases (HCID). This may result in serious harm or death to a patient, unsatisfactory patient experience, significant financial loss; loss stakeholder confidence; and/or a material breach of CQC conditions of registration	1.In response to the COVID-19 pandemic and post COVID -19 all IPC resource was re-directed to support the Trust response. 2.IPC precautions, measures and protective systems are in place including regular testing of patients and staff 3.Appropriate Patient isolation procedures 4.CDI Improvement Plan 5.Quality Improvement methodology adopted with a Trust wide HCAI collaborative 6.Personal Protective Equipment (PPE) 7.Cleaning process 8.Weekly monitoring of performance 9.Post Infection Reviews (PIR) 10.Monthly reporting to Board on infection rates. Further mitigation: The IPCT recovery plan which is essential to be able to monitor performance and reduce risk of Healthcare Associated Infection (HCAI)	Nurse, Chief	01/03/2023	5 - Catastrophic Harm	4 - Somewhat Likely	Significant	1. Both Emergency Departments have developed plans for identifying and housing potential HCID cases within their existing footprint. 2. The actions are captured in the wider IPC improvement plan 3. 23/11/2022-There is a detailed piece of design work needed to enable the trust to achieve HTM compliant ventilation on all the ward across the organisation. The Estates department is going round to evaluate this. 4. 09/01/2023 Awaiting the opening of the new Emergency Department at York Hospital on 04/05/2023 which will allieviate the overcrowding at the Emergency Department and associated IPC transmission risk.	5 - Catastrophic Harm	2 - Unlikely	High
PR1 PR2 PR3 PR6	409	Cyber Security	01/11/2018	There is a risk of a Cyber Attacks through a computer virus or malware, malicious user behaviour, unauthorised access, phishing and unsecure data flows. This could result in significant patient harm, reputational damange, unavailability of systems, financial recovery costs, and inability to meet regulatory deadlines (NHSE, HMRC) and additional regulatory scrutiny/fines/censure (CQC/ICO).	1.Utilisation of the NHS Digital Secure Boundary Service to ensure perimeter protection. 2.Full adoption of the Microsoft Defender product suite on end user devices and monitoring through the Microsoft Tool set. 3.Regular and timely patching in line with best practice guidelines. 4.Adopting where possible the Data Security and Protection Toolkit standards and principles. 5.Compliance to standards i.e. DSP toolkit encompassing key aspects of Cyber Security (Patching, AV management, Education and Training) 6.Trust wide information and sharing of the risk of cyber -attacks occurring and preventative measures to reduce the risk. 7.Joint DIS IG and Security Governance and Forums (Operational, Toolkit and ESP strategy)	Chief Digital and Information Officer	01/03/2023	5 - Catastrophic Harm	4 - Somewhat Likely	Significant	1.Refresh our suit of Information Security Management Policies. 2.Reduce insider threat by improving vetting processes 3.Improve our Vulnerability Management through improved patching response times 4.Introduce improved proactive monitoring of systems to identify potential attacks and responding to them prior to exploitation 5.Review approach to staff training and awareness 6.Review the cyber Target Operating Model 7.Identify and improve our approach to physical security 8. Review our password protocols to align with NCSC guidance.	5 - Catastrophic Harm	3 - Possible	Significant

BAF Ref	ID	Title	Opened	Description	Current Mitigation	Manager	Next Review Date	Severity (Current)	Likelihood (current)	Risk level (current)	Actions (Risk)	Severity (Target)	Likelihood (Target)	Risk level
PR1 PR2 PR3 PR4	1695	Sustained significant pressure in ED	17/10/2022	Risk to patient safety and workforce: 1. Overcrowding: linked to increased morbidity and mortality risk where the number of patients occupying the emergency department is beyond capacity for which the ED is designed and resourced to deliver at any one time. This can lead to delays to treatment for patients, for those requiring resus and those for the main department and thus reduced performance in quality standards. This is due to delayed transfers of care for patients requiring admission and from patients attending the department. In York it is also a result of building work reducing current capacity. This impacts on the ability to take handover of new patients from the ambulance service causing safety risks across the system. 2. Workforce: The above creates an environment that impacts on staff well-being and resilience causing additional risks to staff behaviours and performance and ultimately to patient safety. This affects both recruitment and retention.	Trust wide: 1. CIPHER cohorting of ambulance patients to provide resource to allow release of ambulances and care for patients on the corridor. 2. Clinically focused communication and escalation using the OPEL framework: A clear site-management process is in place with robust communication lines across all services. 3. Communication processes across the whole hospital site include: 2 hrly operational meetings, ED EPIC & NIC hrly huddles; focusing on the day's activity ('At a Glance' board), current status and looking at prediction of capacity and demand. Such processes help inform standard operating procedures and escalation. Links to System Control for support system wide including ambulance diversions. 4. Medical and Surgical processes to pull patients from the ED direct into specialty services, EAU and SAU open 24/7. EAU is open for direct ambulance access and this is being developed for SAU. 5. The High Intensity user Group is in place to ensure anticipatory care plans support decisions about optimal care and ensure rapid assessment is available when an unscheduled care episode occurs. This helps to minimise admissions, reduce length of stay if admission is necessary, and ensure transitions of care occur without delay. 6. HALO provided from YAS at times of surge/overflow requirements, who would provide monitoring, oversight and escalations to the EPIC/NIC. 7. Continued working with Vocare to stream additional patients into UTC.	Operating Officer, Chief	01/03/2023	5 - Catastrophic Harm	4 - Somewhat Likely	Significant	Future mitigations: New ED build, with associated working model and patient pathways. Integrated Urgent Care Model Virtual Wards Discharge Framework 7 day standards Integrated Intermediate Care Integrated models of care for Children and Young people	5 - Catastrophic Harm	4 - Somewhat Likely	Significant
PR1 PR2 PR3 PR6	1696	Workstream Funding	17/10/2022	There is a risk that the Trust will be unable to deliver key work streams within the Maternity Transformation programme, due to a lack of available funding both Capital and Non-Capital. This could result in risk to patient safety, patient experience, regulatory non-compliance and reputational damage.	1.Review (discussion with Senior Leadership) current service and delivery processes which entail a risk assessment to determine the impact on patient experience, regulatory non-compliance and reputational damage. 2.Consultancy commissioned confirmed the outcome of the risk assessment, gaps in compliance and inform ongoing Transformation workstreams and inform the Senior responsible Officer. 3. The Maternity Transformation Group that reports to the Executive Committee was made aware of the Risk description and the impact on Maternity Department. 4. Frequent safety huddles 5. Schedule of audits to monitor compliance	Nurse, Chief	01/03/2023	4 - Severe Harm	4 - Somewhat Likely	Significant	1. Feasibility study plan is to be undertaken to identify the resourcing requirements.	3 - Moderate Harm	3 - Possible	Medium
PR1 PR2 PR3 PR4 PR5 PR7	1699	Failure to deliver the National Activity Plan	01/05/2022	There is a risk of the Trust not being able to deliver the National Activity Plan leading to the failure to deliver: 1. Zero RTT 104 week waits by June 2022 2. Delivery of zero RTT 78 week waits by end March 2023 3. Diagnostic 6-week performance recovery 4. Cancer 63 day waiters 5. Emergency Care Standards 6. Ambulance Handovers 7. Patients spending 12 hours in Department due to Workforce (sickness, vacancies & retention) Clinical capacity (Theatre, Outpatients Beds etc) and the number of patients without a right to reside impacting on the ability to carry out elective work. This could result in regulatory intervention, patient safety and quality of care.	1. Care Group Performance Meetings 2. Weekly Corporate led Elective Recovery meetings to review all potential RTT104 week breeches 3. Development of Care Group Dashboards 4. Build Better Care programme 5. TIF bids (Ramsey & Bridlington procedure space on Lloyd Ward 6. Care Group 12-month priorities for workforce 7. Work Force Planning & Development Lead appointed	Operating Officer, Chief	01/03/2023	4 - Severe Harm	4 - Somewhat Likely	Significant	1. Executive escalation when not on plan 2. Starchambers chaired by Trust Chief Executive with high risk specialities established and commencing January 2023. 3. Trust in National Tier 1 facilitated assistance from National elective IST and Ernst Young	3 - Moderate Harm	3 - Possible	Medium

BAF Ref	ID	Title	Opened	Description	Current Mitigation	Manager	Next Review Date	Severity (Current)	Likelihood (current)	Risk level (current)	Actions (Risk)	Severity (Target)	Likelihood (Target)	Risk level
PR5 PR7	1693	Failure to deliver our Annual Financial Plan	11/05/2022	There is a risk to delivery of our 22/23 annual financial plan due to the failure to control expenditure within resource envelope, failure to manage inflationary pressures, failure to deliver the required level of elective recovery activity to secure ERF and/or failure to deliver the efficiency programme. This could result in reputational damage, our cashflow and our ability to deliver clinical services. There is an additional developing risk to agreement and delivery of our annual financial plan for 23/24 concerning the availability of ICB and national funding levels to meet current and predicted Trust running costs.	1. Trust Business Planning process 2. Agreed Annual Plan 3. Approval of operating budgets 4. Scheme of delegation and standing financial instructions Oversight of Trust. 5. Performance monitoring and performance management arrangements. 6. Executive Committee, Resources Committee and Board of Directors monitoring. 7. NHSE/I Reporting 8. ICB Reporting 9. Corporate Efficiency Team managing delivery of the efficiency programme. 10. Business case process to manage new investment requirements. 11. ICB task and finish groups (including the Trust) working on 23/24 planning.	Finance, Director	01/03/2023	4 - Severe Harm	4 - Somewhat Likely	Significant	1. Develop enhanced reporting to DF&P Committee along with development of the TPR. 2. ICS collaborative working, risk share arrangements 3. Greater scrutiny of business case developments required to ensure a source of funds is sourced before investment is made. 4. Trust has created and is currently delivering an Internal Financial Recovery Plan - March 2023. 5. Additional income recovery with NHSE and ICB to help manage specific pressures. 6. Engagement with the ICB and national teams to understand the movement in funding between 22/23 and 23/24 and the associated consequences at	3 - Moderate Harm	3 - Possible	Medium
PR1 PR2 PR3	377	Deteriorating Patients	20/08/2018	There is a risk in correctly identifying and managing deteriorating patients due to staff not escalating the risk, a key person dependency, inadequate treatment, discharge and admission plans and poor patient flows. This could result in serious patient harm/death, regulatory scrutiny/censure, financial costs and reputational damage.	1.Critical Care Outreach Team 2.Oversight of system entries and segregation of duties 3.Datix safety alerts 4.NEWS monitoring 5.Annual audit by Intensive Care Unit (ICU) on deteriorating patients. 6.Individual escalation protocols 7.National Early Warning Scores (and associated pathways NEWS, MEWS and PAWs) 8.Staff training 9.SOPs/pathways for managing deteriorating patients 10.Deterioration Policy 11.Ceiling of Care Policy within clinical pathways	Director, Medical	01/03/2023	4 - Severe Harm	4 - Somewhat Likely	Significant	QI work on the deteriorating patient pathway to include consideration of human factors, psychological studies and patient feedback on safety incidents	4 - Severe Harm	2 - Unlikely	Medium
PR1 PR2 PR3 PR4	404	Insufficient staff	16/12/2022	There is a risk of delays in offering optimum care and treatment due to the failure to maintain adequate staffing levels arising from staff sickness, difficulties in recruiting, national staff shortages, finding of Nursing establishment reviews, vacancy rates and inability to provide seven-day service in non-emergency care. This may result in increased pressure in clinical services and delays in diagnostics treatments including poor experience for patients and staff.	1.Temporary staffing supports the Trust staff roster gaps, Active bank and workforce resilience initiatives 2. Review of the working environment to make it more positive and safe working environment. 3. Retention initiatives Such as: Fix The Basics, Culture Change, Workforce Planning, E&D actions 4. Pastural work-life package in place 5. Recruitment drive with support from Health Education England &ICS with Ongoing campaign to recruit overseas qualified staff 6.Staffing reports are discussed at the following Committees PACC, QPaS, Executive Committee Quality & Safety Assurance Committee 7.Daily monitoring of staffing levels (temporary/permanent) managed by Associate Chief Nurse Matron of the day and escalated to Chief Nurse Team as appropriate, and this also includes oversight of rotas - e-Rostering	Workforce & Organisational Development, Director	01/03/2023	4 - Severe Harm	4 - Somewhat Likely	Significant	1. Job Plan re-setting of expectations 2. Safer Care Investment Proposals to Board 3. Establishment review 4. Workforce planning	4 - Severe Harm	3 - Possible	High

BAF Ref	ID	Title	Opened	Description	Current Mitigation	Manager	Next Review Date	Severity (Current)	Likelihood (current)	Risk level (current)	Actions (Risk)	Severity (Target)	Likelihood (Target)	Risk level (Target)
PR1 PR2 PR3	1692	Patients With No Criteria to Reside	18/10/2022 CRR 16/01/2023	There is a risk of patient harm, deconditioning and poor patient experience due to an excessive number of patients whom have no Criteria to Reside occupying acute hospital beds. This results in restricted flow from Ed to AMU and downstream wards and leads directly to backlogs in ED and prevents timely ambulance handovers.	Daily monitoring of accuracy and completion of CTR codes by Patient Flow team. Daily tracking of non CTR patients (in both acute beds and local IPUs) on the patient tracker with comprehensive narrative of actions taken to progress discharge. -Daily escalation calls with partners to actively progress pathway 1-3 patients on daily basis. -Weekly Long Length of Stay (LLOS) reviews to ensure internal and external delays are escalated and treated. -System escalation calls as dictated by OPEL score. -System action plan with NY Place & York Place -Bridlington Community Unit - 15+ residential Level care beds for patients with no CTR. -York Community Unit -19+ -Mulberry Ward Scarborough - 16 nursing level care beds (on site) for patients with no CTR. This facility cohorts non CTR patients so we can reduce the consultant cover for these medically fit patients. -Alderson House - Facility in East Riding for D2A but currently under-used.	Operating Officer, Chief	01/03/2023	4 - Severe Harm	4 - Somewhat Likely	Significant	Ongoing discussion with partner organisations via PLACE director to develop a comprehensive response and plan for decompressing non CTR patients off the acute site. Ongoing dialogue with East Riding with offer of support to get Alderson House functioning as a D2A facility. Re-location of BCU to WATERS Ward in Bridlington with a view to expanding capacity. Revision of TAF to make process more streamlined.	2 - Minor Harm	2 - Unlikely	Low
PR1 PR2 PR3 PR6	1388	Major IT Failure	18/12/2020	There is a risk of the failure of the core technology estate (e.g. CPD, clinical or admistrative systems or network infrastructure) due to single points of weakness, loss of power/premises, out of data infrastructure or poor data storage/sharing processes. This could result in patient harm, prolonged service disruption, poor quality of patient care, reputational damage, financial costs and regulatory scrutiny/censure.	1. Pro-active management and maintenance of systems and solutions i.e. upgrades, patching. 2. Increasing resilience of core network and server infrastructure.	Chief Digital and Information Officer	01/03/2023	5 - Catastrophic Harm	3 - Possible	Significant	1 Investment in infrastructure, storage, end user compute, networks and wifi. 2.Improve our Vulnerability Management through improved patching response times. 3. Review our backup strategy and disaster recovery plans. 4.Review portfolio priorities to investigate prioritising non-functional upgrades. 5. Enhanced service management and operations including control, governance, major incident and problem management. 6. Increase pro-active management and maintenance of systems and solutions i.e. upgrades, patching 7. Increase pro-active service management and operations through new event management solutions (Monitor, alert and self fix)	5 - Catastrophic Harm	2 - Unlikely	High
PR1 PR2 PR3	1509	T&O RISK: Failure to offer an effective arthroplasty service	14/10/2021 CRR 19/12/2022	The risk is a failure to offer an effective arthroplasty service. Due to the lack of an elective ward and no alternative spaces. This could result in Patient harm and distress, Poor patient experience, Disability, Reputational damage, Regulatory attention, Increased backlog of patients waiting treatment Breach of targets including GIRFT.	Ramsey contract will deliver a proportion of low risk arthroplasty service High ASA utilisation of side rooms in acute bed base via SOP T&O OSM is micro managing day to day lists	Operating Officer, Chief	01/03/2023	3 - Moderate Harm	5 - Very Likely	Significant	03/08/2022 - Discussion by MQ at Exec Board	3 - Moderate Harm	1- Very Low	Low

BAF Ref	ID	Title	Opened	Description	Current Mitigation	Manager	Next Review Date	Severity (Current)	Likelihood (current)	Risk level (current)	Actions (Risk)	Severity (Target)	Likelihood (Target)	Risk level
PR1 PR2 PR3 PR4	1667	Fragility of Gastroenterology Service	21/09/2022 CRR 16/01/2023	There is a risk that the Gastroenertology service at Scarborough and York will continue to deteriorate due to workforce challenges. This will result in both routine and urgent referrals will not be able to be seen in outpatients for at least 2 years	Look at the feasibility of transferring all new elective patients without an appointment to other providers within the network. Tender for insourcing or outsourcing outpatient services. - Care Groups 1/2 working together to develop interim solutions Working Group has been established to develop and deliver a plan in order to manage the risk.	Operating Officer, Chief	01/03/2023	3 - Moderate Harm	5 - Very Likely	Significant	Working Group has been established to develop and deliver an action plan in order to manage the risk. Insourcing now in place. Acute bleed rota (Monday-Friday) now in place.	3 - Moderate Harm	2 - Unlikely	Low
PR1 PR2 PR3 PR4	1728	Outpatients Services	30/11/2022 CRR 19/12/2022	There is a risk of missed/delayed appointments Due to CPD not being an administrative tool there is a large amount of manual work and a high level of back log due to sickness and vacancy This could result in harm to patients	Agency staffing in place (2). Capacity for a further 4 agency staff, but limited interest from the 200+ agencies approached. All Care Groups advised of capacity issues and asked to support with slot filling and giving suitable notice to the team to fill clinics. All Care Groups asked to let admin staff know of opportunity to undertake additional overtime/bank within the team to support with backlogs.	Operating Officer, Chief	01/03/2023	5 - Catastrophic Harm	3 - Possible	Significant	Continue to try to recruit to agency posts. Continue to try to recruit substantive staff.	5 - Catastrophic Harm	2 - Unlikely	High

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Report to:	Board of Directors
Date of Meeting:	22 February 2023
Subject:	CQC Update Report
Director Sponsor:	Heather McNair – Chief Nurse
Author:	Hazel McAtackney - Head of Compliance and Assurance (Interim)

Status of the Report (please click on the appropriate box)

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ A Regulatory Requirement ☐

Trust Priorities	**Board Assurance Framework**
☐ Our People ☒ Quality and Safety ☐ Elective Recovery ☐ Acute Flow	☒ Quality Standards ☐ Workforce ☐ Safety Standards ☐ Financial ☐ Performance Targets ☐ DIS Service Standards ☐ Integrated Care System

Summary of Report and Key Points to highlight:
This report provides the Quality Assurance Committee with an updated position in relation to the action being taken to address the CQC regulatory conditions.

On the 23rd January 2023 the Maternity action plan 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.

Recommendation:
For the quality Committee to receive the assurance provided in this report.

Report History
(Where the paper has previously been reported to date, if applicable)

Meeting	Date	Outcome/Recommendation
Quality and Patient Safety Group	8th February 2023	Noted

CQC Report – February 2023

1. Introduction and Background

The purpose of this report is to provide assurance of action plan delivery and their impact. In addition, risks to delivery of the required improvements are also outlined.

2. Governance and Shared Learning

The governance structure continues to be embedded, however operational pressures and strike action in January have impacted the schedule for the Quality and Regulatory Assurance Group. The meeting held on 2nd February 2023 was used to receive assurance for topics that had been missed from previous meetings and to revise the programme of assurance.

Table 1: Quality and Regulatory Assurance Report timetable

Assurance Topic	Date
Nutrition & Hydration	11.11.22 – complete
Update MCA/DOLS	24.11.22 - complete
Clinical Risk Assessments	08.12.22 - complete
Deteriorating Patients	22.12.22- complete
Evaluation of Progress	02.02.23 complete
Workforce	16.02.23
Infection Prevention and Control	02.03.23

Lorna Squires from NHSEI was due to be in the trust for two days in January to start the review of corporate and clinical governance. Unfortunately, due to unforeseen circumstances she was not able to attend, and this piece of work is being rescheduled for 28 February 2023.

3. Section 29A – Scarborough Hospital - PEM Consultant

As previously stated, we have requested the removal of this warning notice, they have confirmed that removal of this condition is being considered as part of their recent inspection.

4. Section 31 – York and Scarborough Emergency Departments – Mental Health Risk Assessments

Performance in relation to mental health risk assessment reduced in December which corresponds to the increase in demand for the Emergency Departments during that month. York ED demonstrates more improvement with these assessments, but Scarborough are on an upward trajectory in four of the five areas. The mental health risk assessment is being built into Nucleus and it is hoped it will launch within the next 2-months.

Figure 1: Scarborough Mental Health Audit

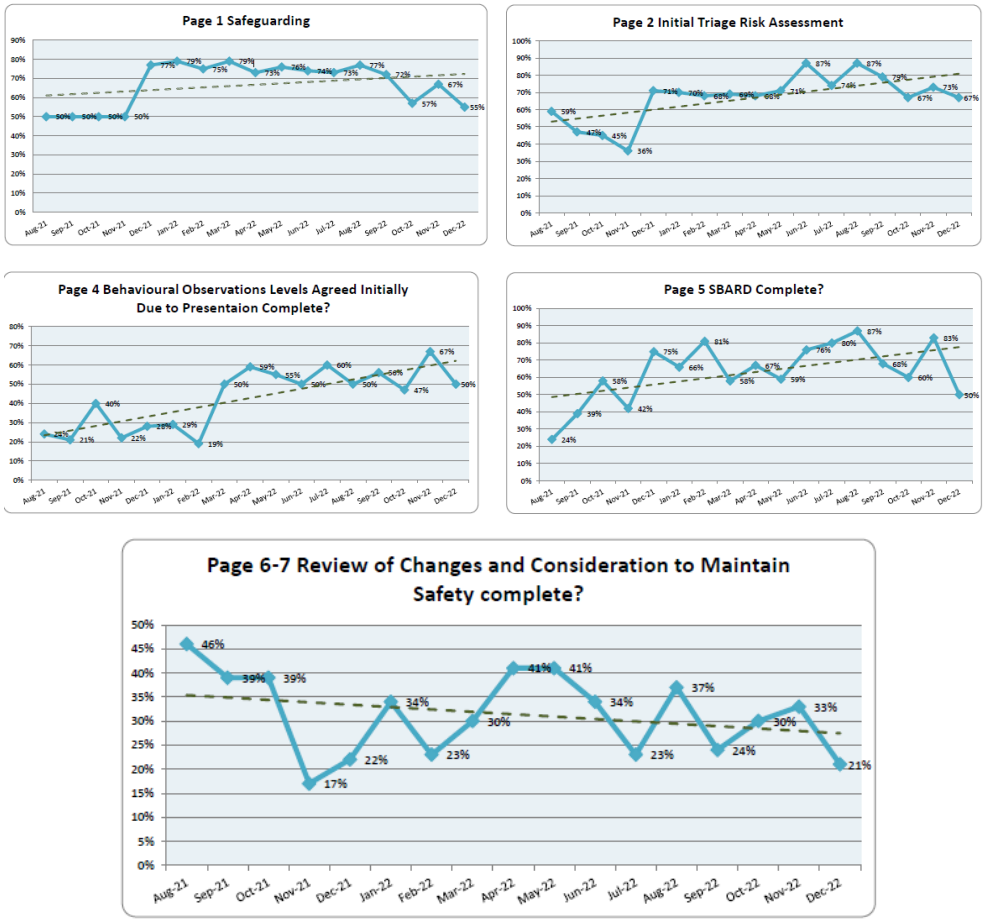
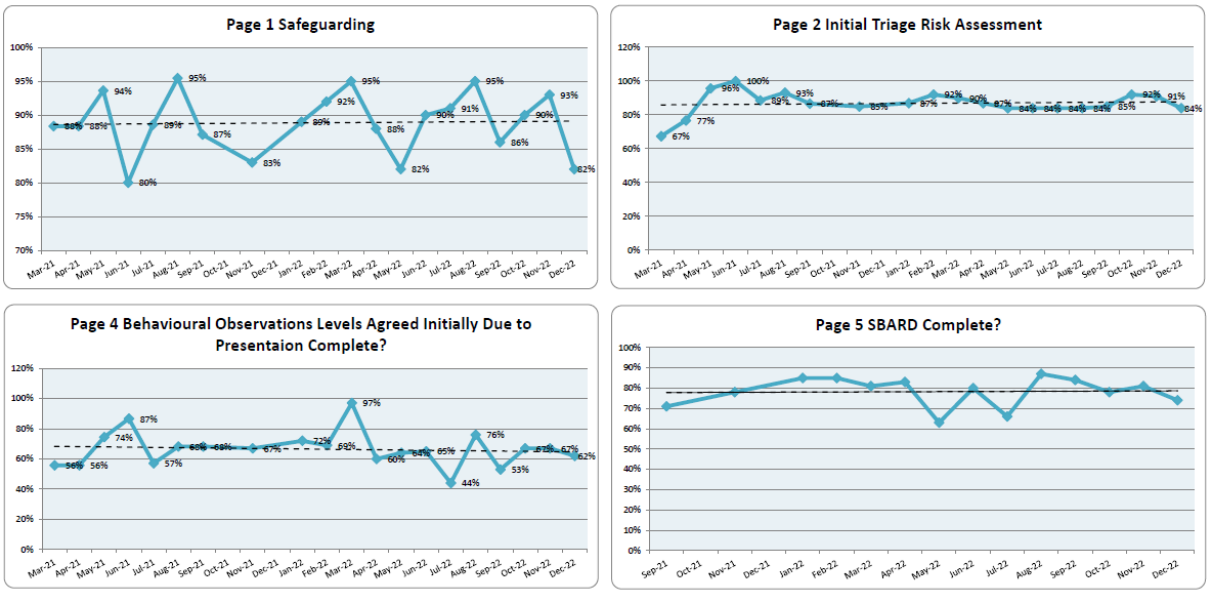
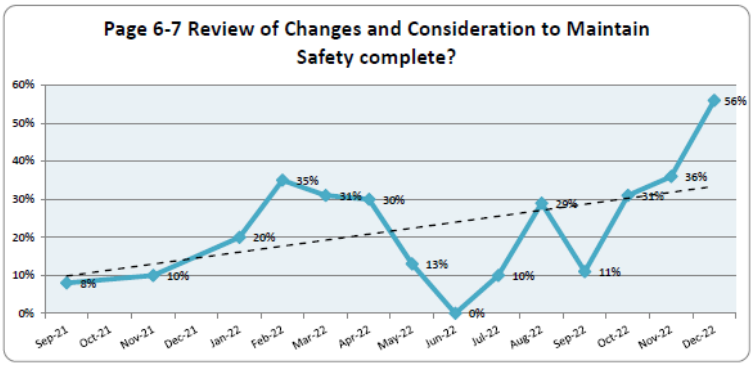


Figure 2: York Mental Health Audit





5. York Hospital Medicine Inspection (March 2022)

5.1 Section 29A (Hydration and Nutrition and management of Risk)

Thirty of the thirty-two actions identified in response to section 29A warning notice are complete. Two actions continue to be outstanding, and progress is reported in table 2.

Table 1: Overview of section 29A action progress

Overview – Section 29A		
	0	**Off Track**
	2	**At risk of exceeding timescale for delivery**
	0	**On Track**
	30	**Complete**

Table 2: Actions at risk of exceeding delivery timescales

CQC section 29A Requirement Off Track	Actions Taken to Mitigate	Mitigation in Place
Nutrition & Hydration Visiting Policy scoping Exercise – promote family and carers to support care delivery	Existing policy was revised and approved by Executive Committee Consultation exercise with carers and external agencies is now complete and the responses are being analysed. The public visiting guidance is due to be ratified at the Patient Experience Steering Group meeting on 28th February 2023. Final Policy due for ratification 30.4.23	John's Campaign carers card pilot initiative in place to encourage carers to visit at mealtimes to support care.

CQC section 29A Requirement Off Track	Actions Taken to Mitigate	Mitigation in Place
Risk Assessment Bumpers and Crashmats	Bumpers have been ordered for both ED departments. 3 suppliers have been identified that can provide the trust specification. Awaiting feedback from procurement re date.	Completion due date is 28th February 2023

5.2 Must Do Actions

Overall, there were 5 Must do recommendations and 25 actions have been put in place to address the recommendations. As reported previously, there are three actions which are not on track for delivery within the timescale. Although there has not been any progress since the last report the actions are detailed in table 4 for completeness.

Table 3: Overview of must do action progress.

Overview – Must Do's		
	0	**Off track**
	3	**At risk of exceeding timescale for delivery**
	1	**On track**
	21	**Complete**

Table 4: Must Do actions at risk of exceeding delivery timescales.

Must Do Requirement - At Risk of Exceeding Timescale	Actions Taken to Mitigate	Mitigation in Place
Mental Capacity Act MCA Advisors – Recruitment and Implementation	Attempts to recruit on two occasions. York post filled but Scarborough post has not been successfully recruited to. Interim Agency expert in place in Scarborough until April 2023.	Agency staff are in situ on the Scarborough site whilst the recruitment process is underway. The role is out to advert with a closing date of 10th February 2023.
Information Governance Review storage and location of medical records on wards	With the introduction of Nucleus, the number of paper nursing records will reduce. As more clinical information is recorded electronically this again will reduce the number of paper records. The IG team carry out regular	The clinical lead for Elderly Medicine has agreed that records will only be requested where necessary and not for all admissions. The storage of paper records on wards will continue to be monitored

	walk rounds on ward areas giving advice on the security of information. Recently a visit was undertaken in York ED by the Head of Information Governance to discuss the security of records and advised on the storage of records particularly in the reception area.	
Information Governance Scope requirements for medical records on wards	As above	As Above

5.3 Should Do Actions

There was one should do recommendation made by CQC. '*The trust should ensure that persons employed receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.'*

One action was put in place to establish a subgroup with the aim to develop consistently high-quality accessible programmes in the trust. This action does not fully address the recommendation and the further actions required will be scoped across February and proposed to the Quality and Regulations Assurance Group.

5.4 Impact of Improvements

In this section the impact of the improvements made to date is outlined.

5.4.1 Risk Assessments

Nucleus

Risk assessments for falls, nutrition, pressure ulcers and bed rails are completed on the Nucleus system. Currently there are 40 areas using Nucleus and performance can be tracked via the Signal BI dashboards. The dashboards capture the total numbers of assessments completed per month and whether they were compliant or non-compliant with the required scheduling of assessments. The data for November and December is shown in table 5 below.

Table 5: Nucleus Data (November 2022 to January 2023)

Assessment	November	December	January
Falls assessment 6 hrs	66.2%	60.6%	59.3%
Falls assessment 24 hrs	89.4%	85.4%	81.5%
Falls reassessment 7 days	73.8%	67.3%	67.3%
Bedrails assessment 6 hrs	64.3%	58.2%	58.8%
Bedrails assessment 24 hrs	88.2%	84.5%	82.3%

Bedrails reassessment 7 days	72.2%	66.2%	66.3%
MUST assessment 24 hrs	63.1%	59.6%	60.5%
MUST reassessment 7 days	61.7%	57.4%	57.6%
Purpose T assessment 6 hrs	69%	64%	63%
Purpose T assessment 24 hrs	Not available	Not available	Not available
Purpose T reassessment 7 days	80%	75%	74%

Table 6 below, show the initial assessment compliance in the 5 areas with highest number of admissions (>50% of admissions) AMU, AMB, Lilac, Ward 14, Maple.

Table 6: Nucleus data the 5 wards accounting for >50% of admissions

Assessment	November	December	January
Falls assessment 6 hrs	82.5%	77.6%	69%
Falls assessment 24 hrs	92.1%	93%	92.3%
Bedrails assessment 6 hrs	79.9%	77.6%	74%
Bedrails assessment 24 hrs	90.9%	89.8%	92.4%
MUST assessment 24 hrs	72.5%	76.1%	81.6%
Purpose T assessment 6 hrs	76.3%	71.9%	75%
Purpose T assessment 24 hrs	Not available	Not available	Not available

The reduction in performance in January is largely due to Maple Ward. The ward has had a lot of patients in January moving in and out of areas using Nucleus such as going to endoscopy. A review of 10 patient records from Maple Ward confirms that although the assessments were not compliant at 6 hours, the results are much improved at 24 hours.

Nucleus was introduced into the ED in January however it does not contain all the records that the department needs, and the main documentation is still paper based. There is currently no scheduling available within ED which means that the system cannot prompt staff to carry out any assessments, observations, or care tasks. This also means that there is no reliable reporting mechanism as there is no concept of compliance within the system. Any audits will still have to be done manually using the paper alongside the digital system.

Development work is underway to make Nucleus more user friendly for ED which includes;

- ED scheduling
- ED filters to enable shorter patient lists (the current patient list is long and therefore difficult to work with)
- Mobile observations on a page (the current mobile observation requires swiping onto different screens)
- Digital PAD document

Tendable data

5.4.2 Mental Capacity Act and DOLS

As reported last month, the Matrons have commenced a qualitative audit approach to assessing compliance with the Mental Capacity Act and Deprivation of Liberty Safeguards. This is the first month this audit has been collated using Tendable and it is important to note that patient numbers are small which impacts on the overall scores. Initial

impressions are that there is more work to do to make the “this is me” document readily available.

Table 7: MCA Qualitative Audit.

Audit criteria	Score %
Is a hospital passport or “what matters most to me” document completed and available?	58.8
If this document is available, is there evidence that care is being delivered as per this document?	75.0
If yes has this been completed fully including specifying the decision to be made?	95.2
Is there a capacity assessment completed within the notes?	96.8
Has a DoLS application been completed?	100.0
If yes, is DoLS application documentation accurate and complete?	100.0

6. Maternity and Midwifery services (November 2022)

The trust is required to submit monthly to the CQC;

- An updated copy of the action plan
- Any reports to senior leadership
- Training figures
- Maternity dashboard

The first monthly submission was completed on 23rd January 2023 and can be found at appendix A.

Progress continues to address the CQC findings and includes developing a weekly integrated audit to include;

1. Documentation standards
2. Consent
3. Fresh Eyes
4. ANRA
5. High Risk Care Pathways
6. MDT Ward round

This audit will replace some of the current individual audits and the outcomes will be overseen by the Specialty Governance Meeting. Any escalations will be provided to the triumvirate through the weekly escalation report.

The care group have established the following groups to drive forward the actions required to deliver the improvements.

- Security Improvement Task and Finish Group
- Maternity Theatres Oversight Group
- PPH Scrutiny Group

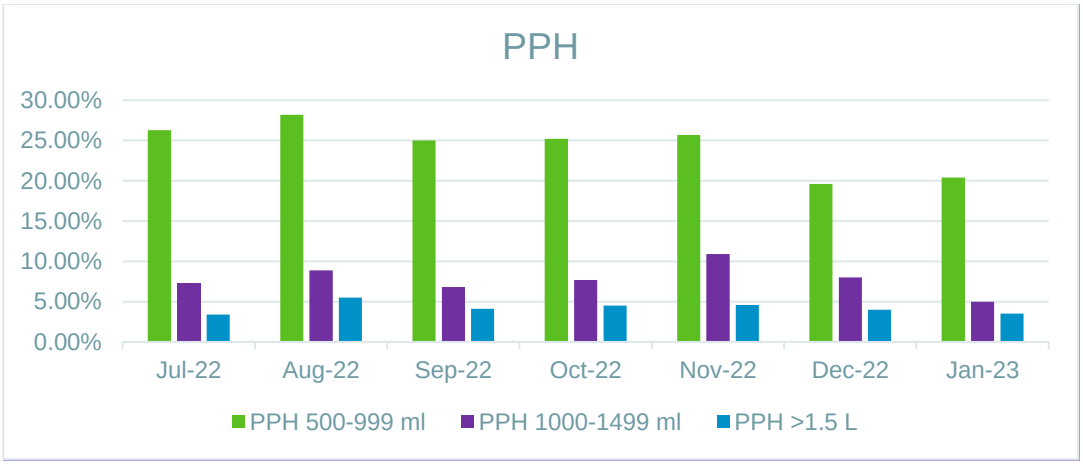
Post-Partum Haemorrhage (PPH)

Several actions have already been implemented since the inspection such as:

- introduction of a new PPH risk assessment form
- Introduction of dedicated easy-to-reach PPH trollies
- Implementation of an updated guideline for managing obstetric haemorrhage that includes changes in practice, the use of weighing scales to provide an accurate estimation of the blood loss to allow the appropriate treatment/blood replacement.

As can be seen in figure 3 there has been a consistent reduction in the incidents of PPH since July 2022.

Figure 3: PPH performance



7. The Emergency Department – York

In response to the concerns raised by the CQC during their inspection of ED in October 2022, a comprehensive action plan was implemented. As can be seen in table 8 below, there are five actions that are at risk of not achieving the required timescale.

Table 8: Action plan progress (York ED)

Overview of Actions		
	0	Off track
	5	At risk of exceeding timescale for delivery
	7	On track
	13	Complete

The actions at risk of exceeding the timescales are detailed in table 9 below.

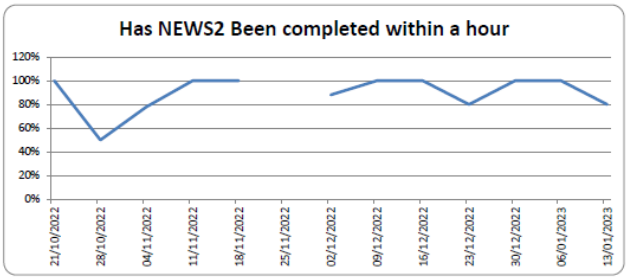
Table 9: Actions as risk of exceeding the timescales

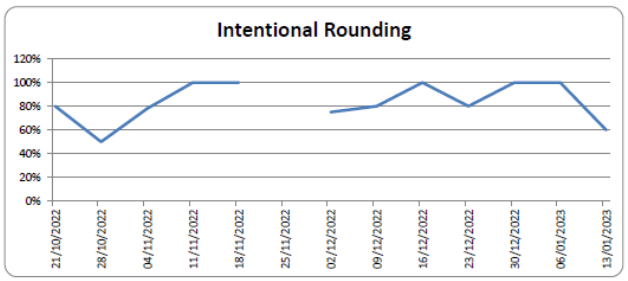
Action	Update
Develop IT solution to provide overview of ED patient NEWS2 scores at a glance for EPIC/NIC	An ability to see the ED ward list on Nucleus was finished and Nucleus went live in ED York on the 15th December and ED Scarborough on the 20th December. This included mobile devices and charging stations. There is still no ability to schedule in ED – this includes for observations. This is being worked on and will hopefully be ready in early February.
Provide additional registered/unregistered staff to support the ambulance overflow corridor to compliment current ambulance streaming nurse policy and processes	Currently staffing is being provided by agency staff.
Clinical educator to include deteriorating patient training in preceptorship.	10 registered nurses were due to start throughout October 2022.
Revise and relaunch SEPSIS screening tool to include pre-hospital NEWS and chemotherapy complications and undertake Trust SEPSIS Q3 audit	Q3 data is being collated and will be readyfor presentation in February 2023
ED Clinical Educators to deliver bite-size medicines management fundamentals training to all registered ED staff	This deadline has been extended from 17th November 2022 to 31st January 2023 due to pressures within the department.

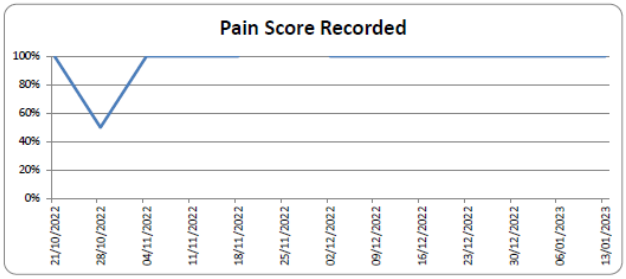
7.1 ED delays (including 12 Hour Stays)

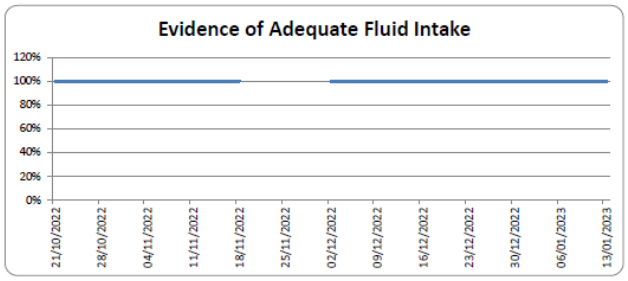
On a weekly basis the ED team undertake audits of key safety metrics for the 10 longest waits in both ED departments. The most recent audits are shown in figures 4 and 5.

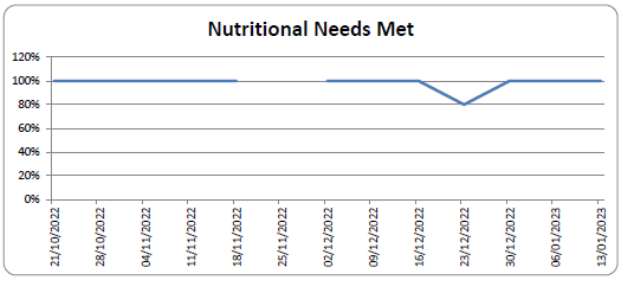
Figure 4: Scarborough ED

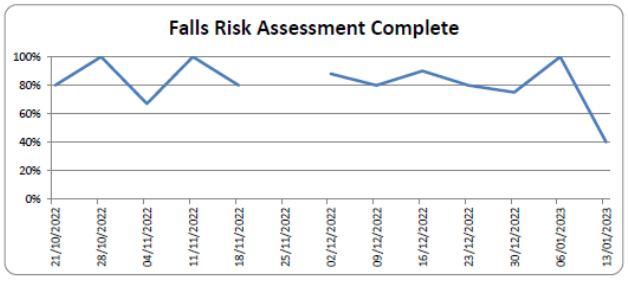


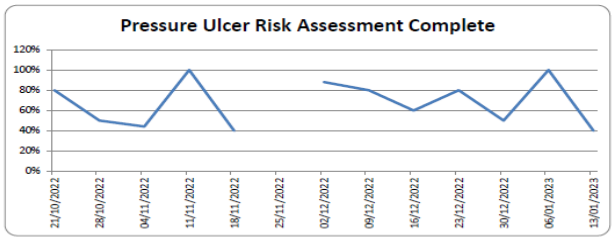


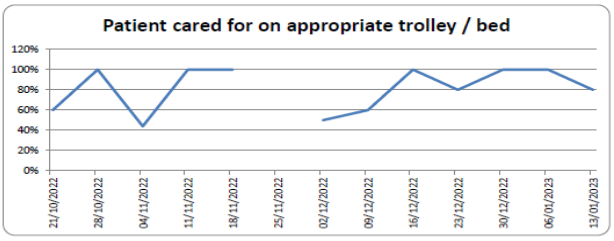


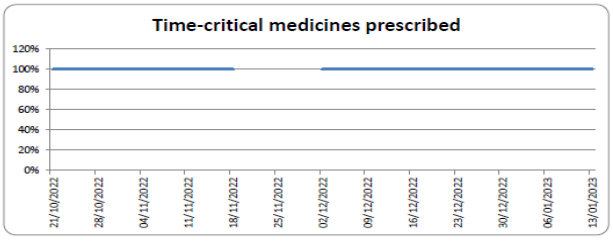


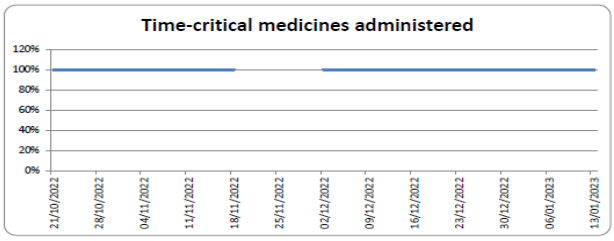


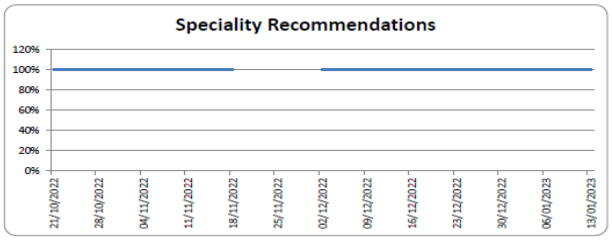


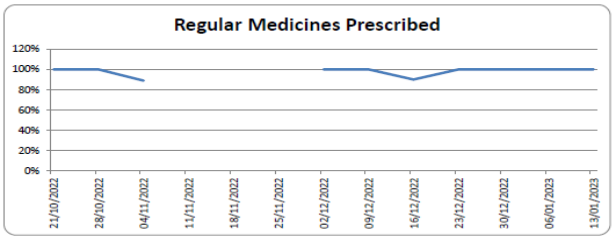


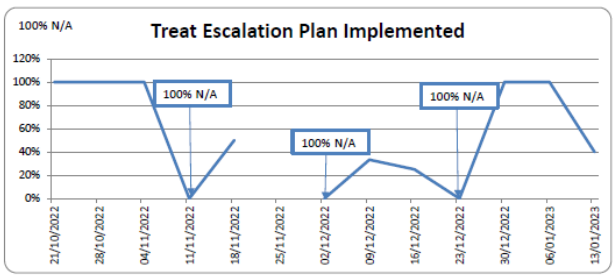


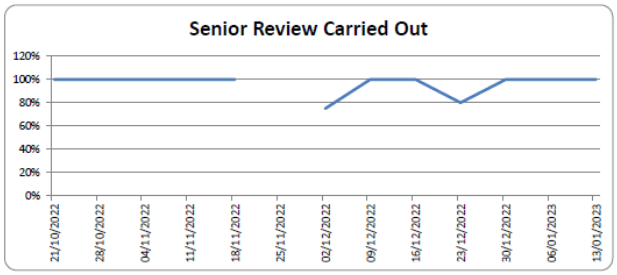


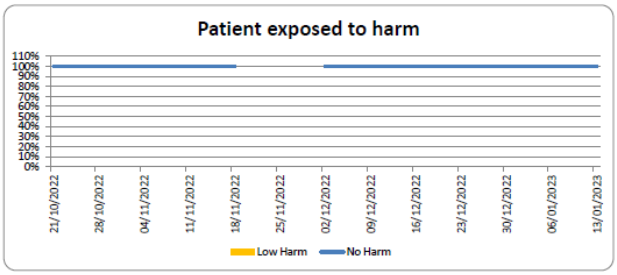








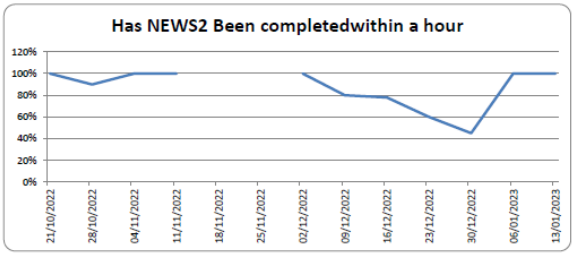


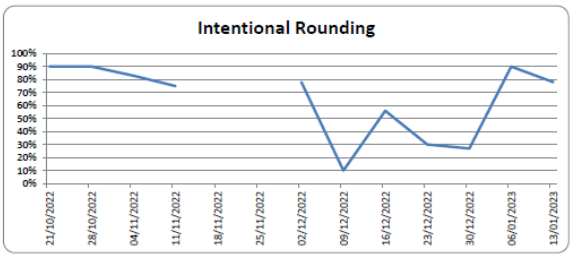


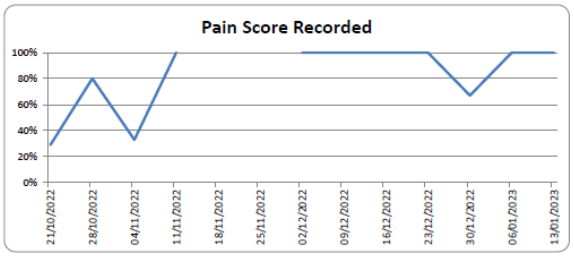
It can be seen that there has been a reduction in NEW2, intentional rounding and fall risk assessments being completed which is not surprising due to the operational pressures the department faced at the start of the year. Of concern is the reduction in treatment escalation plans being implemented.

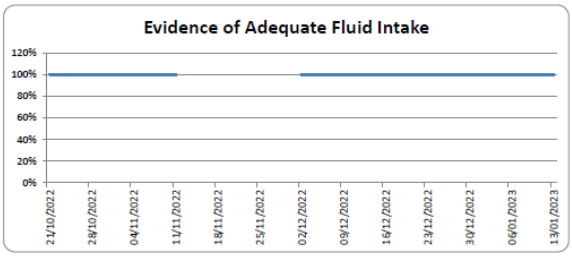
The reductions in performance noted at Scarborough ED are not mirrored by York ED as can be seen below in figure 5.

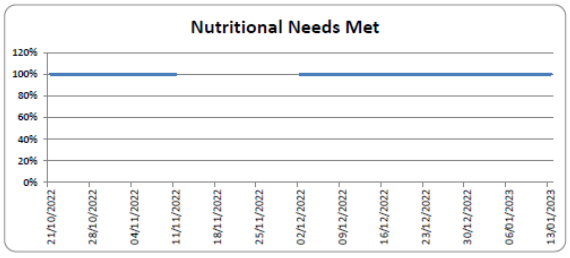
Figure 5: York ED

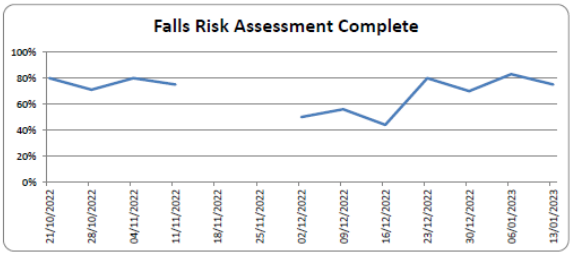


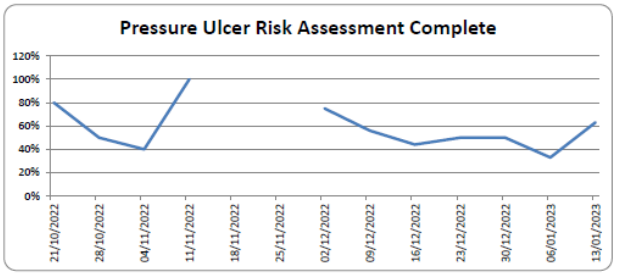


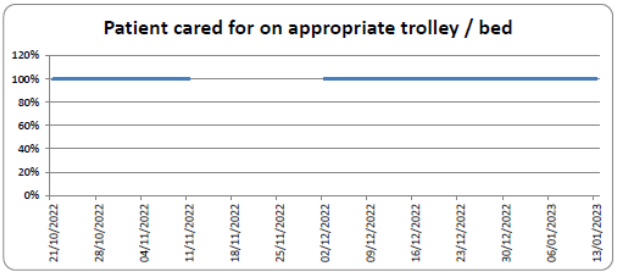


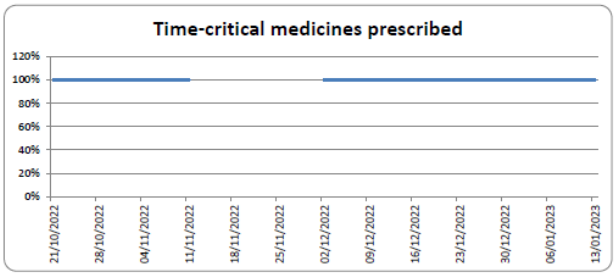


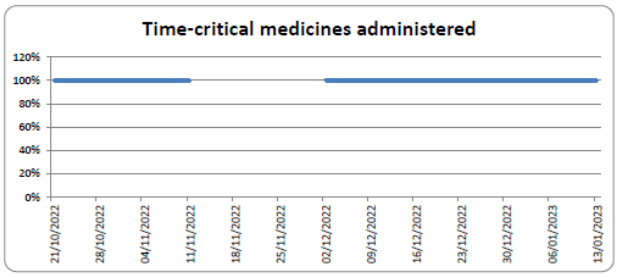


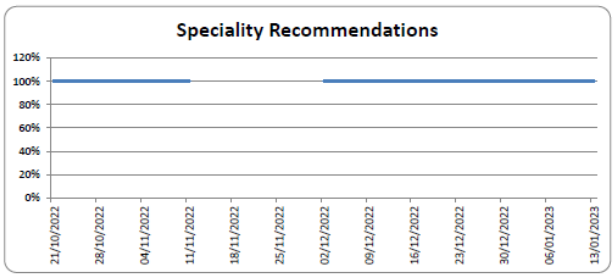


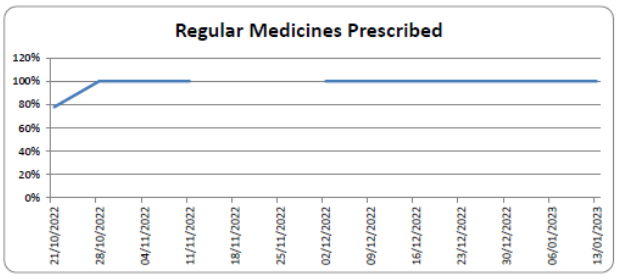


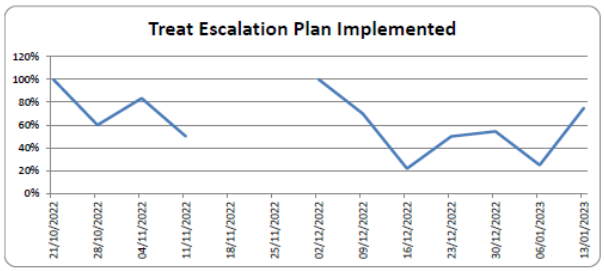


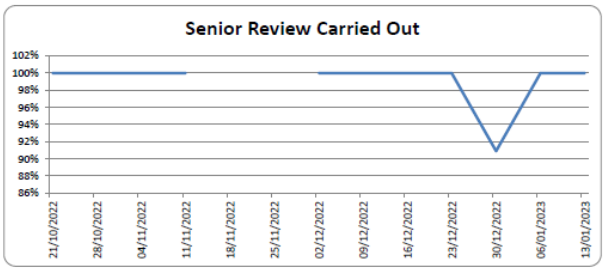


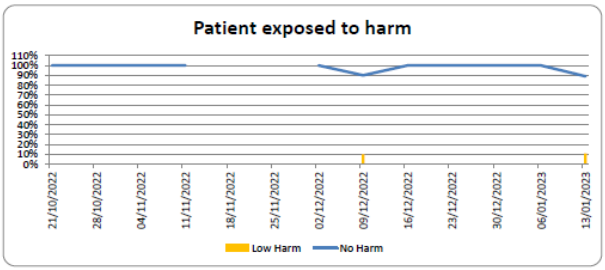












8. Recommendation

The Board is asked to consider the update within this report and receive assurance of the delivery of key actions.

Date: 16.02.23

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Report to:	Board of Directors
Date of Meeting:	22 February 2023
Subject:	Maternity Improvement Plan
Director Sponsor:	Chief Nurse - Heather McNair
Author:	Director of Midwifery - Sue Glendenning Caroline Johnson – Deputy Director of Governance and Patient Safety

Status of the Report (please click on the appropriate box)

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ A Regulatory Requirement ☒

Trust Priorities	**Board Assurance Framework**
☒ Our People	☒ Quality Standards
☒ Quality and Safety	☐ Workforce
☐ Elective Recovery	☒ Safety Standards
☐ Acute Flow	☐ Financial
	☐ Performance Targets
	☐ DIS Service Standards
	☐ Integrated Care System

Summary of Report and Key Points to highlight:

This report summarises the progress of the Maternity Improvement Plan. Positive progress is being achieved in relation to recruitment and actions to reduce PPHs.

Recommendation:

- Receive and note the improvements that have taken place during January 2023

Report History
(Where the paper has previously been reported to date, if applicable)

Meeting	Date	Outcome/Recommendation

Maternity Improvement Plan

1. Introduction and Background

Our Maternity Service, has embarked on a programme of improvement, to ensure that the services we deliver are of the highest possible standard and address the findings from the Ockenden and East Kent reports and the Nottingham report when published, alongside the Maternity Incentive Scheme and the findings from a recent CQC Inspection. The programme of improvement is supported by the regional team and overseen by a Transformation Committee.

This report provides assurance regarding the progress to date in delivering the required improvements in response to CQC inspection feedback.

2. Current Position

2.1 Staffing.

In order to ensure that the right levels of midwives are available across our maternity services, a targeted recruitment drive underway. Progress has been positive however a small number of vacancies remain as shown in tables 1 and 2 below.

Table 1: Band 5-7 Midwife vacancies

	Budget	Vacancy	Percentage
York	104.24	6.32	6.06%
Scarb	56.82	-2.3	-4.05%

Table 2: Band 2-3 HCA/MSW vacancies

	Budget	Vacancy	Percentage
York	29.79	4.03	13.53%
Scarb	15.66	0.35	2.23%

2.2 Daily Staffing

To ensure that the appropriate levels of staff are on duty across each shift, daily staffing meetings were established. This enables senior oversight and consistency with appropriate and timely escalation and action to address gaps in assurance. The staffing huddles have been realigned to meet the escalation policy requirement of dedicated twice daily staffing forums for the MDT to deliver all staffing and activity updates for the 24 hours ahead.

As a result of this oversight closures and diverts have decreased over December, and January 2022 and to date in February which is a direct result of clearer communication and oversight of staffing resource and escalation. Staff feedback received via Regional Midwifery office and RCM is that staff on York site have noticed the improvements in staffing numbers and escalation. We recognise further work at Scarborough is now required to embed support and processes and is being led by the Outpatient Matron.

2.3 Incident Management

We are continuing to embed the process of after-action reviews to review incidents. This methodology is in line with the Patient Safety Incident Response Framework and has been positively received as it provides a safe space to review incidents and share learning. Daily huddles are in place to review all incidents as they are reported. Huddles are led by the Governance Midwives and ensure a rapid response to the review of incidents, enure that the th level of harm assigned to the incident can be reviewed and ensure immediate action is taken as required to prevent recurrence.

The Governance Lead continues to provide a weekly report to the Triumvirate of the moderate harm incidents and update on the status of Patient Safety Incident Investigation reports, and the outcomes and actions from any patient safety meetings. This provides both assurance and an opportunity to escalate issues/risks.

2.4 Policies and Guidelines

We continue to review and develop our policies and procedures, and we approved the following revised versions at our Specialty Governance Group on 10 February 2023:

Table 3: Guidelines and Polices

Guidelines/Policies
Routine Enquiry in Pregnancy and Completion of the CAADA DASH Risk Assessment Datix Trigger List Breast pump cleaning guideline

Table 4: Patient Information leaflets

Patient Information Leaflets
Sacrospinous Ligament Suspension
Post Natal Advice Following a third- or fourth-degree tear after the birth of your baby

The Corporate Quality Team are working with the Maternity Governance team to review the assurance mechanisms to provide assurance that policies have been appropriately embedded. This is to ensure that policies when implemented make the desired impact to care delivery.

2.5 Audit

The integrated weekly audit has commenced to include the following:

1. Documentation standards
2. Consent
3. Fresh Eyes
4. ANRA
5. High Risk Care Pathways

6. MDT Ward round

The initial findings of this audit will be included in next month's report.

Scrub shifts continue to be covered by bank and agency staff whilst the new team leader is going through the on boarding process. Once in post they will lead a dedicated recruitment campaign for permanent staff.

2.6 Fetal Monitoring

The audit of Fetal monitoring is being revised and, from week commencing 20 February a new service wide audit which will include a fresh eye element will support 20 sets of notes being reviewed weekly. This will inform the required improvement plan to improve compliance.

2.7 Training Compliance

The fetal monitoring compliance has been impacted by the requirement to undertake e-learning after the face-to-face training, which resulted in delays in completion Therefore, a change to the training programme has been instigated to ensure the e-learning is completed within the training day. The fetal monitoring figures have been calculated a different way starting from January 2023 and both elements to the training for fetal monitoring, the face-to-face session and then the e-learning are included, compliance is only achieved once both elements have been completed.

In February 2023 we added Bank Midwives and Health Care Assistants into our training numbers which has reduced our compliance figures initially. However, this will staeadily improve.

Table 5 Training Compliance

January-23

OCKENDEN - 1 ROLLING YEAR

York %	PROMPT	NLS	Fetal Monitoring	SBLv.2 (5x e-learning courses)	Personalised Care - Year 2	Perinatal Mental Health	Bereavement	Learning from incidents claims & complaints
Midwives (164)	96% (158/164)	93% (152/164)	61% (100/164)	74%	5% (8/164)	98% 161/164)	89% 146/164)	79% (130/164)
HCA/MSW (37)	84% (31/37)	N/A	N/A	N/A	N/A	N/A	51% (19/37)	N/A
Obs Cons (15)	93% (14/15)	N/A	60% (9/15)	88%	100% (15/15)	93% (14/15)	N/A	100% (15/15)
All other Obs Drs (19)	68% (13/19)	N/A	37% (7/19)	66%	63% (12/19)	63% (12/19)	N/A	58% (11/19)
ODP (52)	77% (40/52)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Anaes Cons (11)	Learning Hub	N/A	N/A	N/A	N/A	N/A	N/A	N/A
All other Anaes Docs (2	Down	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Scarborough %	PROMPT	NLS	Fetal Monitoring	SBLv.2 (5x e-learning courses)	Personalised Care - Year 2	Perinatal Mental Health	Bereavement	Learning from incidents claims & complaints
Midwives (68)	87% (59/68)	87% (59/68)	44% (30/68)	74%	7% (5/68)	87% (58/67)	58% (39/67)	66% (45/67)
HCA/MSW (19)	63% (12/19)	N/A	N/A	N/A	N/A	N/A	63% (12/19)	N/A
Obs Cons (8)	88% (7/8)	N/A	88% (7/8)	65%	75% (6/8)	75% (6/8)	N/A	88% (7/8)
All other Obs Docs (13)	77% (10/13)	N/A	69% (9/13)	91%	92% (12/13)	92% (12/13)	N/A	92% (12/13)
Anaes Cons (7)	71% (5/7)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
All other Anaes Docs (1	63% (5/8)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
ODP (21)	24% (5/21)	N/A	N/A	N/A	N/A	N/A	N/A	N/A

2.8 Stillbirth

Stillbirths are closely monitored by the maternity service, and learning from every still birth investigation informs our ongoing improvement plans for the service as a whole. A recent independent review which also took into account learning from national reports and research evidence has resulted in a number of further actions we have taken. Refresh and embedding of the antenatal risk assessment at every contact to include advice about smoking cessation which we know is a risk factor. All women have an advice leaflet attached to their notes about reduced fetal movements and there are plans to utilise the televisions in the antenatal clinics to show the Tommy's advice videos to women and their families while waiting for appointments. The fetal growth guideline is being developed for launch with Badgernet our new Maternity Electronic Record which we anticipate will eb launched by June 2023.

The stillbirth rate while it rose above the mean in August 2022, had reduced to below the mean by November 2022. There have been no stillbirths in December 2022 and January 2023.

2.9 Post-Partum Haemorrhage

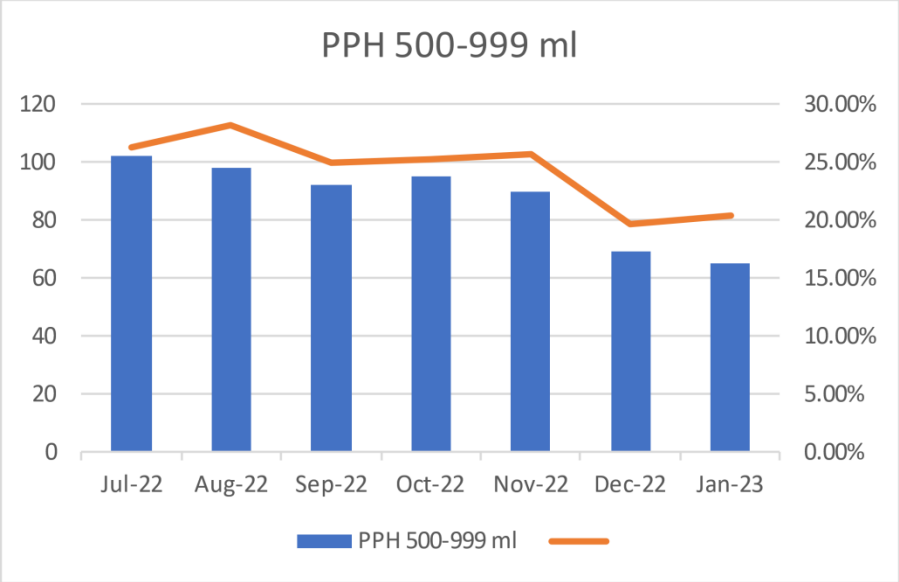
We commissioned an independent review of PPH by an independent consultant who is also an obstetrician; this review supported the work that the maternity department had already begun. The MDT also performed an internal review and a drill in order to address the Trust's PPH rate, this resulted in modifications to existing assessment forms, including a trigger list. An action plan has been developed in response to the report.

Several actions have already been implemented such as:

- introduction of a new PPH risk assessment form
- Introduction of dedicated easy-to-reach PPH trollies
- Implementation of an updated guideline for managing obstetric haemorrhage that includes changes in practice, the use of weighing scales to provide an accurate estimation of the blood loss to allow the appropriate treatment/blood replacement.

To ensure oversight of PPHs and the actions to reduce the incidence, a PPH scrutiny panel has been established. The group is chaired by an Obstetric Consultant or nominated deputy and meets bi- monthly. The aim of the group is to provide a consistent and comprehensive review of the themes identified through the reviews of individual PPH incidents. The improvement plan will be overseen and evaluated by this group. Since we have started using the new PPH risk assessment tool, there has been an improvement in anticipation and increased proactive approach for women at higher risk of bleeding (repeat FBC at 36 weeks, treatment of anaemia, 2 cannulas, prophylactic TXA) and this will be monitored through incident reporting.

We declared a serious incident on 23 January in relation to a major obstetric haemorrhage and will ensure that the learning from this investigation further informs our improvement plan and as can be seen in the charts below, the incidents of PPH continue to reduce throughout January 2023.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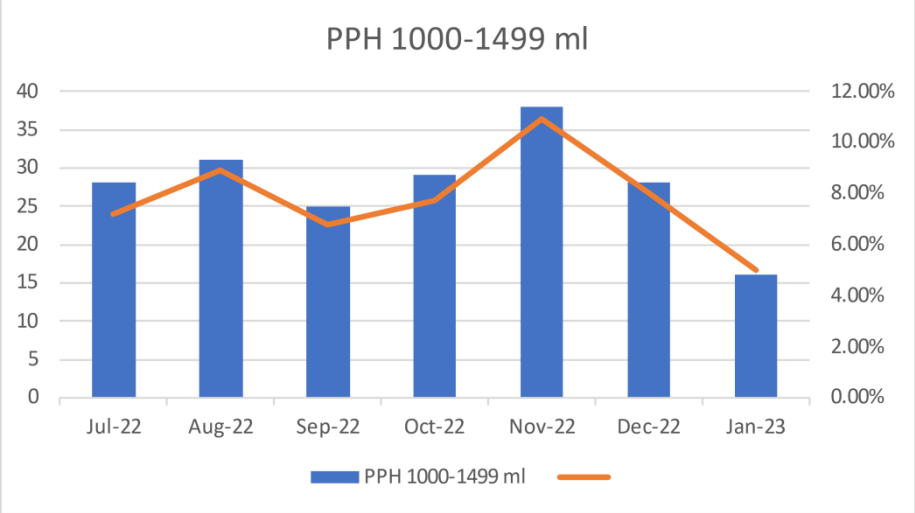
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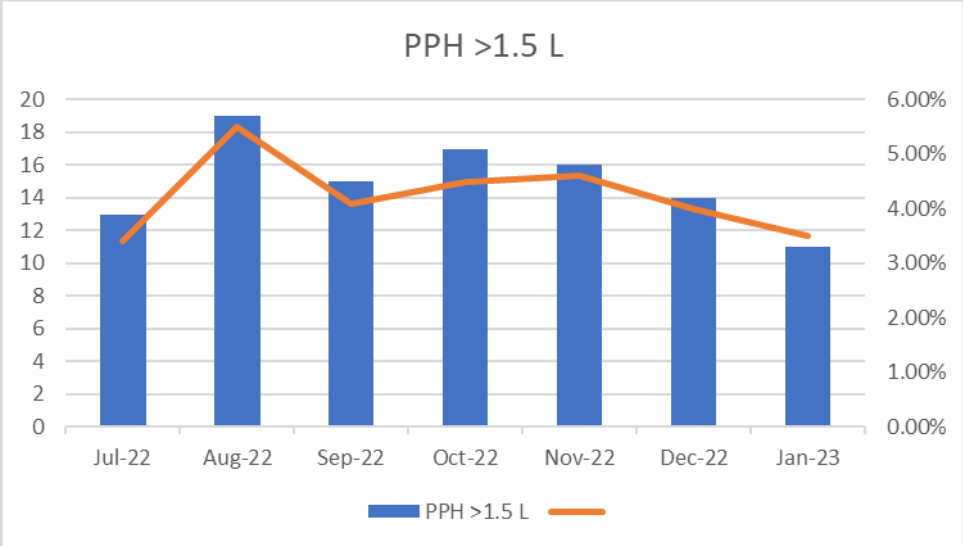
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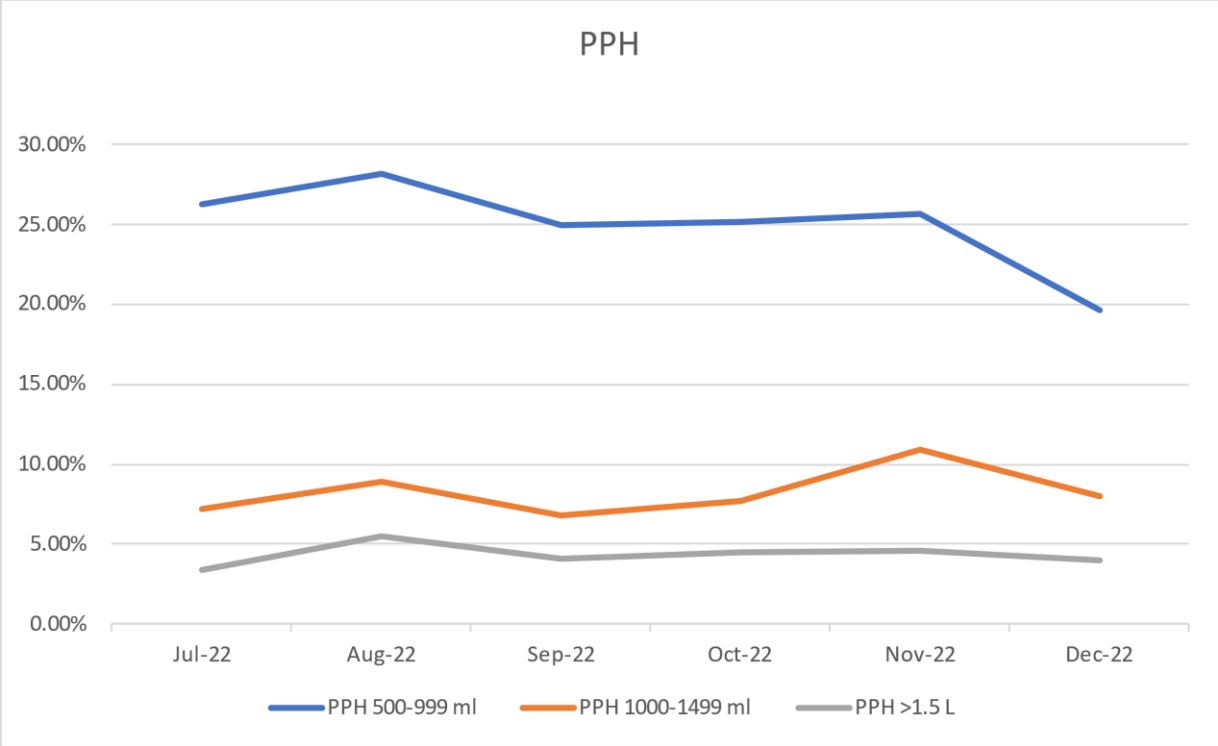

3. Next Steps

The Board are asked to note the improvements that are underway within the maternity department.

Date: 16.2.23

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Report to:	Board of Directors
Date of Meeting:	22 February 2023
Subject:	Quarter 3 Mortality and Learning from Deaths Report
Director Sponsor:	Karen Stone – Medical Director
Author:	Ed Smith – Deputy medical Director Alice Hunter – Patient Safety Specialist

Status of the Report (please click on the appropriate box)

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ A Regulatory Requirement ☐

Trust Priorities	**Board Assurance Framework**
☐ Our People ☐ Quality and Safety ☐ Elective Recovery ☐ Acute Flow	☐ Quality Standards ☐ Workforce ☐ Safety Standards ☐ Financial ☐ Performance Targets ☐ DIS Service Standards ☐ Integrated Care System

Summary of Report and Key Points to highlight:

This report encompasses the following areas:

- York and Scarborough Hospitals NHS Foundation Trust mortality rates:
  - Crude mortality
  - SHMI (Summary Hospital Mortality Index)
  - HSMR (Hospital Summary Mortality Indicator)
- Diagnostic groups most contributing to mortality rates
- Learning from deaths - data:
  - Nationally mandated data
  - Locally mandated data
  - Quality account data
- Learning from deaths – themes and actions
  - Themes from SJCRs considered by the LfD Group in Q3
  - Improvements underway
- Service developments

Metric	Result
Crude mortality	Crude mortality is **2.47%** for this current fiscal year (Apr-Jul) (3.08% last year)
SHMI – HES HED[1] (Data to July 2022)	SHMI for year (Jul 21- Jul 22) 79,809 spells, Observed deaths 2718, Expected deaths 2724 SHMI year July 2021-June 2022 is **99.8**
SHMI - NHS Digital[2] (Data to April 2022)	SHMI for Apr 22 (last complete dataset) was **97** SHMI for the year to Apr 2022 is **96** 84170 spells, Observed deaths 2768, Expected deaths 2869
HSMR[3] alerts	

Mortality Cumulative Summary Aggregated (HSMR) - 108 - Congestive heart failure; nonhypertensive	July 2022	7.00	
Mortality Cumulative Summary Aggregated (HSMR) - 115 - Aortic; peripheral; and visceral artery aneurysms	May 2022	9.03	
Mortality Cumulative Summary Aggregated (HSMR) - 117 - Other circulatory disease	May 2022	5.70	
Mortality Cumulative Summary Aggregated (HSMR) - 125 - Acute bronchitis	May 2022	9.04	

[1] SHMI HES HED - Summary Hospital Mortality Indicator using Hospital Episode Statistics and published by Healthcare Evaluation Data for UK Health Data Benchmarking
[2] SHMI NHS Digital - Summary Hospital Mortality Indicator
[3] HSMR – Hospital Standardised Mortality Ratio published by Dr Foster

- Themes from Learning from Deaths (LfD) remain consistent compared with previous reports
- The number of death reviews completed by the Medical Examiners at the Scarborough and York sites during Q3 continues to increase to almost 100% in line with the national ambition
- The number of open SJCRs is steady although the York site in Q3 received a larger proportion of referrals from the Medical Examiner compared to previous quarters. Scarborough sites referrals also remain high. An audit has commenced to review this.

Recommendation:

For Board of Directors to note the content of this report.

Report Exempt from Public Disclosure (remove this box entirely if not for the Board meeting)

No ☒ Yes ☐

(If yes, please detail the specific grounds for exemption)

Report History

(Where the paper has previously been reported to date, if applicable)

Meeting	Date	Outcome/Recommendation
QPaS	8.2.23	Approved

1. Y&SH NHS FT mortality rates

The references in section 6 provide details about the methodologies for measuring mortality and their context.

1.1 Crude Mortality - unadjusted

Crude mortality is simply the proportion of patients that died. The unadjusted data presented represents the most up to date dataset available.

Figure 1 shows the number of in-hospital and out-of-hospital (up to 90 days) deaths with fiscal year to date (April - July) highlighted.

Figure 1 – Number of deaths by quarter

Fiscal Year of Discharge

Fiscal Year of Discharge	aths	Deaths In-Hospital	Deaths Out-Of-Hospital	1-7 Days	8-30 DAYS	31-90 DAYS	90+ DAYS	Crude Death Rate	Crude In-Hospital Death Rate
2021/22	3131	1533.00	1598.00	281	486	475	356	3.08%	1.51%
2022/23	1255	773.00	482.00	123	208	137	14	2.47%	1.52%
Grand total	**4386**	**2306.00**	**2080.00**	**404**	**694**	**612**	**370**	**2.88%**	**1.51%**

The crude mortality for Q1 stands at 2.47% of all admissions. Crude mortality was 3.08% during the previous year.

Benchmarking of crude mortality against other Trusts is not recommended due to significant operational variations between Trusts. Instead Trusts should monitor local trends comparing data from the same month or quarter each year. This takes account of seasonal variation seen locally and nationally.

1.2 Summary Hospital-level Mortality Indicator - adjusted mortality

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at trust level across the NHS in England. It is the ratio between the actual number of patients who die following hospitalisation at the trust, including those receiving palliative care, and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated at the Trust. It covers patients who died either while in hospital or within 30 days of discharge.

A standard approach is taken to 'adjust' the figures so that the England average is always reported as '100'. Values below 100 represent a better outcome, ie lower mortality, and vice versa.

Further information regarding the methodology can be found in the references towards the end of the report.

Two risk-adjusted mortality rates are presented:

- HED HES-SHMI: This is provided by Healthcare Evaluation Data for UK Health Data Benchmarking (HED). It uses Trust hospital episode statistics (HES) to generate the outcomes. Data is available 3 months in arrears.
- NHS Digital-SHMI: uses HES data and is available 6 months in arrears.

Table 1 gives the latest SHMI data supplied by **HED-HES.** It shows the monthly SHMI figures from November 2021 information and provides an overall SHMI of 99.8 for the year to June 2022. Further context is provided in the Figures 2-4.

Table 1– Latest SHMI data (HED-HES) Data up to July 2022

Table 2a: Export Table (Rebasing period up to April 2022)

Mark items on Table 1 to view details of Table 2a.

All » (Column Names)

Month (of discharge) » Organisation (provider)	Month (of discharge)	Organisation (provider)	SHMI	SHMI95%CI Lower	SHMI95%CI Upper	Expected number of deaths	Number of patients discharged who died in hospital or within 30 days	Number of mortalities occurring in the hospital
	Novembe…	RCB - YO…	104.44	91.80	118.34	235.53	246	161
	Decembe…	RCB - YO…	100.77	89.06	113.58	265.95	268	181
	January 2…	RCB - YO…	101.88	89.17	115.91	226.73	231	163
	February …	RCB - YO…	90.84	78.41	104.67	210.27	191	129
	March 2022	RCB - YO…	87.69	75.69	101.05	217.82	191	139
	April 2022	RCB - YO…	98.48	85.52	112.85	210.19	207	144
	May 2022	RCB - YO…	95.12	82.66	108.93	219.72	209	153
	June 2022	RCB - YO…	98.34	85.69	112.33	220.66	217	153
	Grand total		**99.76**	**96.04**	**103.58**	**2724.53**	**2718**	**1849**

Figure 2 – YTD SHMI benchmark position (Trust position in blue) Data up to July 2022

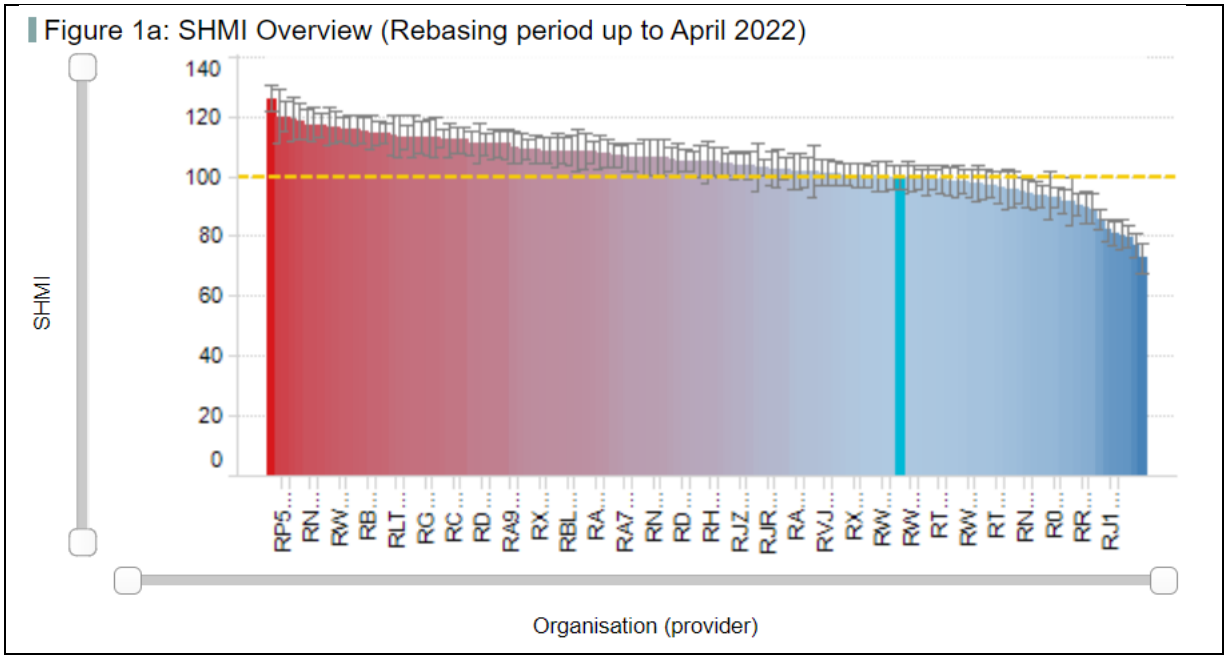


Figure 3 – YTD SHMI as a funnel chart Jul 21 – Jul 22 (Trust is the green diamond)

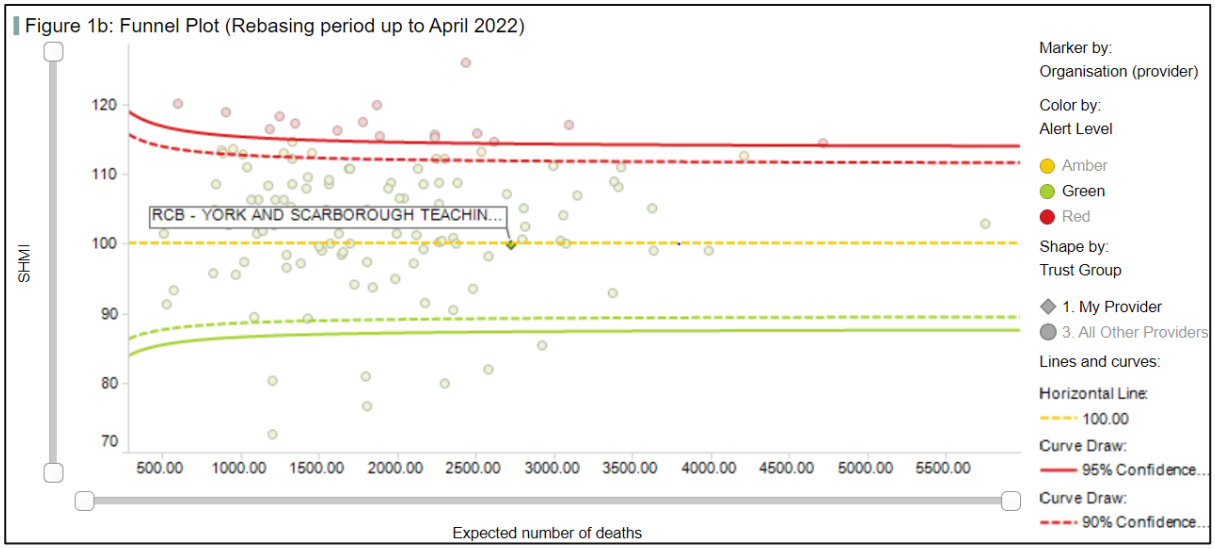
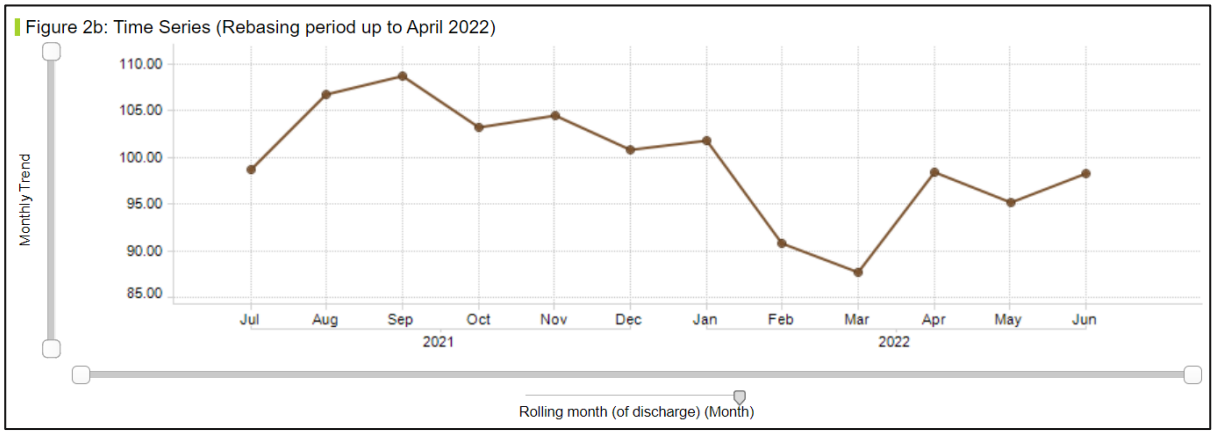


Figure 4 – Time-series of SHMI per month

The lower mortality seen in the first half of the year and end of financial year offsets the increasing mortality rate in the latter half of 2021, thus providing an average YTD mortality rate of 99.8 (Data Jul 2021-Jul 2022).



The latest **NHS-Digital Summary Hospital Mortality Index (SHMI)** to April 2022 shows the SHMI was 99.8.

This is categorised ‘as expected’ and how this compares with all other Acute Trusts is shown in the Chart (Figure 5) and Poisson Distribution Funnel Plot (Figure 6) below. Outcome over time is also shown (Figure 7).

Figure 5 – Rolling SHMI benchmark position (Trust position in yellow)

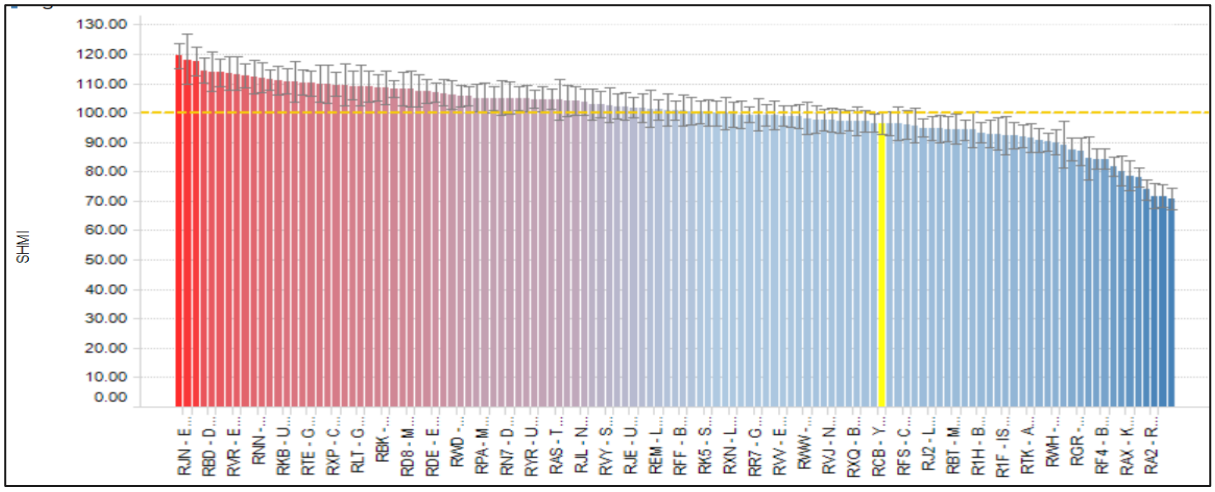


Figure 6 – SHMI funnel chart (Trust is the green cross)

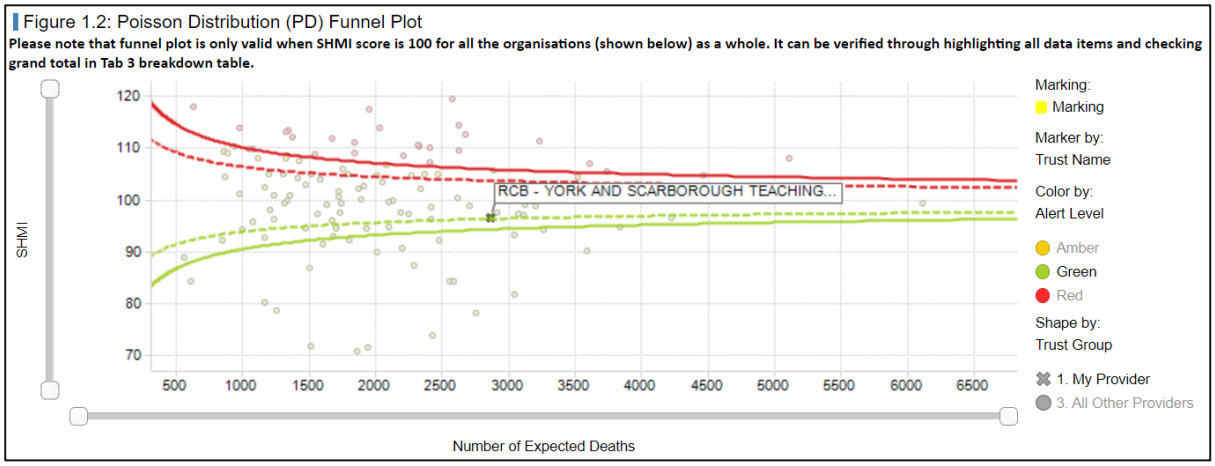
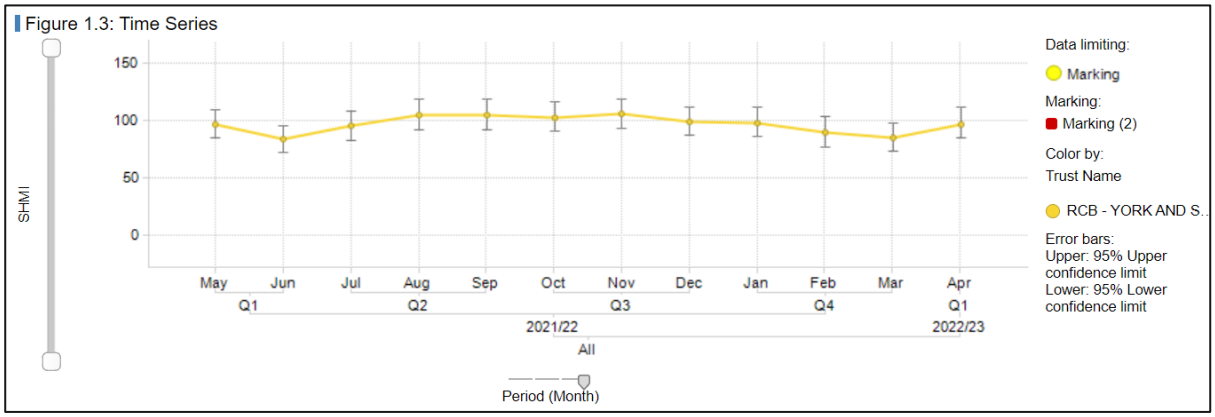


Figure 7 – Time-series of SHMI per month



1.3 Hospital Standardised Mortality Ratio (HSMR)

The HSMR measures the actual number of patients who die in hospital against the number that would be expected to die given certain characteristics e.g., demographics. It is not adjusted for palliative (end of life) care and does not include as many diagnostic groups as the SHMI.

The hospital HSMR is monitored in the background but not reported. However, any flags / alerts identified by HSMR that otherwise are not already identified by other mortality statistics would be reported as they arise.

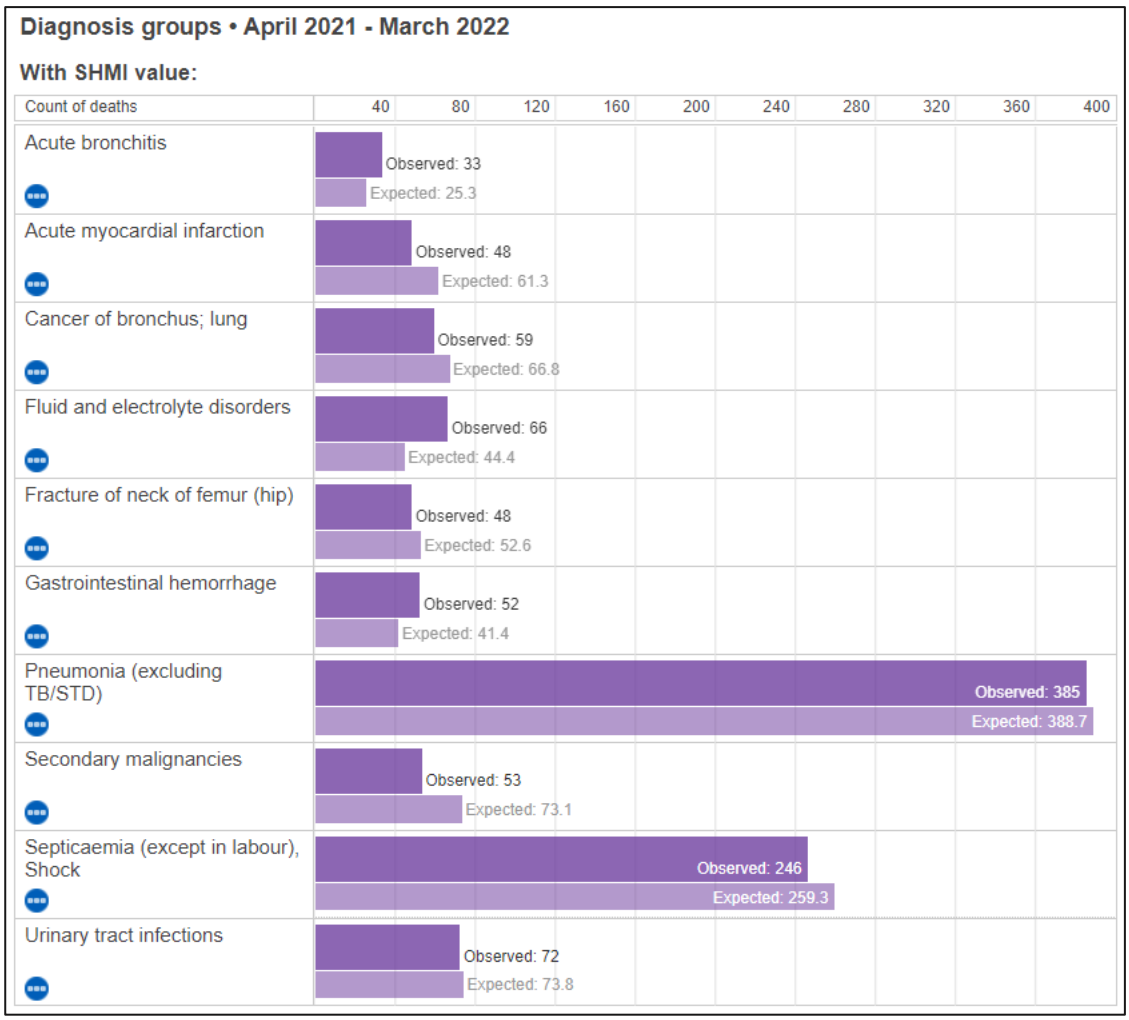
2. Diagnostic groups most contributing to our mortality rates

There are 142 diagnostic codes that contribute to the NHS-Digital SHMI aggregate to give each Trust an overall SHMI value.

For a subset of diagnosis groups, a SHMI value and SHMI banding is also provided. The bandings are 'higher than expected', 'as expected', or 'lower than expected'.

These diagnosis groups are shown below in Figure 8. We look at both these and the diagnostic codes contributing to the SHMI to identify conditions potentially alerting for increased mortality.

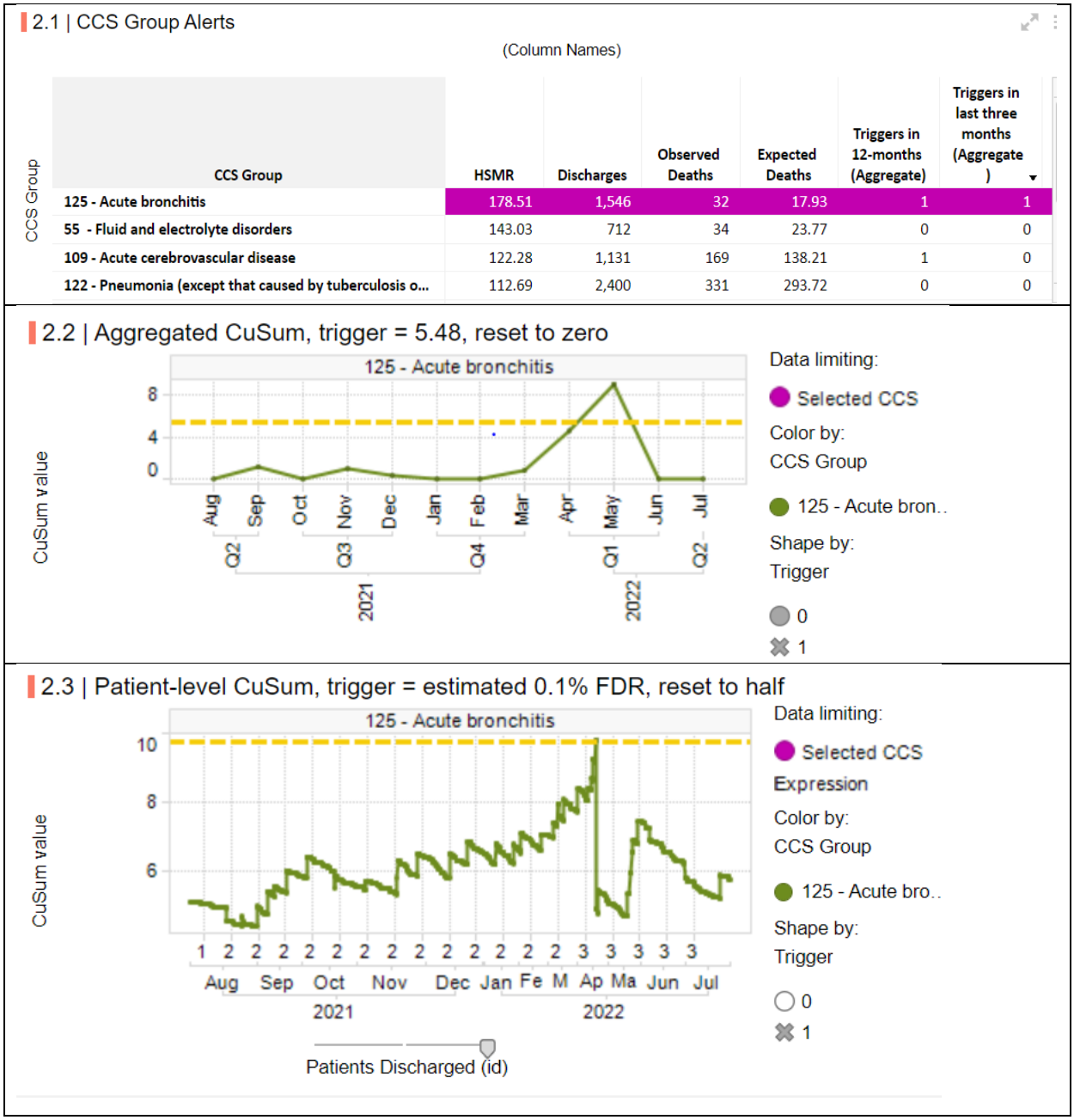
Figure 8 - NHS-Digital SHMI Diagnostic Observed vs Expected Chart



Using the SHMI analysis and alerting system in the Trust had only one CUSUM alert in the last 3 months (Apr 22) for acute bronchitis.

There were 1546 discharges, with 32 observed deaths against 18 expected deaths. The HSMR is 179, CUSUM value 9.8 (trigger is 5.48). (Data from Aug 2021 – Jul 2022). The lists of conditions with triggers, number of spells and observed versus expected deaths are detailed in the table below. The data in graphical form from the latest month only is included in the figure. (Below 5 excess deaths the alerts are censored).

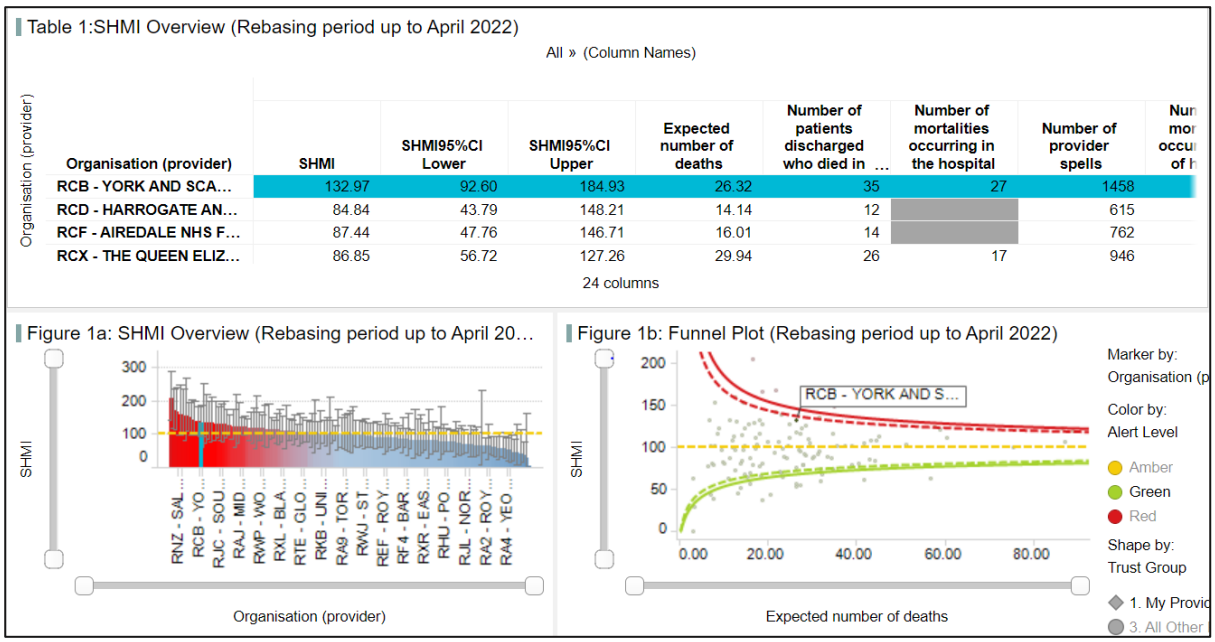
Figure 9 – Acute bronchitis



However, on the HED HES-based SMHI acute bronchitis has a low level of deaths in total. A review of acute bronchitis coded discharges (deaths) from Feb – April 22 would be a good place to start if desired. Triangulation with incidents / PSIRs / SJCRs / SIs relating to acute bronchitis may be difficult as they have not presented as a theme at Q&S / PSIIM or LfD but that may be in a relation to coding interpretation.

Figure 10 shows the SHMI for acute bronchitis over the last fiscal year (with complete data), including the SMHI table, funnel plot and bar chart. Here the SHMI is 132, within the funnel plot.

Figure 10 – SHMI for Acute Bronchitis



Action Taken in Response to Excess Mortality

Diagnostic codes alerting in the SHMI and HSMR data through NHS Digital monitoring are triangulated with LfD themes and reviewed by the medical director's office to assess trends.

3. Learning from Deaths

The national Learning from Deaths (LfD) Framework, 2017 sets expectations for Trusts to conduct reviews of the care and treatment of patients who died in their care, acting on the findings and reporting outcomes. The requirement to publish outcomes from LfD within Quality Accounts was mandated at the same time.

This section provides data and outcomes in line with the requirements of the:

- National Guidance on Learning from Deaths (National Quality Board, 2017)
- Trust's Learning from Deaths Policy
- Department of Health and Social Care NHS (Quality Accounts) Amendment Regulations 2017

Whilst the report focuses on quarter 3 data, some information is provided for quarter 2 for comparison.

3.1 Nationally mandated data and information

The data provided in the table below is mandated by the national LfD framework. A narrative on learning and actions is provided in section 4.

SJCRs are Structured Judgement Case-note Reviews; SIs are Serious Incidents.

Table 2 – National data summary

	July	Aug	Sept	Oct	Nov	Dec
	Quarter 2 (22/23)			Quarter 3 (22/23)		
Total in-patient deaths (inc ED, exc community)	245	179	207	232	214	278
No. SJCRs commissioned for case record review[1]	9	6	5	13	12	11
No. SIs commissioned of deceased patients	3	5	5	5	4	5
No. deaths likely due to problems in care	See tables below					

1 The SJCRs are those requested in month (adjusted to account for reassignments; and including deaths from 2021/22 and 22/23).

National guidance requires the publication of the number of deaths reviewed or investigated judged more likely than not to have been due to problems in care. Whilst avoidability of death is not measured at the Trust, a judgement of the overall standard of care, and the consideration of harm, forms part of the review process.

Tables 3 and 4 show the outcomes of the SJCRs **completed and reviewed** during Q2 and Q3:

- Table 3 - the 'overall score' provides the rating from the Reviewer based on their assessment of care during the last admission
- Table 4 - the 'degree of harm' agreed by the Learning from Death Group having considered the findings from the Reviewer, its context and consideration of any additional information**.**

During Q3 12 SJCRs were reviewed (30 in Q2):

- The overall care score was given in 12/12 of cases.
  - The Reviewer found care to be good in 3/12 (25%) of cases and excellent in 3/12 (25%) of cases.
  - The Reviewer found care to be adequate in 3/12 (25%) of cases.
  - Although the Reviewers found there to be poor care in 3/12 (25%) of cases the Learning from Death Group considered that 1 case (8%) directly influenced the patient's death. This was further investigated as a SI (2022/14090) relating to the failure to review prophylactic treatment dose, causing a spontaneous retroperitoneal bleed.
- The Learning from Death Group agreed any harm to be minor in 5/12 (42%) of cases and no harm in 6/12 (50%) of cases.

Table 3 – SJCR outcomes assigned by the Reviewer (overall score)

Overall score	2022-07	2022-08	2022-09	2022-10	2022-11	2022-12	TOTAL
Very poor care	0	0	0	0	0	0	**0**
Poor care	2	2	5	1	0	2	**12**
Adequate care	1	2	6	1	1	1	**12**
Good care	3	2	5	2	0	1	**13**
Excellent care	1	1	0	1	1	1	**5**
TOTAL	**7**	**7**	**16**	**5**	**2**	**5**	**42**

Data extracted from Datix on 12 January 2023

Table 4 – SJCR outcomes following review by LfD Group (degree of harm)

Degree of harm	2022-07	2022-08	2022-09	2022-10	2022-11	2022-12	TOTAL
Death	0	0	0	0	0	1	**1**
Severe	0	0	0	0	0	0	0
Moderate	0	0	0	0	0	0	**0**
Minor	1	0	2	1	0	4	**8**
No harm	6	8	15	4	2	0	**35**
TOTAL	**7**	**8**	**17**	**5**	**2**	**5**	**44**

3.2 Locally mandated data

Trust policy requires that the national data is supplemented with locally mandated data to provide a richer picture of performance as we move towards the Medical Examiners review of 100% of deaths; and the timely completion of structured judgement case-note reviews.

Table 5 – locally mandated data

	Jul	Aug	Sept	Oct	Nov	Dec
	Quarter 2 (22/23)			Quarter 3 (22/23)		
No. of cases reviewed by ME (Scarborough)	95	56	67	67	75	96
No. of cases reviewed by ME (York)	117	105	99	134	117	145
% deaths reviewed by ME (Scarborough)	96.9%	98.2%	98.5%	100%	98.7%	90.6%
% deaths reviewed by ME (York)	90%	98.1%	90%	97.8%	97.5%	95.4%
% reviews resulting in further enquiry (Scarborough)	25.5%	31.6%	25%	25.4%	21.3%	8.3%
% reviews resulting in further enquiry (York)	5.4%	7.5%	5.5%	20.1%	17.9%	20.7%
No. SJCRs requested[1]	9	6	5	13	12	11
No SIs commissioned	3	5	5	5	4	5

1 The SJCRs are those requested in month (adjusted to account for reassignments and including deaths from 2021/22 and 22/23).

Points to note:

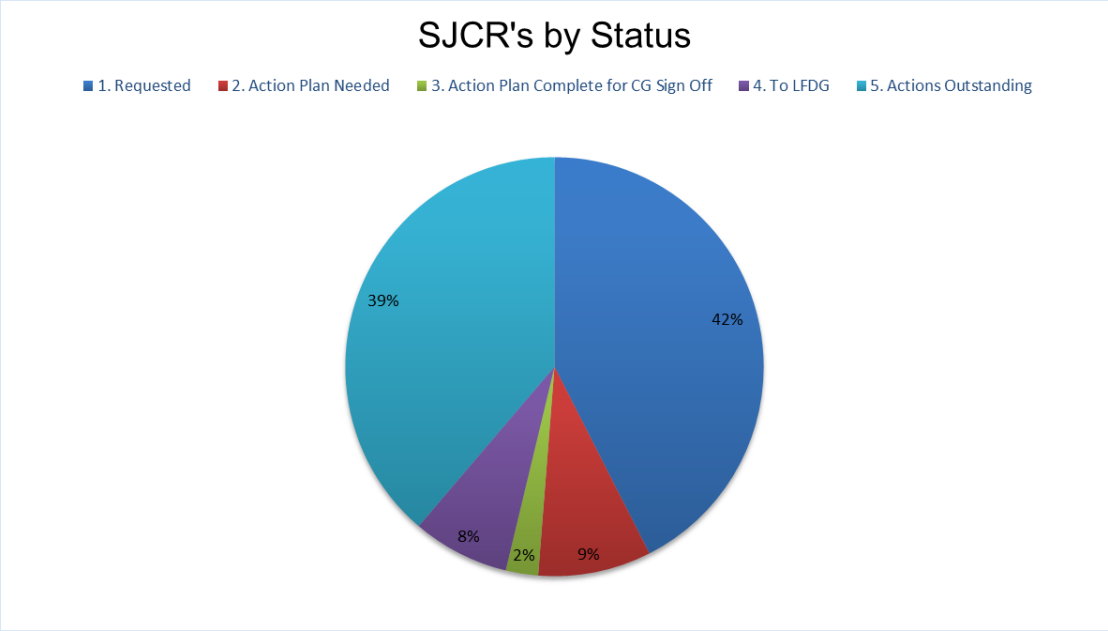
- The % of deaths receiving ME review during Q3 has continued to rise with both Scarborough and York Hospitals almost reaching the 100% ambition. York has improved; however, Scarborough has seen a slight decrease in the month of December.

- The percentage of referrals from the ME for further enquiry was much higher at the Scarborough site (25.5%-31.6%) than at the York site (5.4%-7.5%) in Q2, however in Q3 this has altered with York's number of referrals significantly increasing (17.9%-20.7%). The national figure for further review is approximately 10% so further understanding of the variance across site is essential. The information has been sent to the Lead Medical Examiner for follow-up. There is an audit being undertaken to review this current data and the ME process.

Data at point of reporting (12/01/2023)

Overall no. of SJCRs open: 80 (previously 68)

Figure 11 – Status of open SJCRs



There has been an increase in the number of open SJCRs compared with the previous quarter. This is due to an increase in the number awaiting to be reviewed. However, the reviews are being completed in a timelier manner with 9 now more than 60 days overdue, compared with 11 in the previous quarter.

	Current	Previous report
Number under review	32	18
Awaiting action planning	7	13
Actions outstanding	31	31
More than 60 days overdue (exc. awaiting LfD Group & action implementation)	9	11

3.3 Quality account data

The Department of Health and Social Care published the NHS (Quality Accounts) Amendment Regulations 2017 in July 2017. These added mandatory disclosure requirements relating to 'Learning from Deaths' to Quality Accounts from 2017/18 onwards. The data relates to regulation 27.

Table 6 – Quality Account Data

The data shown for sections 27.1-27.3 relate to the deaths that occurred in 2022/23.

The data shown for sections 27.7-27.9 relate to the deaths that occurred in 2021/22 but were investigated during 2022/23 and hence not reported in the 2021/22 Quality Account.

Item	Requirement	Q1 data	Q2 data	Q3 data	Q4 data
27.1	Total number of in-hospital deaths	629	631	724	
27.2	No. of deaths resulting in a case record review or SI investigation (requested reviews of patients who died in 22/23)	ME: 371 SJCRs: 13 SI: 7	ME: 539 SJCRs: 18 SI: 11	ME: 634 SJCRS:36 SI:14	
27.3	No. of deaths more likely than not were due to problems in care[1] (completed investigations of patients who died in 22/23)	0	1	1	
27.7	No. of death reviews completed in year that were related to deaths in the previous reporting period (2021/22)[2] but not previously reported	SJCRs: 20 SI: 9	SJCRs: 19 SI: 13	SJCR: 3 SI:1	
27.8	No. of deaths in item 27.7 judged more likely than not were due to problems in care	2	3	2	
27.9	Revised no. of deaths stated in 27.3 of the previous reporting period (2021-22), taking account of 27.8	Previously stated: 11 Corrected[3] 7 9	Running total 12	14	

[1] This is where the degree of harm after investigation / SJCR is agreed as death based on the opinion of the members of the SI Group and Learning from Deaths Group

[2] Reviews completed in 2022/23 after the 2021/22 Quality Account was published

[3] This figure was corrected to 7 when the cases were reviewed in Nov 2022.

Items 27.4-6 relate to learning from case record reviews and investigations; a description of actions taken and proposed; and an assessment of the impact of the actions. These items are covered in the next section.

4. Learning from Deaths - themes and actions

There are certain categories of deaths where a full review is automatically expected:

a. Children
b. Patients with Learning Disabilities / Autism
c. Women where death is directly related to pregnancy or childbirth
d. Stillbirths or perinatal deaths

These require review following national processes; their findings are escalated to the Quality & Patient Safety Group (QPaS) as per scheduled report.

Local serious incident investigations, where death has occurred, are considered by the LfD Group to identify themes that are also common to SJCRs. A specific report is escalated to QPaS summarising the learning.

The national LfD Framework requires SJCRs to be undertaken when the following criteria are met:

- Where bereaved families and carers, or staff, have raised a significant concern about the quality-of-care provision.
- Where a patient had a learning disability or severe mental illness.
- Where an 'alarm' has been raised e.g. via an elevated mortality alert, audit or regulator concerns.
- Where people are not expected to die, e.g. elective procedures.
- Where learning will inform the provider's existing or planned improvement work.
- A further random sample of other deaths so that providers can take an overview of where learning and improvement is needed most overall.

Table 7 below shows the source of SJCR requests between April 2022 and December 2022, primarily generated by concerns from the Medical Examiner.

Table 7 – Source of request for SJCR

SJCR Request Source	2022-07	2022-08	2022-09	2022-10	2022-11	2022-12	TOTAL
1. Initial Mortality Review	1	0	0	0	0	0	**1**
2. Medical Examiner Review	3	1	2	5	4	1	**16**
3. Q & S Meeting	0	0	0	1	1	0	**2**
4. Learning Disabilities	3	2	1	1	3	2	**12**
5. Elective Admission	2	0	0	0	1	0	**3**
6. NoK Concern/Complaint	0	1	2	2	2	1	**8**
7. Care Group	1	2	1	2	1	3	**10**
TOTAL	**10**	**6**	**6**	**11**	**12**	**7**	**52**

4.1 Themes from SJCRs considered by the LfD Group in Q3:

Case record review can identify problems with the quality of care so that common themes and trends can be seen, which can help focus organisations' quality improvement work.

Assessment against five themes, collated over many months as part of the SJCR, are shown as per Datix dashboard in Table 8. This information is based upon the judgement of the Reviewer.

Table 8 – Thematic review of all SJCRs reviewed

Theme	Yes	No	Total	Compliance	Previous report
Senior review appropriate	127	23	150	**84%**	84%
Ceiling of Care documented	127	23	150	**84%**	83%
Deterioration recognised and managed	119	30	149	**80%**	79%
Good communication between the MDT	120	27	147	**81%**	81%
Good communication with patient / family	117	24	141	**83%**	83%
Was there a Healthcare associated infection?	124	27	151	**82%**	Data not a/v

Clearly in the vast majority of cases appropriate care was given and communication was reasonable, there has been a slight improvement in 2 of the themes. The Healthcare associated infection data has been added to this Quarters report.

A new addition to Datix during the quarter is the capturing of themes (1&2), aligned with those used for serious incidents. The themes identified are shown in Table 8 (main theme) and Table 9 (secondary theme if relevant).

In 5/11 of the cases reviewed no themes were identified. One of the cases is not reflected in the table below as it was transferred to an SI.

Table 8 – Primary themes identified

	Oct	Nov	Dec	Total
No Themes Identified	2	1	2	**5**
Comms / Documentation	1	1	2	**4**
Delayed Diagnosis / Treatment	1	0	0	**1**
Escalation	0	0	0	**0**
Pathways/Process	0	0	0	**0**
Capacity / Demand	0	0	0	**0**
Clinical Assessment	0	0	0	**0**
Nutrition and Hydration	1	0	0	**1**
Medication Errors	0	0	0	**0**
Total	**5**	**2**	**4**	**11**

Table 9 – Secondary themes identified

	Oct	Nov	Dec	Total
Environment	1	0	0	**1**
Capacity / Demand	1	0	0	**1**

More specific detail about the themes can be seen in the boxes below.

Communication / Documentation at End of Life

- Admission and initial assessment/ongoing care/EOL
- Failure to ensure specific consideration of antiepileptic medication when initiating EOL care.

Observation / Assessment / Escalation

- Poor documentation at initial assessment in ED
- No formal falls assessment
- Significant delay in following up investigations and acting on results
- Lack of follow up/handover between ward teams
- Delay in diagnosis and change of management
- Lack of MDT involvement/mobility assessment
- Delay in review and initiation of sepsis pathway

Nutrition and hydration

- Poor documentation and evidence of mouth care given
- Inadequate completion of the fluid input/output charts
- Inadequate completion of NG feeding documentation.
- Dietician review 7 days post referral

Operational matters

- Decision making effected by several ward moves.
- Patient delay in review due to in ambulance corridor despite high NEWs.

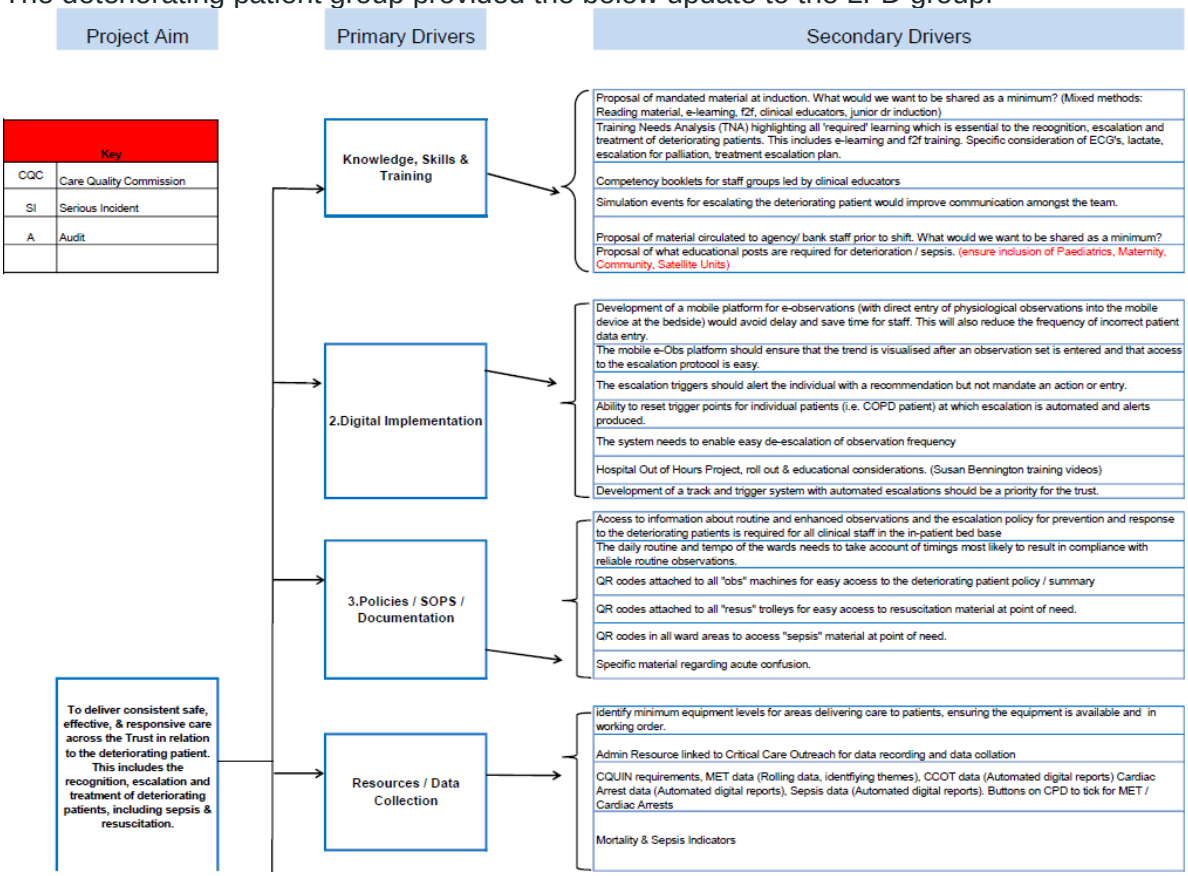
4.2 Improvements underway:

Most of the themes identified from death reviews are aligned with existing improvement initiatives.

The following sections describe the key initiatives.

4.2.1 Deteriorating patient (incorporating sepsis) via the Deteriorating Patient Group

- The deteriorating patient group provided the below update to the LFD group.



4.2.2 Hydration via the Nutrition Steering Group:

The Nutrition Steering Group has a comprehensive improvement plan against which updates are routinely provided to the Quality & Patient Safety Group.

The Staff Matters newsletter in December promoted the nutrition and hydration training now being live on the Learning Hub.

Staff Matters, December 2022

Nutrition and hydration now live on Learning Hub

The Trust recognises the importance of adequate nutrition and hydration for patients and is committed to providing adequate training for staff. As such, all clinical staff must now complete the nutrition and hydration e-learning package on Learning Hub as part of their 'required' learning.

This mandated consistent approach to nutrition and hydration education and training will provide assurance that staff are equipped with the necessary knowledge and skills to identify patients who are at risk of malnutrition, to adequately meet the nutrition and hydration needs of patients and will help mitigate risk.

4.2.3 Communication and documentation via the Treatment Escalation / DNACPR / End of Life Group:

Audit of Ward Moves in patients at EOL

All deaths in the month of October were reviewed, the data was extracted from CPD. In total there were 132 deaths. The results showed a median number of inpatients days from admission to death was 8 (0days -304days). The median number of ward changes were 2, 1 being the least amount of moves and 15 the most. Out of the 132 patients only 26% had a individualised care plan with 74% reviewed by SPCT and among those reviewed by the SPCT 65% suggested an individualised care plan.
The LFD recommended to share this audit with the operational/patient flow teams for further learning.

4.2.4 Specific actions undertaken by Care Groups:

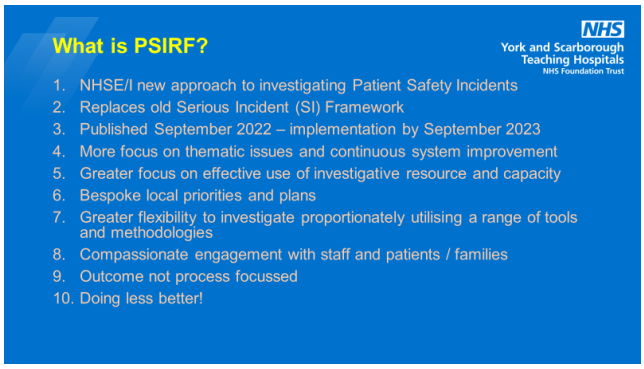
- Ward moves have been added to the ward screens, this is hoped to help decision making when reviewing patient moves, having a positive impact on patient safety as well as patient experience.

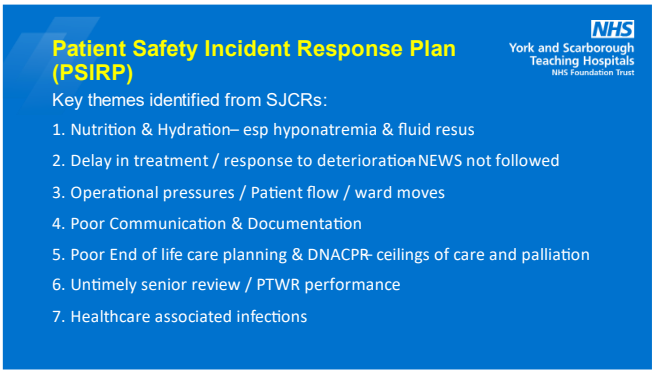
5. Service developments

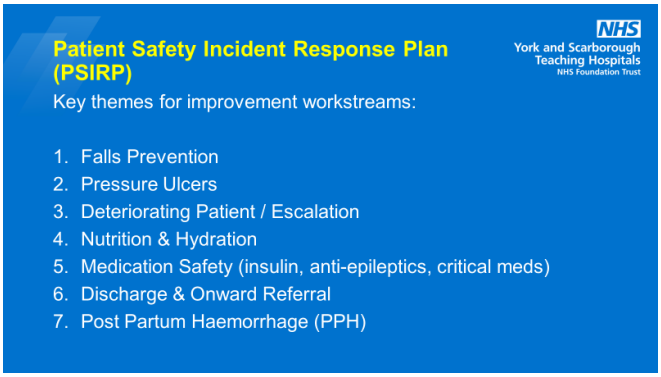
1.1 Developments undertaken

5.1.1 PSIRF

An update of the implementation of PSIRF has been shared with the current position and an analysis of the trusts SJCR, incidents, SI's and legal data has highlighted the key themes. There is a project plan developed and a project group established.







5.2 Developments planned

A series of audits have been requested to monitor the effectiveness of the SJCR. These include an assessment of the quality of SJCRs and an analysis of the activity of the reviewers. At the time of writing the Q2 and Q3 report an additional audit looking at the referrals from the Medical Examiners is being explored. The findings of these audits will be reported in the Q4 LfD report.

The Patient safety team have added the date of a patient's death for applicable clinical SI's for those either declared or submitted to the ICB since 01/10/22 and will continue to add where necessary. This will help the LFD monitor this data and collate it for the yearly quality account.

6. References

1. Crude Mortality rate is the percentage of patients that died. The crude percentage includes all deaths up to 30 days post discharge. The crude mortality percentage is the sum of the in-hospital deaths and the out-of-hospital deaths.
2. NHS-Digital SHMI: SHMI is a hospital-level indicator which reports mortality at trust level across the NHS (acute care trusts only) in England. The methodology is transparent, reproducible and sensitivity analysis of SHMI model had been carried out independently. The indicator is produced and published monthly by NHS Digital. University Hospitals Birmingham (UHB) is actively involved in developing and constructing SHMI as a member of Technical Working Group. In comparison to Hospital Standardised Mortality Ratio (HSMR) produced by Dr Foster, there are a few of key advantages advocating the use of SHMI -
   a. SHMI methodology is completely open and transparent. It is reproducible by third parties and less confusion has been caused within NHS hospitals compared to HSMR.
   b. SHMI gives a complete picture of measuring hospital mortality by including deaths up to 30 days after discharge from hospital, whereas the HSMR only includes 80% of in hospital deaths.
   c. SHMI does not account for palliative care (published as a contextual indicator instead) in the model due to coding issues. It could largely reduce the chance of gaming by coding more palliative care to reduce mortality ratio.

d. Death is only counted once in SHMI to the last discharging acute provider. HSMR will attribute one death to all the providers within a chain of spells which are linked together due to hospital transfer (i.e., superspell if existing).

However, due to the limitations of administrative datasets (lack of clinical information in SUS/HES), SHMI-type indicators **cannot** be used to quantify hospital care quality directly and count the number of avoidable deaths.

HED's SHMI (NHSD) Module is built on the *SHMI Dataset* which is created by NHS Digital on a monthly basis. The dataset only includes necessary data fields for the purpose of validating SHMI model.

3. HES-SHMI: The HED team replicate the SHMI methodology by using our subscribed Hospital Episode Statistics (HES) and HES-ONS Linked Mortality Dataset from NHS Digital.

HED SHMI (HES-based) module is designed to provide a national, regional and bespoke peer benchmarking of overall SHMI and contextual indicators (released by NHS Digital) within all NHS acute hospitals in a more timely and detailed manner. The module will be refreshed every month after we receive monthly subscribed HES and HES-ONS datasets.

SHMI (NHSD) vs. SHMI (HES-based)

1. SHMI (NHSD) is built on the data with the same time period as that for the monthly official SHMI release (by NHS Digital); The SHMI (HED-based) module is refreshed on a monthly basis using the latest data available to the HED team through subscriptions to HES and ONS extracts. Therefore, monthly SHMI scores after the modelling data period are provisional and will be updated after the next SHMI model rebasing period.
2. SHMI (HED - based) utilises the same model built for monthly SHMI to make predictions on new data. It enables the trust to see a timely update of (provisional) SHMI figures prior to national monthly release. It also enables the trust to 'drill down' to patient level detail to facilitate local audit.
3. There is a slight difference in the data used to build SHMI (NHSD) and SHMI (HES - based). Since SHMI (HES - based) allows access to patient level detail it is not permitted to include data relating to patients who have chosen to 'opt-out'. These patients are those who have exercised their right for their personal data to only be used for purposes related to their own healthcare. Nationally this usually equates to approximately 2% of patients. HED believes that the benefit of being able to view patient level details outweighs the disadvantage of a slight mismatch with public SHMI figures. If an exact match to NHSD SHMI figures is required, then the SHMI (NHSD) module should be used.

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Minutes

Quality and Safety Assurance Committee
17 January 2023

Members in Attendance: Stephen Holmberg (SH) (Chair), Jenny McAleese (JM), Karen Stone (KS), Heather McNair (HM), Caroline Johnson (CJ), Mike Taylor (MT), Lorraine Boyd (LB)

Attendees: Sue Glendenning (SG) (item 104-22/23 only), Benjamin Adekanmi (BA) (item 104-22/23 only), Lee Fry (LF) (item 111-22/23 only), Mark Quinn (MQ) (item 111-22/23 only), Karen Priestman (KP) (item 111-22/23 only), Helen Ketcher (HK) (item 103-22/23 only), Ruth Render (minute taker)

Observer: Michael Reakes (MR)

97-22/23 Apologies for Absence

None

98-22/23 Declaration of Interests

None

99-22/23 Minutes of the meeting held on 13 December 2022

The minutes of the last meeting held on 13 December 2022 were agreed as a true and accurate record.

100-22/23 Matters arising from the minutes and outstanding actions

Action 61 – CJ to send Care Group escalation reports to SH to determine which issues should come to the Committee - Closed
Action 101 – SH to escalate number of leavers to Workforce Group - Closed
Action 102 – Mike Taylor to feedback to Team regarding alterations to report - Closed

101-22/23 Escalated Items

There were no escalations raised.

102-22/23 Quality and Patient Safety Escalation Report

To forward to February meeting.

KS confirmed the QPAS meeting took place the day after the last committee meeting therefore gave an update here. Escalations from December include ED pressures and particularly the week after New Year regarding patient quality and safety experience risks. It was difficult for staff as well as patients. Endoscopy capacity is an issue, but the Gastroenterology Service as a whole is significantly challenged, both sites losing Consultants.

HM confirmed the CQC maternity response was submitted on time on 23 December, the next submission date is 23 January but no feedback has been received as yet regarding the first submission.

KS flagged CDIFF which is possibly slowing down and confirmed MRSA bacteraemia.

KS spoke regarding the ongoing industrial action and potential to cause harm. There is a full response with gold and silver in place to keep the organisation running which will be reported as per EPR policy.

SH added outlining escalations from QPAS is helpful.

103-22/23 Annual Patient Equality Diversity and Inclusion Report

HK, Patient Equality Diversity and Inclusion Lead discussed the content of the report. The purpose of the report is to summarise the position to June last year. The trust needs to report progress against equality objectives on an annual basis under public sector reporting duty which forms part of the PSED reporting. The other part relates to workforce which was historically reported separately but the plan is to align to create a single report. The workforce report is sent to the Workforce Committee.

HK commented regarding the timelines during Covid and the annual report being paused. This report covers 2 years to June and the next report will start in June and cover an 18-month period and will then align.

HK confirmed the three key areas of focus since June included the interpreting service performance, the interpreting provider was not meeting the agreed targets. A proposal has been made for a new provider. The second area is regarding the roll out of video interpreting tablets across the trust site. The intranet page has been updated regarding where to obtain the tablets. The third area involves work preparing the equality delivery system and action plan.

HK spoke regarding the key areas going forward. The trust must deliver on the public sector equality duties, the team need to develop new equality objectives from 2024 and need three services to focus on in 2023.

HK confirmed the trust has been missing a summary and proposed if inequality is thought of as a safety risk, in order to mitigate need to do equality by design and need to involve people. There is more work to do to gather information regarding incidents/complaints from delays and the need to map inequality of harm to determine who is having the least good experience of services in the organisation.

SH asked what the committee should be looking for to demonstrate that the trust is on a positive journey and queried if compliance is good enough. HK confirmed the test will be what people say about the trust and can highlight in the feedback data. HK added that Care Group level auditing around real people is important.

JM commented it is pleasing reference was made to a plan which gives assurance using limited resource to address the areas with most concern.

SH encouraged HK to work with teams to include data which gives assurance that the trust is a good organisation and highlighted that there is a need to do more with the IA's within the organisation.

104-22/23 Ockenden Update Report

SG spoke regarding the maternity reports. Work is being done on the rapid improvement plan and long-term action plan. The trust maternity department is being supported by National and Regional Maternity Teams as part of the Maternity Safety Support Programme. SG confirmed a Strategic Improvement Director started in January. The maternity incentive scheme paper has been signed off by the Trust Board and is to be discussed at ICB Board in January. The team are continuing to review the midwifery structure. SG commented that midwifery staffing has improved slightly but does remain a challenge particularly community and antenatal services. SG added diverts is a better picture although the maternity dashboard is a concern as data collection is incorrect but there are plans to meet with the Chief Digital Information Officer.

LB queried the Ockenden IA's noting just starting to benchmark against standards. LB queried regarding assurance – is it felt necessary stability in the midwifery team to be able to make rapid progress?

SG raised a risk regarding the midwifery senior leadership team. SG confirmed at present do not have the infrastructure in place for rapid progress but as start to engage more with wider team hopefully will be able to give more assurance, initial stages. BA in agreement with SG, hoping in a better place but still difficult to say stability in place.

LB asked regarding a timescale. SG confirmed starting with weekly meetings and plans to integrate Ockenden and East Kent, conversations that will be approximately March time.

CJ suggested having one improvement plan to avoid confusion.

SG confirmed required to submit maternity transformation report to CQC on 23 January, currently in draft. SH/CJ discussed review of maternity transformation report including still birth graph, staffing and structure of report and level of detail. SH expressed concern regarding the still birth graph. CJ advised to use the report structure discussed with not quite as much detail required and can then report on improvement plan. CJ added moving forward the Quality & Safety Assurance Committee will receive the CQC report before it is sent to the CQC to have an opportunity to amend.

LB flagged page 42 regarding the on call senior maternity team and asked what the benefits of the maternity team on call are. SG confirmed not currently an on-call team. HM confirmed organised in haste with a significant cost of £90,000 and queried good use of money as already a robust on call system in place which is currently being reviewed. CJ suggested adding a maternity element to the on-call training package for new on call managers.

JM queried regarding the York based community team pressures and regarding mitigations. SG clarified more information is needed to understand if roster fill rates are accurate. The vacancy rate is improving. JM added regarding junior doctors feedback stating the 'trust is a weird place to join as a new starter'. SG confirmed the feedback was received from the culture MDT and related to the trust not just maternity.

KS added that training needs to be improved so that new starters receive training sooner than two months.

105-22/23 Serious Incident Report (Including Maternity and Never Events)

KS confirmed SI's continue and added the SI's are discussed and sent to the SI panel to determine if fit the criteria. KS flagged getting them to completion is a challenge. This year

there is a new patient safety incident framework to launch and embed which will change the way investigations are carried out with more thematic reviews.

SH commented regarding statutory obligations to see the SI's in the Quality and Safety Assurance Committee and does not feel have had the best value in the meeting.

CJ explained the serious incident report would have come through committee but via QPAS first. QPAS was stood down. The team have carried out a review of SI, incidents, claims and complaints to look at the themes and trends and areas to focus on which will give a good oversight. Looking to move to targeted improvement approach to areas.

MT explained regarding issues with papers meeting assurance standards needs to be raised. There is difficulty getting the message across to the Care Groups and other committees.

CJ highlighted the organisation is data rich and information poor. The aim when working with Lorna Squires (LS) is to reduce the industry of report writing to capture the layers of the organisation and improve the reporting with more detailed quarterly reporting. LS to set up a series of training sessions regarding writing for assurance.

JM flagged the importance of a robust process and having clear responsibilities and is not sure key learning is captured.

HM highlighted equity of services and possible differences between Scarborough and York which is not discussed enough.

SH summarised that there is possibly the perception that the organisation is financially driven but the organisation is not quality and safety driven.

KS highlighted inequality at York and Scarborough risk, one trust with one service delivered on multiple sites. Service delivery differs due to for example geography. Need to mitigate the inequality as much as possible.

106-22/23 CQC Compliance Update Report

CJ sked to note Mental Health risk assessment is still listed as section 31 and added that a new assessment is being written for Nucleus.

CJ commented that action plans are progressing. A recent audit has shown some wards are still not that compliant with Tendable risk assessment but known areas to target. Now seeing a reduction in PPH since the CQC visit.

CJ highlighted December had the highest ED attendances for the last three years in the same month. Professor Matthew Cook reviewed the ED Department and following ED overcrowding in York he anticipated 3-4 excess deaths a week in York. CJ has commissioned Gary Hardcastle (GH) from the Information Team to do some analysis of data around deaths.

LB queried the independent review and where it will be reviewed from an assurance point of view as opposed to just to Executive Committee.

CJ confirmed had an independent review. Currently no action plan but asked regarding this matter.

107-22/23 Q2 Falls Report and

HM spoke regarding an overriding observation related to workforce, not being able to provide timely care around turns, 1:1's, significant link to not being staffed appropriately on the wards. Esther Lockwood, Falls Prevention Lead has joined the trust.

LB asked regarding falls in the community.

HM confirmed reports regarding community units and not getting the basics right e.g. lying and standing BP, much better with risk assessments and care planning. HM does not think there is enough training in place and highlighted gaps with healthcare assistants. Risk assessments offer false assurance as care plan generated but nothing further. Need to look at care plan delivery.

108-22/23 Q2 Pressure Ulcer Report

Discussed in item 107-22/23

109-22/23 Quality and Safety Assurance Metrics (TPR)

SH added unhelpful report with current configuration and misleading.

MT confirmed work to be done to improve report.

110-22/23 Safeguarding Update

HM pointed out there will be an Autism post. Work to be done regarding autism pathways.

KS noted not getting child safeguarding from the report and asked if picking up safeguarding concerns in ED regarding Paediatrics.

HM stated all paediatric attendances are screened.

KS asked regarding data and safeguarding activity.

HM confirmed data shown in annual report and added there is an integrated Safeguarding Committee which HM chairs.

111-22/23 Care Group 6 Assurance Report

SH welcomed the Care Group 6 Team.

Care Group 6 made their introductions. Karen Priestman (KP) Associate Chief Operating Office Care Group 6, Mark Quinn (MQ) Care Group Director Care Group 6, Care Group Director and Lee Fry (LF), Associate Chief Nurse Care Group 6 and Care Group 4.

KP discussed the most pressing issues, outlining mitigations and next steps. KP confirmed that there are a number of areas that have started to move forward in response to the recent ESIT visit and report. There has been the first star chamber with the Executive Team last week which will be occurring fortnightly in order to face issues. The main areas to draw attention to include outpatients administration services functionality. The national electronic referral support service is not being used. CPD is used as a referral function but the administrative teams have a lot of work surrounding this.

SH queried why the national electronic referral support service is not being used?

KP explained the decision was made by the previous Head of Digital and Executive Team that CPD would be used. KP confirmed it takes 12 minutes to process one referral.

KP added ESIT met with the outpatient team and reinforced the administrative function is complicated which includes all services and it has been recommended to streamline the process. A meeting has been organised on Thursday with James Hawkins (JH) to progress. There have been a number of change request forms submitted which have been categorised in priority order and benefit realisation.

SH asked regarding the block to ERS. KP confirmed this is due to the current system. When a new EPR system is in place may move to ERS but until that time it is not possible as so reliant on CPD.

LB asked regarding the impact on patient safety and experience. SH flagged regarding patients on the Ophthalmology waiting list coming to harm. KP confirmed any service that book clinics will process through the same system, there is a backlog of referrals therefore a delay in booking patients into clinics, may not be capacity within the Specialty.

LF added there has been a theme in Datix coming through via Q&S, whilst can understand the delay, difficulty understanding the harm, specialities have differing wait times and harm may not be evident for some time.

MQ added regarding a capacity flow issue and reduced manpower having an effect, sickness and vacancies/retention.

SH asked regarding mitigation. MQ added digitisation will free up manpower.

SH queried waiting list alerts to hot spots. MQ added high, medium and low risk prioritisation.

LF commented on measure of harm in differing specialties and that some areas are easier to measure than others.

LB queried how are teams working with Primary Care to manage the unknown risk.

MQ replied that Consultants have made themselves available in different ways to try and get patients seen through REI's and direct patient contact.

JM expressed the concern regarding the administration time to process referrals and retention of staff. JM asked if anything can be done to expedite.

KP confirmed request made through Star Chamber and the ESIT report in support. Have over recruited and have agency staff in to support. The Team knowing they have support has made a difference to morale.

MQ added the digital change will make a difference but competing interests within the organisation, hoping for this work to be prioritised.

KP commented on the cultural challenges within DIS. Had an early meeting with colleagues in DIS re progress. There is a level of concern regarding CPD.

SH asked if there is any value in escalating to the Digital committee.

KP favoured additional support.

KP added that to resolve a lot of issues around delays and booking patients in a timely manner unable to roll out partial booking until get API and reduce backlog. Unable to flag the length of wait on the work list at present but a change request form has been forwarded.

CJ confirmed there are issues with the Oracle platform and lack of developers to create the new platforms required. CJ asked regarding timeline.

KP confirmed some of the required changes do not take a long time. Challenge back regarding developers attending meetings in pairs. There is good visibility through the Outpatient Transformation Programme.

SH spoke regarding there being a lack in clear cite down to departmental/ward level regarding where the risks are. Delay due to not wanting to put more strain on Care Groups and to organise clinical governance prior to attendance.

KP welcome, in terms of governance. There are different areas and issues and different care groups configurations and complexities.

KS asked regarding obtaining hard data related to those patients who have had two appointments cancelled. KS added harm is difficult with chronic illnesses, asked if track and if GP or patient escalated and the appointment has been brought forward.

MQ confirmed advice and guidance support has increased and that an outpatient appointment is not always used.

KS queried looking into patients who have had an adverse outcome if they have come in for surgery.

SH highlighted by having people waiting 18 months for treatment are patients being harmed, can patients be identified before waiting the standard time.

KS confirmed there are long waiting lists which should be managed first in clinical order and then chronological order. Clinicians/GPs and patients to help regarding escalation of increased difficulty.

KP confirmed there are currently 28 vacant PA's, 3 Consultant posts in Dermatology.

JM queried the potential risk to patient safety and quality of those listed which is the most risky?

MQ confirmed the unknown in the administration department as uncertainty.

HM added the worry with ophthalmology. Do not know if would happen anyway. Patients coming through SI's have been waiting and their sight has been lost or deteriorated.

KP expressed not being able to give a timely quality service to patients is the biggest worry.

SH summarised to encourage Care Group to look for evidence of data to support what is being done to identify areas where can get greatest return for intervention regarding patient safety.

Action: To escalate to Digital and Finance Committee concern regarding pace of transformation in outpatients and the impact on patient safety.

112-22/23 Risk Management Report

MT added working with KS in the future regarding medical director risk on the BAF. Pleasing to note from corporate risk register perspective now Care Groups are attending Risk Committee has improved.

113-22/23 Issues to escalate to the Board and/or other Committees

Digital and Finance to Board and to escalate Maternity and dashboard.

114-22/23 Issues to escalate for BAF and CRR consideration

No items escalated.

115-22/23 Any other business

Care Group 5 to attend next committee meeting.

HM confirmed the staffing paper to go through People & Culture committee tomorrow and next month there will be a paper regarding HARMs.

116-22/23 Date and Time of next meeting

The next meeting will be held on 21 February 2023 2.00pm-4.00pm

Report to:	Board of Directors
Date of Meeting:	22 February 2023
Subject:	Chief Operating Officer's Report
Director Sponsor:	Melanie Liley, Chief Operating Officer
Author:	Lynette Smith, Deputy Director of Planning and Performance Gemma Ellison, Programme Lead Urgent and Emergency Care

Status of the Report (please click on the appropriate box)

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ A Regulatory Requirement ☐

Trust Priorities	Board Assurance Framework
☐ Our People	☐ Quality Standards
☐ Quality and Safety	☐ Workforce
☒ Elective Recovery	☐ Safety Standards
☒ Acute Flow	☐ Financial
	☒ Performance Targets
	☐ DIS Service Standards
	☐ Integrated Care System

Summary of Report and Key Points to highlights

The Trust has seen some improvement of key metrics compared to December for acute flow. This includes ambulance handovers over one hour (38% in December to 16% in January), initial assessment in 15mins (38% December, 54% January) and 12 hour trolley waits (1234 December, 808 January) despite the operational pressures experience at the beginning of January.

The Trust is currently forecasting an improved end of March position for 78 weeks compared to the trajectory of 397. This progress is monitored on a weekly basis by the Chief Executive and national team. The Trust is off trajectory for the number of patients waiting over 62 days on a Cancer pathway, at 335 against a target of 133 for January. The Trust will be required to report against the asks in the recent national letter on Cancer backlogs.

The Trust has completed the first iteration of the activity and performance plan. The level of activity identified to date equates to 104.5% of 19-20 activity levels. The ICB has been given an overall target of achieving 109% of 19-20 activity. Work continues to assess activity and productivity opportunities in advance of the draft plan submission in February. The current levels of activity are anticipated to maintain the current waiting list levels, and further work will be required to deliver significant improvement in waiting times.

Recommendation:

1. **That the Board note the report and associated actions**

Report Exempt from Public Disclosure (remove this box entirely if not for the Board meeting) No ☒ Yes ☐
(If yes, please detail the specific grounds for exemption)

Report History (Where the paper has previously been reported to date, if applicable)		
Meeting	**Date**	**Outcome/Recommendation**

Chief Operating Officer's Report

1. Introduction and Background

This report sets the operational update for Digital, Performance and Finance Assurance Committee oversight. The operational performance position is provided in the Trust Priorities Report.

2. Considerations

That the Digital, Performance and Finance Assurance Committee notes the updated position.

3. Current Position/Issues

The Trust experienced unprecedented site pressures at the start of January, with enhanced OPEL measures in place. At the time of writing the report, the COVID inpatient numbers have reduced to 74 across the Trust, and Influenza inpatient numbers have reduced to 16. The Trust is managing industrial action for both the Yorkshire Ambulance Service and the Royal College of Nursing. Further industrial action is anticipated throughout February.

Whilst remaining a challenged position, January has seen an improvement on a range of acute flow metrics in comparison to December. This includes ambulance handovers over one hour (38% in December to 16% in January), initial assessment in 15mins (38% December, 54% January) and 12 hour trolley waits (1234 December, 808 January) despite the pressures earlier in the month.

3.1 Board Priorities: Acute Flow

The refreshed Urgent and Emergency Care Programme key aim is:

To deliver high quality, safe, urgent and emergency care, for our communities, with our partners, delivered in the right place, at the right time, appropriate to our patient's needs.

The focus of the programme in the last month has been on expanding the Programme Team's resource. The Programme Lead has now been appointed on a permanent basis and two Programme Managers and two Project Managers will be joining the team on a permanent basis from 1st April.

External support has also been sought to further build the capacity and strengthen the team. An Improvement Manager from ECIST has joined the team at the end of January for 2 days a week and a Senior Manager from NHS England is joining the team for 1 day a week from February.

The national UEC Recovery Plan was published on 30th January and an initial assessment has taken place to ensure key actions are covered by the programme. In February a more detailed analysis will take place and the programme updated if required to ensure the plan will be fully addressed.

Each workstream has continued to be developed with key updates as below:

3.1.1 Urgent Care: The first workshop is being scheduled in February to bring together Place teams, commissioners and clinical teams to further build upon the discussions to co-produce the new Integrated model of Urgent Care.

3.1.2 Children and Young people Integrated Care and Assessment: The initial focus has been on understanding children and their family's behaviour around accessing healthcare. The partnership group will be reviewing this in February and starting to discuss options for integrated models of care which can be tested ahead of next winter. The CAT hub continues as the initial test of an integrated model of care with recurrent funding options being discussed with the Place team this month.

3.1.3 Virtual Ward: Virtual Wards are specifically identified in the national recovery plan with a requirement to expand capacity. Clinical leaders are to be identified in February, with a clinical workshop being scheduled for March, to review learning from other organisations and identify the requirements for implementation here.

3.1.4 SDEC: The actions identified in the December UEC Programme Board continue to be progressed alongside developing the improvement support from ECIST. A missed opportunity audit will take place in March to clinically identify opportunity to maximise SDEC services across the organisation. Additionally, the Acute Provider collaborative has prioritised SDEC and the Trust is taking part in an assessment and associated development work with The Collaborative.

3.1.5 Discharge: The January Programme Board focused on the development of a pan trust discharge framework. The proposal will be further developed at the February board and will cover the full patient pathway from admission. The ECIST Improvement Manager and Clinical Lead will also support this work initially with a criteria to admit audit in March which will be carried out in both hospitals with the clinical teams. The framework will set standards for consistency across the organisation and build upon existing work in this area. It will provide a refreshed focus especially for patients on Pathway 0 (no additional support required on discharge).

3.1.6 7 day standards: Work is continuing towards the four priority standards in relation to post take, diagnostics and review of patients. Standard 6 is achieved by the organisation and an internal audit has been completed which provides clearer assessment of performance against standards 2 (post take) and standard 8 (daily senior review). The audit is now being reviewed with the Medical Director and Care Group Directors to agree actions.

3.1.7 Access to post hospital care: In relation to Transfer of Care a commitment has been made with the York Place Director to progress work in relation to developing integrated intermediate care.

The system plan continues to be developed with partners covering all three areas, of pre hospital, in hospital and transfer of care. A monthly partnership session is now being established to support further development and delivery of the plan alongside the weekly action meetings.

3.2 Board Priorities: Elective Backlogs

3.2.1 The Intensive Support Team and EY consultancy have commenced on site at York Hospital at the end of January. The teams are working to support the Trust on a range of issues including governance, speciality recovery planning, skills and development of the teams and data to support operational teams.

3.2.2 The Tier 1 regime has refocussed to a weekly meeting with the Chief Executive, Medical Director and Chief Operating Officer as the end of March target approaches. The Trust is currently forecasting to be below the planned trajectory of 397 at the end of March. Additional support had been offered through the national Digital Mutual Aid System (DMAS) and NHSE expertise to Humber and North Yorkshire.

The focus of the Tier 1 meetings is ensuring all 78 week patients have booked appointments or TCI dates for surgery, chronological booking of patients and validation.

3.2.1 RTT 78-week position:

The Trust has continued to see improvements in the long wait position in January, with no 104 week waiters declared, and the number of 78 week patients reduced to 529. The Trust has revised all speciality plans, mapping our core capacity, mutual action and additional actions to stop clocks.

The Trust remains non-compliant to the national ask for 0 78 week waiters by the end of March, and is continuing to work to offer patients alternative providers where shorter waiting times are available. The Elective Recovery Board is established and a revised weekly schedule of patient tracking, performance monitoring and executive oversight will be implemented from February.

The Trust has seen some improvement in the total waiting list position, dropping back just under 50,000 at 49,186. A sustainable waiting list for the Trust is around 26,000 open clocks.

3.3.1 Cancer Position:

The Trust is under Tier 1 for the Cancer 62-day backlogs. The Trust is off-trajectory to meet the 121 target for the end of March 23, with 335 patients waiting over 63 days at the end of January, against a target of 133. NHSE issued a letter of action to all Trusts at the end January (attached appendix A) to support cancer backlog recovery.

The cancer performance data for December and diagnostic performance data for January was not available at the time of writing the report.

4. Operational Activity Plan 2022-23

The Trust was affected by extreme winter pressures at the beginning of the month, with a step down of routine surgery to support de-escalation. The Trust also experience strike action in January, which affected some outpatients and surgery. This will continue in the February position.

January Activity

January 2022	Planned	Actual	% Plan	% 19-20 outturn
Advice & Guidance	3334	2805	84%	125%
Outpatient 1st	18387	14224	77%	90%
Outpatient FU	30220	34788	114%	93%
Day Case	7213	6607	92%	98%
Ordinary Elective	466	452	97%	73%
Non-Elective	6714	5652	84%	92%

The reported data does not include the additional activity at the Ramsay elective hub, which will be included within the final Elective Recovery Submissions.

5. Operational Plan 2023-24

The national NHS 2023/24 priorities and operational planning guidance was published on 23rd December, with the technical guidance released in January. The detailed financial elements are still to be clarified. The operational guidance has set three core tasks:

- Recover our core services and productivity.
- Make progress in the key ambitions in the NHS Long Term Plan.
- Continue transforming the NHS for the future.

The headline ambitions for the recovery are:

1. Improve ambulance response and A&E waiting times (with a revised 76% Emergency Care target)
2. Reduce elective long waits (eliminate 65 weeks by end March 24) and cancer backlogs (continue to reduce the number of patients over 62 days on cancer pathways) and improve performance against the core diagnostic standards.
3. Make it easier for people to access primary care services, particularly GP services.

The operational planning priorities remain in line with the 'Delivery plan for tackling the COVID-19 backlog of elective care' published in February 2022. The financial planning guidance introduces an expanded variable element for elective care to incentivise electives and 1st outpatient appointments and procedures.

The guidance reinforces system working as part of the transformation of the NHS, with a focus on maturing collaboratives and place-based partnerships and the development of a Joint Forward Plan.

5.1 Humber and North Yorkshire planning

The ICS has established a fortnightly steering group to oversee the plans, comprising Place and Collaborative representatives, and a weekly task and finish group across sectors, coordinating the returns and narrative requests. The Steering Group will also lead on confirm and challenge sessions on Trust, Collaborative and Place based plans and assumptions before the draft submission.

The activity expectation has not yet been confirmed, however for Humber and North Yorkshire, it is expected to be c109% of 19-20 weighted activity. The Trust's indicative activity 'ask' has not been confirmed, but is anticipated to be around 104% of 19-20 activity.

5.2 Acute Planning Position

An Operational Planning Group has been established across the four Trusts comprising Trust planning and BI leads and the ICB BI lead who coordinate the activity submissions. The group has commenced and meet weekly during planning round to respond to the system requirements. This group will feed into the weekly system task and finish group.

5.3 Current position:

- First iteration of the draft plan has been produced, with headlines below
- The draft does not take account of counting and coding changes for 2023/24
- In light of the Elective Recovery Fund guidance, Care Groups have been asked to consider any additional opportunities available.
- The first draft does not take account of mutual aid that has not yet been agreed

5.4 Headline Plan summary (initial draft)

Activity by POD against 2019/20 Outturn	2023/24 Full Year
DAY CASES	101.0%
ORDINARY ELECTIVES	104.1%
OUTPATIENT FIRSTS	123.4%
OUTPATINET FOLLOW UPS WIT PROC	87.0%

This activity delivers a weighted ERF value of 104.5% (All ICB commissioners) and >85% Day Case rate.

Trajectory	End March 2024
RTT 65 week waits	0
RTT Total Waiting List	c.47,500
FDS Cancer	75%
63+ Cancer Waits	143

5.5 Timetable;

- Draft Plan submission to the ICS – 16th February
- Draft Plan submission to NHSE – 23rd February
- Final Plan submission to ICS – 16th March
- Final Plan submission to NHSE – 30th March

5.6 Next Steps:

- Share acute planning assumptions with place and other collaboratives to support triangulation of demand
- Assessment of the risks identified within the
- Confirm and Challenge sessions w/c 6th February

- Additional activity opportunities to be incorporated
- Draft plan submission.

Date: 6th February 2023

To:
- NHS trust and foundation trust:
  - chief executives
  - chairs
  - medical directors
  - chief operating officers

cc.
- NHS England regional directors
- ICB chief executives
- Cancer Alliances

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

1 February 2023

Dear colleagues,

Maximising 62 day backlog reductions

Firstly, we would like to thank you for all your efforts to reduce the 62 day backlog, while continuing to see significant numbers of new patients. Following the letter on 12 January 2023 about *Elective actions for the 78 week cohort,* which outlined the key areas of immediate focus, we wanted to also set out the equivalent priorities for the cancer 62 day backlog.

There has been significant progress over the Autumn where we have consistently seen backlog reductions nationally which are far higher than in previous years. It is clear that the vast majority of services are now tackling the capacity increases that need to take place in order to fully meet demand, particularly in the diagnostic stage of the pathway, where we know that focus can make the most improvement in backlog reduction. This is especially the case for trusts within the Tiering process who have been able to radically reduce their backlogs – from Birmingham, to Bristol, to Cumbria.

Prioritising Community Diagnostic Centre Capacity

NHS England has asked all CDCs in geographies with high cancer backlogs to prioritise capacity within imaging and endoscopy to accelerate diagnosis for people currently awaiting diagnostic treatment within the 62 day backlog. Remaining CDC revenue funding is being prioritised for this purpose, and we would ask trusts to speak to their nearest CDC to confirm what capacity could be made available over the coming 10 weeks. NHS England is also linking trusts with high cancer backlogs in with those who have succeeded in reducing backlogs through optimising their imaging and endoscopy services so that they implement those tried and tested arrangements locally.

Implementing FIT triage for 2WW patients on endoscopy waiting lists

We are already seeing very strong progress on the rollout of FIT, with the proportion of Lower GI referrals accompanied by a FIT more than doubling in the last five months. Whilst we know many trusts are now actively triaging *new referrals* on the basis of FIT, it is clear that there are still many 2ww patients on endoscopy waiting lists who have not yet been FIT tested. We are asking trusts to ensure FIT is also applied retrospectively to that cohort, where clinically appropriate, so those patients with a FIT negative result and no ongoing clinical concerns indicating colorectal cancer, can be stepped down onto alternative pathways or discharged in line with British Society of Gastroenterology & Association of Coloproctology of Great Britain & Ireland guidance, and colonoscopy capacity can be prioritised for higher risk patients.

Making maximum use of wider local capacity

We know that many of you are now maximising diagnostic capacity in the Independent Sector, including through additional funding made available through Cancer Alliances, and intend to increase volumes over the course of the next 8 weeks. This will be a critical contributor to backlog reduction given we remain in a period of high UEC pressures. NHS England is currently working with the Independent Healthcare Providers Network to identify areas of surplus colonoscopy capacity in particular and we would encourage all trusts unable to secure sufficient IS capacity to contact their Regional IS Lead, including consideration for using local tariff agreements to increase volumes up to the end of March.

Continued focus on data validation and accuracy

Finally, in common with elective recovery, it is important that active validation in line with published guidance is in place to ensure an accurate understanding of patient progress along the pathway and specifically recorded clock stops where patients receive a definitive diagnosis or treatment. Particular areas where there is potential to make progress before March include:

- Skin data, where appropriate validation work is essential for a clear understanding of the current PTL position.
- Robust administrative processes to ensure patients are removed from the PTL as soon as cancer is excluded (with endoscopy a particular area of opportunity) with communication of this decision to patients as soon as possible.

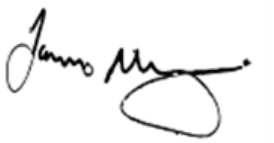
- Patients should only be counted once on the Cancer PTL, so where a patient is transferred to another provider only the provider who is currently responsible for the patient's ongoing care should report the patient.

Trusts should work on validation so that the position reported at the end of March is as accurate as possible to use as the basis for future planning.

Thank you again for your significant efforts to date to support cancer patients, where the early diagnosis data shows us that clinical outcomes are likely now to be significantly improved compared to 2021/22. With your further support over the next ten weeks we are confident this progress can continue and provide us a strong foundation for our ambitions to further improve outcomes for patients over the coming year.

Yours sincerely,

Dame Cally Palmer
National Cancer Director
NHS England



Sir James Mackey
National Director of Elective Recovery
NHS England

Prof Peter Johnson
National Clinical Director for Cancer
NHS England

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Minutes

Digital, Performance & Finance Assurance Committee
17 January 2023

71-22/23 / Attendance: Lynne Mellor (LM – Chair), Denise McConnell (DM), James Hawkins (JH), Melanie Liley (ML), Mike Taylor (MT), Jim Dillon (JD), Lynette Smith (LS), Luke Stockdale (LS2), Nik Coventry (NC), Janet Farr (JF), Kim Hinton (KH), Jenny Piper (JP), Abbi Denyer (AD – observing)

Apologies for Absence: Andrew Bertram (AB)

LM welcomed AD (Governor) NC (Chief Nursing Information Officer), JF (Project Manager, Nucleus), KH (Associate Chief Operating Officer, CG4) and JP (Consultant Surgeon & Lead Cancer Clinician) to the Committee.

72-22/23 / Declarations of Interests

There were no declarations of interests.

73-22/23 / Minutes of the meeting held on 13 December

JH made a couple of minor amends:

- 'More' changed to 'relevant' on P8, paragraph 6.
- 'National' changed to 'Place' on P9, paragraph 5.
- Wording updated from 'we will not be able to deliver' to 'we are unlikely to be able to deliver' on P9, paragraph 7.

Aside from these changes, the minutes of the last meeting held on 13 December were approved as a correct record.

74-22/23 / Matters arising from the minutes

DM asked if there was a confirmed Board date for the presentation on cyber security and MT said this was pending confirmation. LM asked for it to be prioritised. The Committee also noted the importance of Board recognition of our waiting list position and agreed that a Board session on elective recovery following the IST visit was still required. MT said there was a half hour session scheduled to focus on post-Christmas pressures, but the Committee felt more time was required to allow a more in-depth strategic focus in February. MT agreed to discuss this further with Alan Downey (Chair).

Action 28 – LS2 confirmed that the plan has been finalised and will be actioned on 23 May. Action closed, noting that there may be further iterations before 23 May.

Action 54 – LS2 said a change request to PMO has been resubmitted and the team is trying a new approach to look at where value can be released early. The first meeting was

held yesterday and focused on CPD integration. JH said he wanted to bring a list of priorities for the next financial year for Executive oversight, noting that Medisight was not prioritised last year but felt it would be this year. This action remained open, and the deadline was updated to March 2023 for further review.

Action 89 – closed as covered in presentation.

Action 103 – closed as covered in presentation.

Action 102 – agreed closed ahead of deadline as covered in agenda.

75-22/23 / Escalated Items

There were no escalated items to discuss early in the meeting – a summary is included in the Chair's Briefing.

76-22/23 / Trust Priorities Report – Digital, Finance and Performance, to include:

Digital and Information Report Update (to incl. digital strategy update / information governance / cyber security)

P1 incidents remain steady with no significant increase but the Committee noted a specific incident around CPD performance, which is not as good as it has been previously. JH said that we are due a hardware upgrade, which will have a positive impact on performance but may not be enough. We are looking at using additional money for Oracle licences and infrastructure. P2 incidents remain normal whilst service desk calls and abandoned calls have increased. Open calls have increased but are now decreasing. We are using EPR funding to invest in new devices as the number of devices over 4 years old has increased and JH said he is working with AB on regular capital investment on a yearly basis. Information incidents and FOI's remain steady, but SAR's have increased. JH said a specific cyber KPI is being proposed.

LS2 shared a presentation on cyber security and Trust capability.

Action: LS2 to provide update on the device refresh

EPR Plan

JH said we are working collaboratively with the ICS, which is positive but presents some challenges in terms of staying aligned. The focus is preparing a suite of materials for pre-market testing, which will hopefully go to market on 06 February. The market response will help to inform the outline business case and by the end of May we hope to release invitation to tender depending on our preferred options. Four options are being taken through the outline business case process and JH agreed to share these in the next quarter. LM noted that this was strategically important to the Trust and asked if it would also go to Board. JH said that it would but that more work is needed to understand the options.

There was a discussion about the expectation that the Trust move at some stage towards a cloud-based infrastructure. LM said it was important to understand our strategy outside of the EPR solution and that it would be good to understand our cloud strategy position. JH said we have had investment approval and justification to draw on EPR funding this

year, and we have placed an order of c.£11m against these funds for infrastructure investment, including replacing Wi-Fi across all sites. We expect to receive this funding this financial year.

Nucleus Update

JF and NC shared a presentation on the benefits of Nucleus. The Committee noted the excellent progress with Project Nucleus including the benefits especially to patient safety by releasing time to care for nurses. Since August 2022 there have been 61k nursing assessments using 320 mobiles and 100 tablets. LM asked what was being done in terms of benefits realisation and how we can roll out across the rest of the specialties.

The Committee is keen to understand the forecasted benefits vs costs of this programme as its scales up to encompass other specialities and roles. The Committee suggested the production of a case study/further stories about Nucleus success.

LM asked how we could encourage clinician involvement. NC said she was working with Victoria Mulvana-Tuohy (Head of AHP Standards) on OT and physio referral forms to try and achieve the goal of logging data once and seeing it across many specialties. JF said the engagement with AHP staff should help to develop the case for medical documentation and help to establish digital clinicians within the Trust.

Action: JF/NC to provide Nucleus update around AHP engagement

Operational Performance (Trust Operational Performance to national standards, Recovery Plans and Chief Operating Officer Report)

The Committee noted the exceptional pressures over the Christmas period, and ML said this is one of the most challenging times that the organisation has experienced in her tenure. There will be a more detailed discussion around this at January Board. The Committee noted, following conversations with NHSE and other partners around what constitutes a critical incident, that these are now referred to as enhanced OPEL 4 measures following Executive agreement.

We have started to see a downturn in flu and Covid numbers – as at today there are 43 flu patients and 107 Covid patients.

ML highlighted the following key points:

The report following the visit from Dr Matthew Cooke (previous clinical chair of the Royal College of Emergency Medicine) validated and supported our plans, specifically around York ED but can translated across both sites. He gave advice on progressing the operating model for the new build, which will be utilised for a live exercise at Strensall Barracks where the ED footprints will be mapped out and stress tested. The Committee noted that Dr Cooke's report was instrumental in this and noted the recommendations, which included improvements in plans for patient flow, professional standards and a clear 5-year strategy.

Discharge work continues but ML asked the Committee to note that HNY ICS has been allocated £5.9m additional allocation to support the discharge piece. There is significant scrutiny at the centre around reporting back and the current ask is very in-depth, so regional colleagues are pushing back to stress the importance of starting the work. DM said that she thought the discharge issue was more around a lack of places to discharge

to rather than funding. ML said that the two were related in that residential/nursing home capacity was not available at the price within the local authority spectrum. From a spot purchasing perspective, this should help the local authority to achieve more. The Committee asked for further assurance on the impact of this system allocation to the discharge performance and consequential impact on UEC performance at pace.

With regards to elective recovery, we have come to a position with both the IST and EY Consultancy to provide support, and they have been very flexible and responsive. This will look at the granular detail to support operational teams as well as supporting more planning and production of planning in a more detailed way.

The Committee noted the significant impact of the industrial action in addition to winter pressures and enhanced OPEL 4 actions, which included standing down of some elective activity. We will also be in the next round of RCN industrial action, which is a concern for our position. At this stage 16% daily outpatient activity and 20% elective work has been cancelled, including 23 P2 patients, which includes some cancer patients and an additional 10 urgent endoscopy patients. The Committee noted that these had all gone through the robust derogation process internally as well as through RCN panels. It has also been flagged through the Tier 1 process in terms of the impact on our ability to deliver against the revised trajectory.

LS said further discussion at Board around triangulation of elective, non-elective, cancer and finance was required. In terms of the operational plan for next year, the expectation is to eradicate 65 weeks, and the same ask for cancer as this year. This is a significant risk. The Committee requested that further assurance is needed on Elective backlogs and that the Committee reiterate the need for a Board session i.e., the real concern over the total waiting list trajectory, which is forecast to rise to over 50k patients. This is a significant risk to patients, and of much concern, given the Trust's current operational systems and plans are designed for a waiting list of circa 26k patients.

Action: The Committee would welcome a Board deep dive addressing both short term and longer-term issues/needs particularly on how the Trust can mitigate the risk of elective backlogs rising by almost 50% (suggested to have a deep dive review session following the Elective Intensive Support team visit in December. *The Committee requests that this session now includes Cancer deep dive).*

Cancer Performance Update

KH shared a presentation (Appendix A) on our current cancer performance position using three main performance metrics:

- FDS (Faster Diagnosis Standards) – patients should be diagnosed within 28 days of referral
- 62 days – 85% of patients should have received treatment by this stage
- PTL – this is under the most scrutiny nationally around recovering our PTL size to pre-Covid levels

There was also a focus on cancer priority interventions and their impact, our Tier 1 position and cancer focus, areas of good practice/achievement and a summary of cancer clinical harm reviews.

KH highlighted the following salient points:

Colorectal and skin as areas of concern, noting that some specialities are larger and therefore have more patients waiting. The number of patients over 62 days awaiting diagnosis equates to 80%, which clearly identifies diagnostic elements as the issue.

62-day analysis showed that patients waiting for letters to confirm a benign diagnosis accounted for a significant amount. Whilst we believe patients are being told they do not have cancer, this is not being evidenced on CPD, which means that the clock cannot be closed. JP said she had asked DIS to look at adding an FDS button to CPD to ensure that benign patients are contacted.

In terms of interventions, we have been awarded £900,000.00 re imaging turnaround times from the national team for Q4. Endoscopy turnaround was awarded some money from the Cancer Alliance last week (this was already approved at Executive Committee) for insourcing for the rest of Q4.

The Committee discussed the issue around not getting letters sent out to patients that do not have cancer, noting that this should be a quick fix. KH gave assurance that specialties have been asked what would work best for them, and different areas are trialling different solutions such as pathway navigators. KH said the challenge was that there is no way to audit letter turnaround time despite having an Executive Board mandate that they should be dictated and typed within 47 hours for fast-track patients. The Committee asked why this couldn't be audited and KH said she had been told that there is no way to pick out the two key milestones – the date of the outpatient clinic or histology result/radiological report. There was a discussion about whether Audit Committee could support this given its involvement in process effectiveness, noting that they would need to focus on recommendations for process improvement. JD asked for the Board to raise an action for the Executive Committee to reiterate the importance of patients need to be informed of the outcome of their Cancer review within 48 hours

The Committee requested that more assurance is given and that the priorities are clear, with clear dates and one clear set of interventions. The Committee asked if a patient experience survey could be conducted for those patients on the waiting lists, both those who need cancer care and those who don't.

Action: The Audit Committee to consider auditing the process for dealing with cancer patients particularly in the delay between their outpatient appointment and the histology report and the sending of benign letters.

Action: JH to look at replicating FDS button that has proved successful in Endoscopy to confirm that benign patients have been contacted

Action: For the Board to support and reiterated the importance of patients being informed of the outcome of their Cancer review in 48 hours

Action: KH/JP to provide cancer performance update in next quarter

Finance Update
(to incl. Income & Expenditure position / Efficiency Programme update / Cash & Capital)

The report was received, and DM raised the following questions for AB to address outside of the meeting:

- The Trust is £18m behind on its capital spend. Do we expect to deliver the capital spend plan before the year end?

- The actual cash flow for the Trust is £30m compared to plan of £33.5m. Since we are £18m on capital spend and with a deficit of £6m behind on plan I would have expected cash to be £45.5 (£33.5 +18-6). Could you please explain the current balance.

- At the last DPF meeting I asked if the Trust would still come in at balance and was assured this was the case. The Trust deficit has increased again in December with the pay variance increasing from £8.5m to £10.2. Does the Trust still believe it will end the year in balance, and if not, what are the consequences?

77-22/23 / Mandatory Reporting Scorecard

This was received for information and there was no further discussion required.

78-22/23 Risk Management Update

This was received for information and there was no further discussion required.

79-22/23 / Issues to escalate to Board and/or other Committees

LM confirmed that these would be included within the Chair's brief for Board of Directors.

80-22/23 / Issues to escalate for BAF and CRR consideration

The Committee discussed risk throughout the meeting and the Chair during the meeting checked with Committee members that there was nothing specific to escalate on this occasion other than the Cyber risk.

81-22/23 / Any other business

There was no further business to discuss.

82-22/23 / Time and Date of next meeting

The next meeting will be held on 14 February at 9am-11:30am.

Chair Brief: Digital, Performance & Finance (DPF) Board Assurance Committee	Chair: Lynne Mellor	Date: 14 February 2023

2022-3 – Trust Priorities covered by DPF Board Assurance Committee: Acute Flow & Elective Backlog

	Summary	Receiving Body: Board/ Committee	Recommendation/ Assurance to the receiving body: Information, Action, Decision
The Committee welcomed a number of guests to the meeting including the Governor Michael Reakes, Procurement: Edd James, Operations: Kim Hinton, DIS: Nicky Slater, Nik Coventry.			
Digital			
i)	- The Committee was informed of a major incident regarding the Trust Learning Hub. It noted that the Trust was in the process of informing all regulatory bodies and had informed the ICO. The Committee sought assurance that i) communications about the issues and next steps were clear, open, honest and kept staff informed regularly of progress ii) the Committee requested a report on the key risks and the mitigation plans prior to the next Committee meeting including staff impact iii) lessons learnt to be shared once review completed. - The Committee briefly discussed EPR and asked for a more detailed presentation in March once more of the market testing had been completed.	BOARD	INFORMATION
Performance			
i)	- The Committee noted the Trust has seen some improvements in Acute flow including ambulance handovers in one hour, initial assessments and an improvement in ED of 12-hour trolley waits reduced from 1234 in December to 808 in January. The Committee also welcomed the extra Programme/project resource which is being brought into the Trust to alleviate some of the pressures, including support from NHSE. The Committee asked to see however further improvements on the current position with regards to Acute Flow including the output of the analysis on the UEC Recovery Plan at the next meeting.	BOARD	INFORMATION
ii)	- The Committee noted the RTT 78 week position, and that the Trust is still forecasting to be non-compliant to the national ask to have zero 78 week waiting patients. Currently the Trust has 397 trajectory with the revised forecast looking more favourable. The Committee sought assurance that the Trust is doing all it can to move to the zero target if possible. - The Committee discussed the Cancer position including it being off trajectory on the major measures e.g. P2 position where patients should be operated on within 4 weeks down to 56% owing to volume pressures predominantly urology stone patients. The Committee asked for a report back on plans to address, and was pleased to note that the Elective Backlog deep dive session which the Committee requested to understand the	BOARD	INFORMATION

	Trust's full plans to address the backlog is scheduled for the February Board. The Committee did discuss areas of risk mitigation and how Diagnostics could help this position. The Committee asked for a future deep dive into plans on Diagnostics both short and longer term. - The Committee also asked for a deep dive into Outpatients to seek assurance on plans particularly addressing the backlog of first visits taking priority over follow ups.		
iii)	- The Committee noted the work ongoing around the build of the operational plan for 22/23 and that this is the first year the ICB has a statutory responsibility to submit the overall operational plan for the ICS. The Committee noted the tight timescales for submission. The Committee discussed the risks and requested that the 22/23 operational plan risks reported had clear mitigations, actions and owners in place to address the gaps highlighted across the Care Groups.	BOARD	INFORMATION
Finance			
i)	- The Committee welcomed the procurement presentation to provide a single shared service. It was assured that a thorough review had been undertaken with a clear benefits profile and plan of action. The committee recognised the complexity of the exercise; however, it did wonder if further synergies could be realised particularly on staffing, and asked if in six months an update on progress could be provided to the committee.	BOARD	INFORMATION
ii)	- The Committee noted the Trust's Income and Expenditure (I&E) position with an adjusted deficit of £5.1M against a planned deficit of £0.2M i.e., £4.9m adversely adrift of plan. The Committee noted the Trust is forecasting to balance at year end. - The Committee noted a risk around the community stadium, and if the Trust could meet the March deadline to sign the lease. - The Committee discussed the finance work on RPA and welcomed the news that the Trust was collaborating with Leeds Trust and the ICB, and asked for an update at an appropriate juncture to the committee.	BOARD	INFORMATION
YTHFT			
i)	The Committee received the EPAM minutes	BOARD	INFORMATION
Governance			
BAF/Corporate	- The Committee did request a review of Actions, owners and dates was improved on the Corporate risk register. No immediate updates were made to the BAF.	BOARD	INFORMATION

Trust strategic goals assured to Committee	**1. To deliver safe and high-quality patient care as part of an integrated system**	☐	**2. To support an engaged, healthy and resilient workforce**	☐	**3. To ensure financial sustainability**	X ☐
	PR1 - Quality Standards	☐	**PR2 - Safety Standards**	☐	**PR3 - Performance Targets**	X ☐

	PR4 - Workforce	☐	**PR5 - Inadequate Funding**	X ☐	**PR6 - IT Service Standards**	X ☐
	PR7 - Integrated Care System	X ☐	**Comments: PR7 is interrelated across our agenda, and will be noted as discussions arise.**			

	Key Agenda Items	RAG	Key Assurance Points	Action
PR6 – IT Service standards	Digital		New measure around cyber will be brought to the committee. LLP cyber desktop discussed. The issue on learning hub was discussed	The ask remains from the Committee that the presentation of the report goes to Board early in 2023 to support the speedy implementation of the priorities. Committee welcomed a date has now been scheduled by DIS to conduct the review i.e. LLP cyber desktop exercise needed to ensure we mitigate any risks should an attack happen. The ask is for a report on lessons learnt, with an interim report on risks and actions to be shared with the committee
PR3 – Performance Targets	Performance Targets		Significant operational pressures noted.	Focused plans on acute flow and elective backlog to address significant operational pressures – ask for continued identification of focus areas to alleviate biggest pressures.
PR5 – Inadequate Funding	Deficit issue		Deficit issue particularly with premium pay	Monitoring needed with continued focus on areas with gaps such as CIP. Concern re stadium lease.

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Humber & North Yorkshire
Health & Care Partnership
Procurement Collaborative

HUMBER & NORTH YORKSHIRE PROCUREMENT COLLABORATIVE

Business Case for the establishment of a shared procurement collaborative

Version 1.2
December 2022

Contents

Document History

Version No.	Implemented by	Organisation	Revision date	Approved by	Approval date	Description of change
0.1	Edward James	Humber & North Yorkshire Procurement Collaborative	17/03/2022	n/a	n/a	First draft
0.2	Edward James	Humber & North Yorkshire Procurement Collaborative	12/10/2022	n/a	n/a	Incorporating comments from L Bond and A Bertram
0.3	Edward James	Humber & North Yorkshire Procurement Collaborative	28/10/2022	n/a	n/a	Updated recommended structure following Procurement Board 26/10/22.
1.0	Edward James	Humber & North Yorkshire Procurement Collaborative	01/12/2022	Procurement Board	01/12/2022	Version updated to reflect approval at Procurement Board.
1.1	Edward James	Humber & North Yorkshire Procurement Collaborative	19/12/2022	HUTH Performance & Finance Committee	19/12/2022	Approval from HUTH Performance & Finance Committee
1.2	Edward James	Humber & North Yorkshire Procurement Collaborative	23/12/2022	n/a	n/a	Including comments from YSTH Business Case Panel

List of Figures

List of Abbreviations

Abbreviation	Full Text
AP	Accounts Payable
BAU	Business as usual
CCF	Central Commercial Function
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CIC	Community Interest Company
DHSC	Department of Health & Social Care
DoP	Director of Procurement
DPOW	Diana Princess of Wales
EBME	Electrical and Bio-Medical Engineering
EDI	Electronic Data Interchange
ENT	Ear Nose and Throat
ERP	Enterprise Resource Planning
FTE	Full Time Equivalent
HMRC	Her Majesty's Revenue & Customs
HNY	Humber & North Yorkshire
HNYICS	Humber & North Yorkshire Integrated Care System
HNYPC	Humber & North Yorkshire Procurement Collaborative
HoP	Head of Procurement
HR	Human Resources
HRI	Hull Royal Infirmary
HUTH	Hull University Teaching Hospital
ICB	Integrated Care Board
ICS	Integrated Care System
IM&T	Information Management & Technology
IT	Information Technology
JCT	Joint Contracts Tribunal
KPI	Key Performance Indicator
MCIPS	Member of the Chartered Institute of Procurement & Supply
MoU	Memorandum of Understanding
MPC	Manufacturers Product Code
NEC	New Engineering Contract
NHS	National Health Service
NHSEI	NHS England & Improvement
NHSSC	NHS Supply Chain
NICU	Neonatal Intensive Care Unit
NLAG	Northern Lincolnshire & Goole
NOECPC	North of England Commercial Procurement Collaborative
P2P	Purchase to Pay
PCR	Public Contract Regulations 2015
PEPPOL	Pan-European Public Procurement Online

Abbreviation	Full Text
PO	Purchase Order
PPE	Personal Protective Equipment
PPN	Procurement Policy Note
PTOM	Procurement Target Operating Model
ROI	Return on Investment
SCCL	Supply Chain Coordination Limited
SCS	Spend Comparison Service
SDCS	Strategic Data Collection Service
SFI	Standing Financial Instructions
SGH	Scunthorpe General Hospital
SME	Small & Medium Enterprise
SO	Standing Orders
SRM	Supplier Relationship Management
STA	Single Tender Action
STP	Sustainability & Transformation Partnership
VAT	Value Added Tax
WAU	Weighted Activity Unit
YSTH	York & Scarborough Teaching Hospitals

Foreword

I am delighted to see the progress made by Humber and North Yorkshire Procurement Collaborative (HNYPC) and commend Hull University Teaching Hospitals NHS Trust, Northern Lincolnshire & Goole NHS Foundation Trust and York & Scarborough Teaching Hospitals NHS Foundation Trust for their leadership and commitment to drive transformational change in commercial activity across their ICS.

I fully endorse the collaborative approach set out in the business case which aligns with our national objectives of the NHS Central Commercial Function to reduce unwarranted variation, leverage NHS buying power and deliver value for money for patients and the taxpayer.

It is clear the HNYPC leadership team have worked together with persistence and pace to engage with stakeholders and their approach has empowered all staff involved to embrace the challenges ahead. I look forward to seeing the sustainable benefits the shared service can bring to improve patient pathways and outcomes and deliver best in class commercial services for the Trusts.

We should be proud that the NHS already spends public money wisely and is one of the most efficient health services in the world, spending 2p in the pound on administration. However, we know we still need to go further and do more to ensure we are using our resources more effectively.

I hope ICSs across the country follow the excellent example of this programme as a blueprint for how to do that and to demonstrate how corporate and support services can be structured to enable greater collaboration.

Jacqui Rock
Chief Commercial Officer, NHS England

1. Executive Summary

1.1 The Opportunity

This business case is requesting investment to establish a collaborative shared procurement service, across Humber & North Yorkshire. Initially this will be for three acute provider organisations but the design is such to allow other partners to join later. The organisations currently engaged are Hull University Teaching Hospitals NHS Trust (HUTH), Northern Lincolnshire & Goole NHS Foundation Trust (NLAG) and York & Scarborough Teaching Hospitals NHS Foundation Trust (YSTH). The case is for the consolidation of the three procurement functions into a single shared service. There will be in all cases a visible, local presence retained in all organisations.

The NHS spends around £15 billion on non-medical goods and services encompassing food, digital infrastructure, workforce, estates and transport from around 80,000 suppliers. Procurement is de-centralised and undertaken by individual NHS trusts. Although some collaboration between NHS trusts exists, this is unstructured and informal with each Trust deciding when and if it participates.

Various reviews of NHS Procurement have been undertaken which all identify greater collaboration as an opportunity to improve value for the tax-payer as well as better clinical outcomes through the standardisation of products used in clinical settings. In a time of reducing funding and increasing expectations from our patients, commissioners and tax payers, it is more important than ever that we are able to maximise benefit from procurement and commercial arrangements.

As part of the NHS blueprint and moving to Integrated Care Systems (ICSs) procurement is a specific workstream established to improve the way in which NHS procurement is undertaken. These national procurement initiatives play an increasingly important role in the drive for efficiencies and trusts need to have the governance in place to utilise ICS procurement to its full potential and maximise benefit.

In response to this HUTH, NLAG and YSTH have decided to appoint a single Procurement Director and to centralise the procurement function under a single management structure hosted by HUTH. The three trusts are the Partner Trusts of the new procurement collaborative, Humber & North Yorkshire Procurement Collaborative (HNYPC).

Obtaining a single version of the truth on Partner Trust expenditure which should be managed by a procurement function has proved incredibly difficult. For the purpose of evaluating expenditure to inform this business case accounts payable data for the calendar year 2021 has been used as this is broken down to line level detail allowing interrogation. This data identifies that the three Partner Trusts have a non-pay spend of £1bn, £538m of which is classified as addressable by Procurement, non-addressable spend includes: drug expenditure which is out of scope, NHS to NHS payments and rent and rates. 41% of the addressable expenditure is with the top 10 suppliers and 60% of addressable spend is covered by contract. 87% of the suppliers used have an expenditure of less than £100k and 60% less than £10k. There is significant opportunity for consolidating the supplier base, especially as HUTH and NLAG pay a fee for invoice transactions. In total 161,576 invoices were processed, 53% of which cost £2.30 to process, rather than the lower cost of £0.50.

National Model Hospital data has shown the lack of investment in procurement and the transactional and administrative nature of the function. Across the three Partner

Trusts procurement is the second lowest invested back-office function on both pay and non-pay budgets. Less than 1% of non-pay spend is invested into procurements pay spend and 0.05% in the non-pay spend budget. On average across Partner Trusts, back office functions have 1.86% of non-pay spend invested and 0.39% on their pay budget. This produces one of the biggest challenges with the current structure as over 65% of the Procurement function are band 4 or below. With investment in training and development well below the national average - £98 per person per year against a national average of £216 per person per year.

Across the three Partner Trusts there are 3,008 contracts managed by procurement, 37% of the contracts held have expired and almost 50% of all contracts held on the work plan are flagged for renewal in 2022/23. Of the 3,008 contracts, 35 contracts don't have end dates, 145 are with unknown suppliers and 332 have an unknown contract value.

There is also an opportunity to improve stock management. Model Hospital Data shows that the national peer average for stock holding is 36.1 days of static stock. HUTH performs well, reporting 30.8 whereas YSTH (67.2) and NLAG (69.1) sit significantly higher. A reduction in stockholding would reduce the risk of stock obsolescence and deliver a one-off cash benefit. The Scan for Safety programme at HUTH has been rolled out in a quarter of all clinical areas and has identified £143k of expired stock with a further £80k of stock expiring in the next 3 months. Better stock management would reduce wastage through expired stock and give better visibility of where short dated stock sits across the system.

Each department has differing strengths and weaknesses depending on where and how the current resource is deployed. There is a need for a more holistic commercial culture around procurement and supply chain activity in the NHS in general and the shared service model provides the scale for this to be achieved locally whilst retaining the connectivity to the individual organisations.

The proposed structure will create Procurement Business Partners, Clinical Procurement Specialists, Data Analysts and expand the Materials Management offering, staff who will engage with customers and suppliers to identify the right procurement strategies, deliver financial and non-financial benefits to the Partner Trusts and enable our staff to develop to their full capability.

Procurement is a critical function to ensure safe and efficient patient care as well as supporting financial sustainability. Over the past couple of years procurement has been expected to do a lot more by way of supporting other political objectives. Brexit has seen disruption to supply chains which have had to be managed locally with procurement staff reacting at short notice to identify clinically acceptable alternative products, ensuring clinical delivery can continue. Brexit will also see a new set of Procurement Regulations issued in 2023/24 which requires re-training all procurement staff. The pandemic also brought significant supply chain disruption and highlighted the importance of good procurement data, something the NHS lacks. Procurement is also expected to delivery other government horizontal policies such as the SME agenda and net zero. This is all at a time when the public sector is being asked to do more with less.

This business case provides the strategic direction to develop a combined service and the case for change. The case considers national guidance around procurement transformation and selects best practice to be embedded locally.

The proposed solution can be described as a single shared service, based on a common partnership approach and standardisation of processes, systems and strategy. A single Board with representation from each Partner Trust, will decide the direction of the function and agree work plans and strategy. A single senior management team will ensure consistency of service levels across all areas.

Technology and processes will be standardised, with “back-office” transactional activity consolidated and centralised. Supply chain and stock replenishment activities will have dedicated resources at each hospital site. Specialist procurement experts will be aligned to care group areas and will be responsible for the category spend across all Partner Trusts but will have a very local presence and develop close working relationships with expert stakeholders including clinicians.

In an economic environment where costs are increasing it becomes increasingly difficult for procurement to only be measured upon cash releasing savings. We need to work differently to release value, increase efficiency and to support clinical colleagues in delivering their aims and objectives. To do this, this business case suggests the adoption of value based procurement, an approach that delivers tangible, measurable financial benefit to the health system over and above a reduction in purchase price. Procurement will move closer to the customer to understand their needs and constraints and will develop procurement strategies which deliver value with our suppliers. We will make data based decisions, consider our impact on the environment, how we can use procurement to support social value and we will manage the contracts we award to ensure the value promised is delivered.

1.2 Background & Partner Trusts

In June 2022, Partner Trusts from HNYPC signed a Memorandum of Understanding which agreed to move to a fully shared procurement service.

It has been agreed that the following NHS organisations will join the collaborative as Partner Trusts:

- Hull University Teaching Hospitals NHS Trust;
- Northern Lincolnshire & Goole NHS Foundation Trust;
- York & Scarborough Teaching Hospitals NHS Foundation Trust.

Other NHS and CIC organisations within the Humber & North Yorkshire ICS region may join the Procurement Collaborative at a later date, on the agreement of the HNYPC Board. These other NHS and CIC organisations have been consulted and inputted into the development of this business case and associated policy documents.

1.3 Scope of the Procurement Service

HNYPC will be responsible for:

- Procurement – including developing category management, sourcing, contract management and supplier relationship management for revenue and capital expenditure;
- Materials Management – in accordance with current arrangements for the existing Partner Trusts being transferred into HNYPC.

The spend within scope of the procurement service, includes all non-pay expenditure other than Pharmacy medicines expenditure which is managed through the shared service agreement in place with Leeds Teaching Hospitals NHS Trust on behalf of

NHS England & Improvement's Commercial Medicines Unit. Any changes to addressable spend will be reviewed periodically and approved by HNYPC Board.

Procurement is often referred to as a procure-to-pay service however payments tend to be the responsibility of Finance. At HUTH and NLAG the payments process is outsourced to East Lancashire Financial Services and includes access to e-financials and e-procurement systems from Advanced Business Services. YSTH outsource their payments process to North East Patches and includes access to e-financials and e-procurement systems from Oracle.

1.4 Governance Structure

HNYPC will be governed through a procurement board which has executive representation from each Partner Trust. An operational delivery group within HNYPC will manage all procurement activity within the agreed procurement strategy endorsed by the Board and will report progress on a monthly basis. The HNYPC Board will report into each Partner Trust Board as and when required.

1.5 Options Considered

The following options were considered as part of the business case with option 5 being the preferred option.

Option #	Option	Description	Average 5 Year ROI	Decision
1	Business as Usual (BAU)	Maintain the procurement structures as-is under the current Partner Trusts with each procurement team providing dedicated procurement support to their own Trust.	0.59	This option is discounted on the basis it does not meet the objectives set for collaborative procurement.
2	Do Minimum (Soft Collaboration)	Maintain procurement as is in separate Partner Trusts but have a more formal arrangement around working together. This could be undertaken by adapting the MOU as to how to work together which has already been agreed by the three Partner Trusts. This could see the three Partner Trusts agree their joint work plans at the start of the year and how resource would be equally released to deliver joint procurement. It would however result in the awarding of separate contracts, therefore not delivering volume benefits.	1.64	This option is discounted on the basis it does not meet the objectives set for collaborative procurement.
3	Establish Outsourced Shared Service	Establish a separate strategic procurement function which each Trust pays into based on spend/use. The establishment of the function would be similar to the York Facilities Management LLP, whereby the shared service provides services to its members but can also attract commercial	n/a	This option is discounted on the basis that it would require special approval from NHSEI and HMRC as it would be considered a significant transaction which would require the tax treatment of such an agreement to be approved. It is not believed that this approval would be given.

		income from selling procurement services to other organisations.		
4	Single Procurement Organisation/ Separate Finances	Centralise the existing Trust procurement teams but leave the operational elements of Procurement (PO raising and invoice management) at a Partner Trust level.	2.82	This option is discounted as it does not deliver all of the efficiencies that a fully collaborative procurement function can bring.
5	Single Procurement Organisation and Finances	Centralise the existing Trust procurement teams as well as non-pay spend so only one system for PO/invoice is required for each contract awarded.	3.74	Preferred Option.
6	Join Another ICS Procurement Collaborative	Speak to other ICS Procurement collaborative organisations who may be further advanced to add HNY strategic procurement requirements to their existing structures and plans. Use the existing operational procurement workforce to manage local engagement as business managers.	n/a	This option is discounted as following discussion with NHSEI there are no other ICS procurement teams far enough advanced to be able to provide this service.
7	Outsource Procurement	Run a competition to outsource the procurement function to a standalone provider.	n/a	This option is discounted as it does not establish a commercial centre of excellence nor ensure that all staff are given the opportunity to develop.

Figure 1 – List of Options

1.6 Option 5 Investment & Benefits Summary

This business case seeks a total investment of £1,223,530 which is to be split equally between each of the three Partner Trusts:

Investment Type	Total Investment	Partner Trust Investment	Investment Delivers
Pay	£760,307	£253,436	• Procurement Business Partners linked to each care group; • Clinical Procurement Specialists linked to each Partner Trust; • Dedicated resource for Contract Management and Supplier Relationship Management; • Data Analysts; • An expanded Materials Management service releasing clinical time spent putting stock away and ordering stock.
Non-Pay	£330,322	£110,107	• A single Catalogue Management system across all Partner Trusts which standardises prices; • A single ordering system and catalogue across all Partner Trusts standardising the prices paid for goods and maximising our collective buying power; • Investment into the training and development of our staff.
Capital	£132,900	£44,300	• A single Inventory Management system across all Partner Trusts which aligns to the Scan for Safety programme; • Moves all Procurement staff onto a single IT hardware platform.

Figure 2 – Investment Ask

This investment will deliver the following benefits:

Opportunity	2023/24	2024/25	2025/26	2026/27	2027/28
Cash Releasing					
Exiting Trust Savings Plan	£2,185,806	£2,185,806	£2,185,806	£2,185,806	£2,185,806
NOECPC Rebate	£90,000.00	£90,000.00	£90,000.00	£90,000.00	£90,000.00
NHS Supply Chain Collaboration	£151,545.00	£215,772.00	£215,772.00	£215,772.00	£215,772.00
Price Standardisation	£358,005.00	£463,628.00	£633,478.00	£633,478.00	£803,328.00
Volume Savings	£3,197,060.63	£5,888,493.94	£8,579,927.26	£11,271,360.57	£13,962,793.88
Value Based Procurement	£0.00	£50,000.00	£100,000.00	£150,000.00	£200,000.00
Capital Buyer Recharge	£116,191.76	£116,191.76	£116,191.76	£116,191.76	£116,191.76
Tail Spend Management	£43,000.00	£86,000.00	£86,000.00	£86,000.00	£129,000.00
Sustainability	£52,770.00	£52,770.00	£112,000.00	£112,000.00	£112,000.00
Stock Management Improvements	£54,000.00	£100,000.00	£250,000.00	£250,000.00	£250,000.00
Cash Releasing Sub-Total	**£6,248,378.39**	**£9,248,661.70**	**£12,369,175.02**	**£15,110,608.33**	**£18,064,891.64**
Cost Avoidance					
Inflationary	£100,000.00	£150,000.00	£100,000.00	£50,000.00	£10,000.00
Contract Management	£500,000.00	£2,000,000.00	£5,000,000.00	£10,687,002.49	£10,687,002.49
Supplier Rationalisation	£100,000.00	£100,000.00	£50,000.00	£20,000.00	£10,000.00
Cost Avoidance Sub-Total	**£700,000.00**	**£2,250,000.00**	**£5,150,000.00**	**£10,757,002.49**	**£10,707,002.49**
Total Benefit	**£6,948,378.39**	**£11,498,661.70**	**£17,519,175.02**	**£25,867,610.82**	**£28,771,894.14**
Cumulative Benefit	**£6,948,378.39**	**£18,447,040.09**	**£35,966,215.11**	**£61,833,825.93**	**£90,605,720.07**
Total Cost	£4,959,296.75	£4,816,396.75	£4,816,396.75	£4,816,396.75	£4,816,396.75
Return on Investment	1.40	2.39	3.64	5.37	5.97

Figure 3 – Return on Investment

The new structure and strategy will deliver a step change in the performance of procurement, delivering financial and non-financial benefits to HNYPC Partner Trusts, whilst minimising disruption to existing services and providing continuation of local representation.

Non-financial benefits will include improved customer experience and quality of services, transparency of spend and KPI reporting, enhanced supplier performance and innovation, reduced supply chain risk, reduced transaction volume processing of purchase orders and invoices through supplier consolidation, greater focus on social value and sustainability in-turn supporting the Green Plan, improved procurement compliance and efficiencies across several other business areas that interact regularly with procurement.

Financial benefits are driven by enhanced procurement practices, including the embedding of value based procurement and more effective collaboration across HNYPC leading to a greater spend being managed at an ICS level – which will result in greater procurement savings year-on year.

The financial benefits are outlined within section 8, and a high-level financial summary is provided below:

- From £1bn of annual non-pay spend, £538m has been identified as addressable spend;
- An assessment of addressable spend across clinical and non-clinical categories identified numerous opportunities to deliver between £10.9m (option 1) and £90.6m (option 5) in aggregate savings over 5 years.

The savings forecasts were developed through analysis of the spend data, contracts, and data analysis undertaken by North of England Commercial Procurement Collaborative (NOECPC), NHS Supply Chain (NHSSC) and the current collaborative work-plan for HNYPC.

Due to the number of contracts which need to be re-procured, a 5-year timeframe is used for the financial benefits and the return on investment calculations to enable all addressable spend to be tackled, and for benefits from the transformation and saving delivery programme to fully accrue.

1.7 Decisions Required

This business case is seeking approval of the following decisions:

Decision #	Decision	Recommendation
1	The extent to which all options set out in the long list are explored in full detail.	Option 3 (outsourced shared service), option 6 (join another ICS procurement collaborative) and Option 7 (outsource procurement) should be discounted at the long list stage.
2	Host Partner Trust.	HUTH are the host Trust for Humber & North Yorkshire Procurement Collaborative.
3	HNYPC pay and non-pay costs.	All pay and non-pay costs are fully centralised to a single Partner Trust - HUTH. Additional costs are proportioned across Partner Trusts equally with budget transferred to HUTH.
4	HNYPC HR and employment.	All staff will remain employed by their existing Partner Trust and would only transfer if they applied for a new role within HNYPC. All new roles and vacant roles would be recruited by HUTH with budget adjustments made as appropriate. Each Partner Trust also retains their own HR risk around any future structure.
5	Contracting Authority and risk management.	HUTH acts as Contracting Authority however existing contracts are not novated to HUTH, it is only for future contracts. These legacy contracts would still be managed by HNYPC on behalf of each Partner Trust.
6	Non-pay spend management.	Non-pay spend is centralised to HUTH and recharged to each Partner Trust as part of a cash account ensuring no detrimental impact to HUTHs accounts. Costs to be charged at a cost centre and budget holder level so they can take ownership of all expenditure.
7	Addition of new Partner Trusts.	New Partner Trusts who choose to join HNYPC will centralise as per decisions 3-6 above with proportion recalculations happening at the start of the next financial year. Any new Partner Trust joining part way through a financial year will be charged based on the point at which they join.
8	Governance structure.	The proposed governance structure meets the needs of the Trust Board.
9	Procurement strategy.	The three-year procurement strategy is approved as meeting the needs of the Partner Trusts and is fully supported by the Trust Board.
10	Standing Financial Instructions.	The proposed changes to the Trust Standing Financial Instructions are approved by the Trust Board as providing adequate governance. Partner Trusts support a move to a no-PO, no-Pay policy, a standard set of thresholds and support that all contracts (other than those for the purchase of medicines managed by Pharmacy) have to be signed by someone within HNYPC.
11	Resource grading.	HNYPC will not align to NHSEI suggested bandings for procurement staff due to affordability and accept the risk this could lead to talent leaving HNYPC to undertake a similar role at a higher grade at another ICS. This is currently tracked on the risk register as high risk and will

		be monitored on an ongoing basis. Directors of Finance have escalated to the Director of Finance at NHS England.
12	Agile working.	To ensure HNYPC attract the best talent there will not be a requirement for HNYPC strategic procurement team to be office based. Individuals will be expected to work flexibly to deliver their aims and objectives and will be expected to be on site(s) for key meetings with stakeholders.
13	Proposed structure.	HNYPC should be structured to align with care groups and should establish Procurement Business Partners.
14	HNYPC future structure.	The preferred structure should be adopted to generate the benefits set out within business case, this includes the appointment of specific Procurement Business Partners, Clinical Procurement Specialists, Contract Managers and Data Analysts to improve the customer experience around Procurement.
15	Contract and supplier relationship management.	Contract and supplier relationship management is deployed across HNYPC to ensure the value promised during the tender process is delivered by the supplier throughout the contract period.
16	Materials management service offering.	The materials management service offering should be standardised across sites to ensure that stock management is the responsibility of HNYPC.
17	Procurement data and technology.	HNYPC should move towards standard technology and therefore be able to report data centrally in a consistent manner. National systems should be utilised even where local systems have been contracted for where the local system does not offer full functionality.
18	Benefits realisation.	HNYPC should be measured upon and report on the range of benefits delivered including, cash releasing savings, cost avoidance savings, service improvement and sustainability improvements.
19	Apportionment of savings.	All savings to be calculated back to a cost centre level, will be approved by the cost centre budget holder and link to the respective Trust resource management teams.

Figure 4 – Decision Log

1.8 Next Steps

Following endorsement of this business case by HNYPC Partner Trusts, work will commence:

- On procurement transformation supported by existing procurement teams to deliver the benefits outlined and fully embed the new strategy and organisational structure by September 2023;
- Deep dives on key supplier contracts, and specific spend areas. The work will be planned in a way that minimises, as far as possible, any disruption to existing procurement service delivery for HNYPC Partner Trusts.

1.9 Business Case Structure

The remaining parts of the business case are split into the following structure:

- Section 2 sets out the strategic case and the case for change;
- Section 3 identifies the key metrics and baseline data used to inform the options appraisal;
- Section 4 discusses the options considered as part of the business case and scores them to identify a preferred option;
- Section 5 sets out the governance structure for the preferred option;
- Section 6 proposes the resources required to deliver the preferred option and the structure they will be established in;
- Section 7 identifies the data and technology requirements to deliver the preferred option;

- Section 8 shows the benefits that can be delivered from the preferred option and the return on investment that can be expected;
- Section 9 discusses the process for change.

2. Strategic Case - The Case for Change

2.1 National Context - Procurement Target Operating Model (PTOM)

The NHS spends around £15 billion on non-medical goods and services encompassing food, digital infrastructure, workforce, estates and transport from around 80,000 suppliers. NHS England and Improvement (NHSEI) have launched the PTOM which is primarily focused on the £10bn spent on non-clinical goods and services. It aims to move NHS procurement from a local Trust level to an ICS level. This is to deliver better value for money to tax-payers, create a category approach to procurement which will see some categories managed locally, some regionally and others nationally and to upskill procurement professionals. It directly supports the delivery of the ambitions set out in the Carter Review and the Long Term Plan. It aims to:

- Improve patient outcomes;
- Influence supplier markets to deliver better products and services;
- Maximise commercial value.

As ICS's begin to operate as legal entities and patient care reviewed as part of a care pathway, it will be essential for procurement to ensure it is aligned to this way of working to deliver contracts and operations fit for the future. Procurement will be a key enabler to ensure that the support services which exist to allow clinical services to function, continue to do so as clinical services are restructured.

The outcome, vision and mission of the PTOM programme is set out in the following graphic:

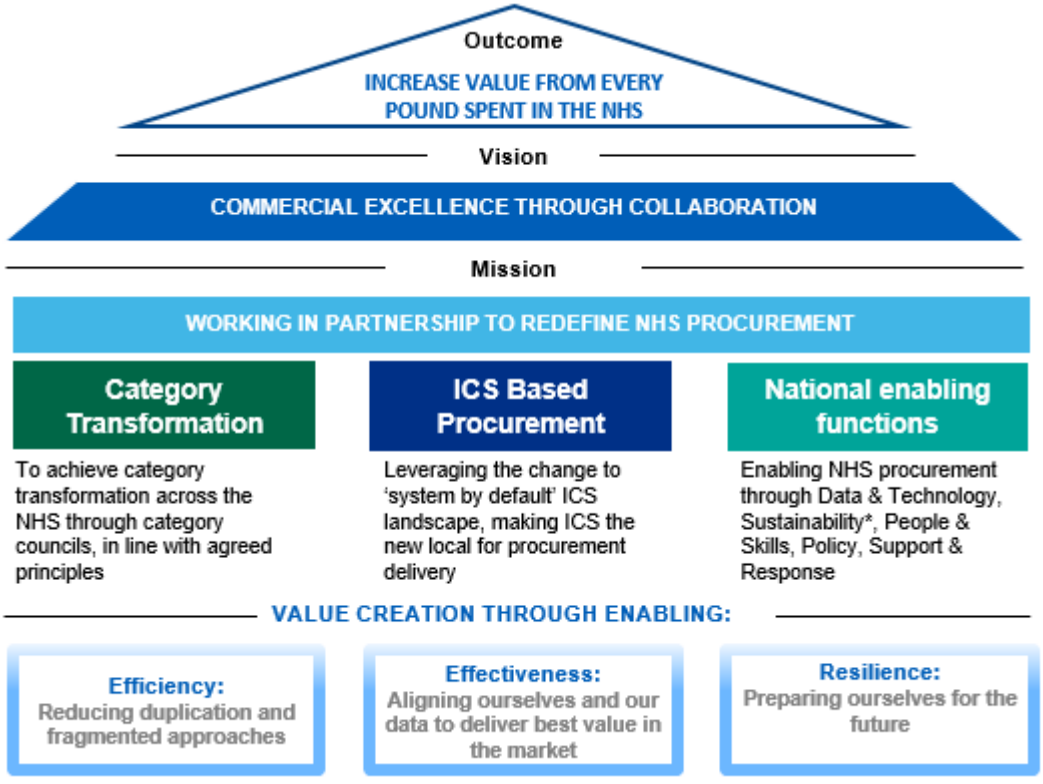


Figure 5 – PTOM Vision & Mission

PTOM uses a category-led approach which means procurement expertise is used in a particular category to benefit both NHS buyers and suppliers by ensuring consistent

commercial terms and standards when embarking on complex procurements. For example knowledge of interoperability and cyber security when procuring digital systems or building regulations for estates procurement.

NHSEI state that Procurement is not currently achieving its full value potential and that there is:

- Opportunity to make better use of our collective resource as a whole system;
- Limited ability to unlock scale and continue to deliver the differentiated value our profession is built on;
- Sufficiently addressing the macro-risks that now face our broader supply chain activities is easier through collaboration, not competition;
- Lacking a coordinated and consistent approach to demand management and aligning needs at scale, leading to variability and subsequently, lesser value gained from each health pound spent.

The benefits of moving to an ICS model are identified by NHSEI as:

- Improved Resilience - Covid-19 taught us that working together is essential to mitigate risk. Working together across the ICS and at greater scale (where appropriate) provides greater protection from supply failures, price increases and quality defects;
- Reduced total Cost - The ICS represents a publicised and policy driven way of driving 'at scale' procurement delivery; enabling greater efficiency and effectiveness through the potential to standardise and reduce repetition;
- Greater Value - The ICS enables us to demonstrate social and financial value across organisational boundaries to drive better outcomes for our patients;
- Better Supplier Management - Working closer together helps leverage scale and value attained through our supplier base through a single voice for categories;
- Optimised Workforce - The ICS enables us to make best use of our collective resource through reduction in duplicated activities and access to more diverse roles across the system;
- Improved Capability - Working together frees up capacity to give us time to develop and leverage specific skills and expertise;
- Great Careers - ICS provides a great platform for career growth with a more diverse set of challenges and opportunities across the commercial life cycle;
- Empowered Culture - The ICS provides an opportunity to fundamentally change and shape the way we work across the system and into the future.

The aims set out by NHSEI for the move to ICS based procurement are:

- To have procurement capabilities deployed across the ICS, with common spend policies underpinning procurement processes, shared access to key data sets, and staff with roles dedicated to delivery across the ICS;
- To have category-based procurement management in place across the vast majority of total ICS third party spend. ICS categories managed by nominated and accountable category leaders, who coordinate stakeholder inputs from each Partner Trust;
- To build out from the new ICS procurement delivery model, putting in place firm channels of communication with neighbouring ICSs across the region. Extending those channels to the National team – to ensure ICS needs are met via existing, and new, nationally let contracts/ agreements where that scale will drive value on behalf of procurements customers.

There are seven dimension set out by NHSEI for NHS organisations to follow as part of the change programme:

- Strategy & Organisation - The strategy that outlines the vision, defines the priorities, and sets out how leadership intends to deploy its collective procurement resources at an ICS level. Inclusive of the skills of its people and its financial, data and technology assets;
- Policies & Procedures - The shared policies and processes that show intent and help determine all key decisions for ICS procurement activity on a day-today basis. Ultimately enabling decisions to be made rapidly, whilst reducing risk and improving value;
- People & Skills - The capacity and capability put in place at the ICS level that ensures effective, efficient and resilient delivery of targeted priorities. Shared access to skilled support. Critical roles in place with accountability and responsibility to the system itself;
- Data, Technology & Performance - The data that is codified, cleansed and shared, and the systems that are integrated or collectively invested in across the ICS which drive insight on future value opportunities, risk mitigations and performance outcomes;
- Strategic Procurement - The delivery of best in class sourcing and procurement activity on behalf of the ICS. Aligning activity to targeted spend categories, and using regional and national networks to drive aggregation, commitment and value for ICS service users;
- Supply Chain Management - The management of our suppliers, their extended supply chains, our assets and inventory at an ICS level to reduce supply risk, cut waste, release space and ensure right product is at the right place at the right time to ensure patient safety;
- Sustainability - The improvement of environmental (Net Zero), social value (anchors and levelling up agenda) and Modern Slavery impacts on the whole ICS supply chain lifecycle; from product design, to material selection, packaging, transportation, warehousing, distribution, consumption and disposal.

Under these seven headings there are 34 actions to deliver:

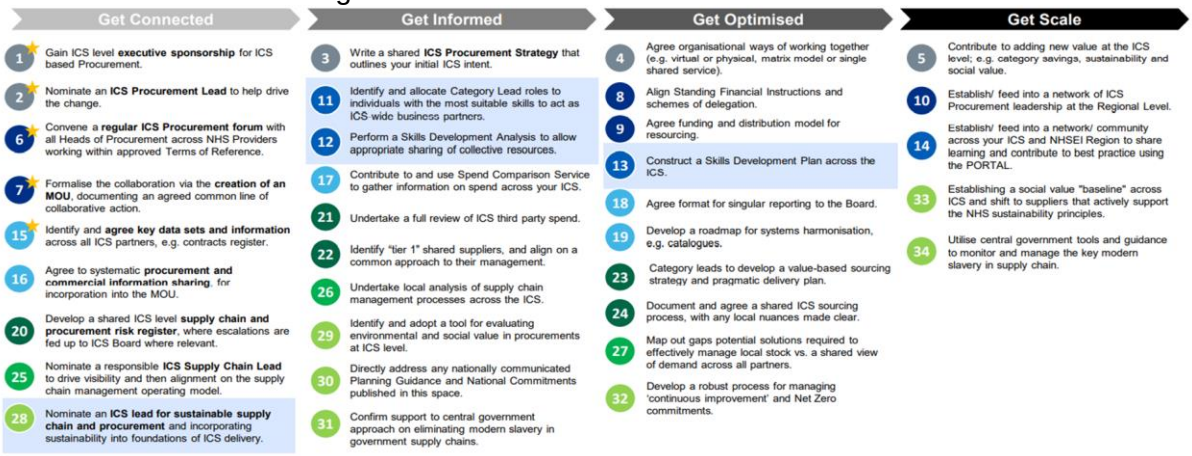


Figure 6 – PTOM 34 Actions

NHSEI identify four core capabilities that ICS procurement teams should be founded upon and built into the way of working to enable ICS procurement delivery:

- Transformation & Enablers:
    - Strategic leadership to focus and drive the change towards ICS ways of working for procurement by setting and delivering the vision for ICS journey–defining and sharing best practices in the form of enablers. Focus on setting aligned targets, measuring progression and supporting delivery effectiveness;

    - Enabling infrastructure will ensure coordination, consistency, and effectiveness across the joint ICS Procurement function. While many of the key frameworks and tools are in place already, consistent ways of working, robust governance, planning and measuring performance will bind the new ICS Procurement operating model;
    - Whilst maintaining the relationships, expectations and services that exist within their Trust landscape, ensuring continuation of the delivery throughout the transformation.
- Category Leadership:
    - Category Management approach is to drive strategic, high value, complex opportunities using specialist market knowledge and insight;
    - Procurement categories (including NHSEI PTOM as well SCCL category towers) are selected to best leverage the ICS purchasing power; aligned with the spend, timing and characteristics of ICS landscapes;
    - Demonstrating the high value a Procurement function provides to the business and acts as a true business partner through engagement to ensure requirements and are effectively captured and communicated;
    - Develop and document, consistent processes with clear indication of owners and hand-offs between Procurement teams and the business.
- Data & Technology:
    - Effective use of available tools and systems will be a key enabler in supporting ICS collaboration, efficiency improvements, identification of savings opportunities and management of risk;
    - Development and implementation of a data and technology transformation roadmap, including development of data standards, delivery of key datasets, analytics-based insights and best in class digital technology deployment (Atamis, Spend Comparison service etc.);
    - Supporting the ICS procurement teams to focus on value-add activity by providing streamlined processing and access to insight. Reducing duplication and adding consistency in information sharing and reporting.
- Sustainability:
    - The improvement of environmental (Net Zero), social value (anchors and levelling up agenda) and Modern Slavery impacts on the whole ICS supply chain lifecycle; from product design, to material selection, packaging, transportation, warehousing, distribution, consumption and disposal;
    - 65% of NHS emissions stem from our extended supply chain. We are collaborating across the system to: 1) develop procurement policy and practices that support the whole system to procure with purpose; 2) leading supplier engagement efforts centrally to align our delivery partners to our sustainability ambitions, and; 3) providing guidance on key operational interventions that will allow front line teams make more sustainable day-to-day delivery decisions.

2.1.1 NHS Central Commercial Function

In June 2022 NHSEI announced that the PTOM programme was being replaced with a new NHS Central Commercial Function (CCF). The change is being communicated as building on the PTOM programme so this business case should still align with the aims and objectives of the CCF as these are built over the coming months. The CCF

is built around seven areas, although these may change following feedback from Trust leads.

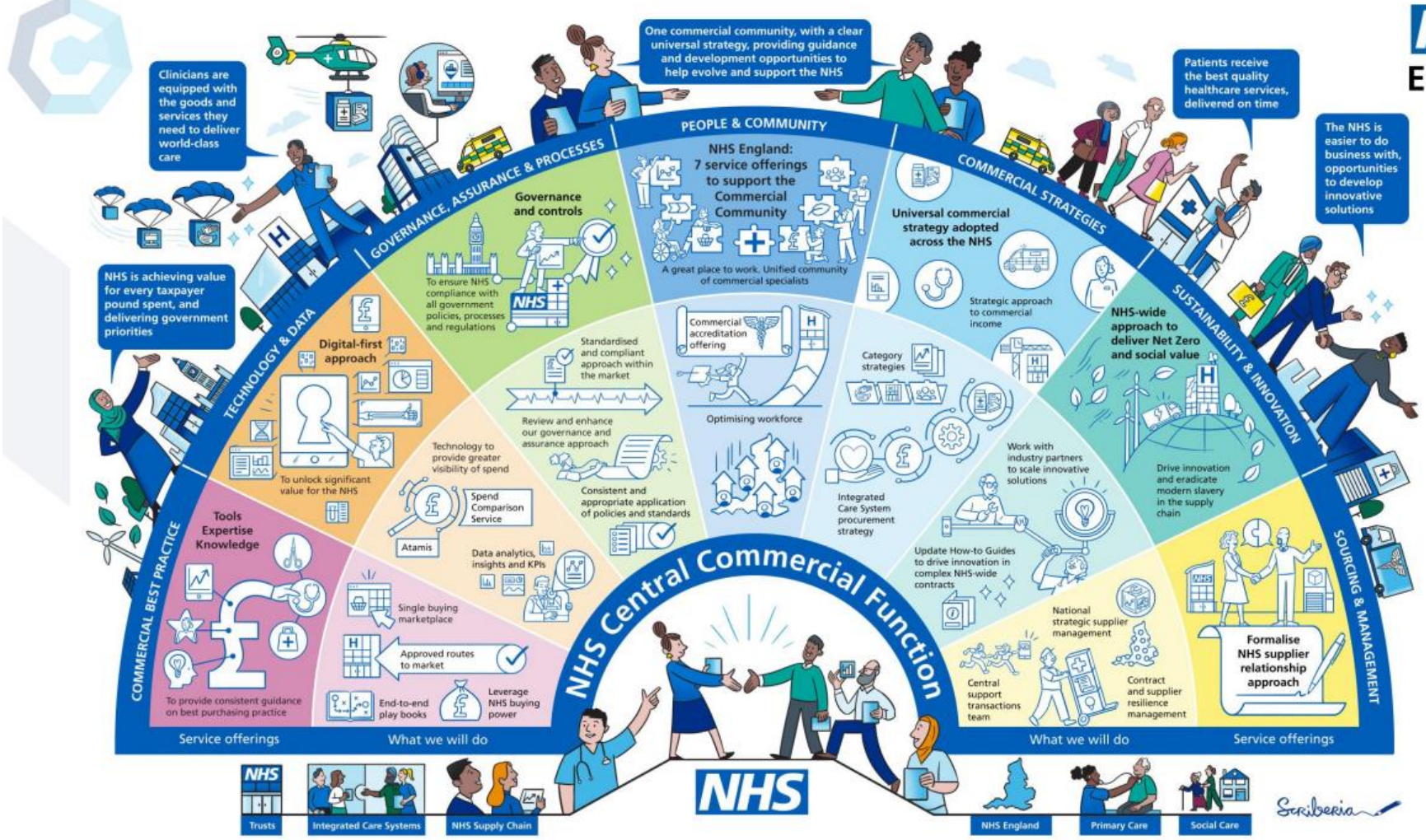


Figure 7 – CCF 7 Areas of Focus

2.2 Local Strategic Healthcare Developments – Humber & North Yorkshire ICS (HNYICS)

ICSs are new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups. They exist to achieve four aims:

- Improve outcomes in population health and healthcare;
- Tackle inequalities in outcomes, experience and access;
- Enhance productivity and value for money;
- Help the NHS support broader social and economic development.

Integrated care is about giving people the support they need, joined up across local councils, the NHS, and other partners. It removes traditional divisions between hospitals and family doctors, between physical and mental health, and between NHS and council services. In the past, these divisions have meant that too many people experienced disjointed care.

The HNYICS footprint was established in 2016. It covers the areas of Hull, the East Riding of Yorkshire, North Lincolnshire, North East Lincolnshire, the Vale of York, Scarborough and Ryedale and North Yorkshire:

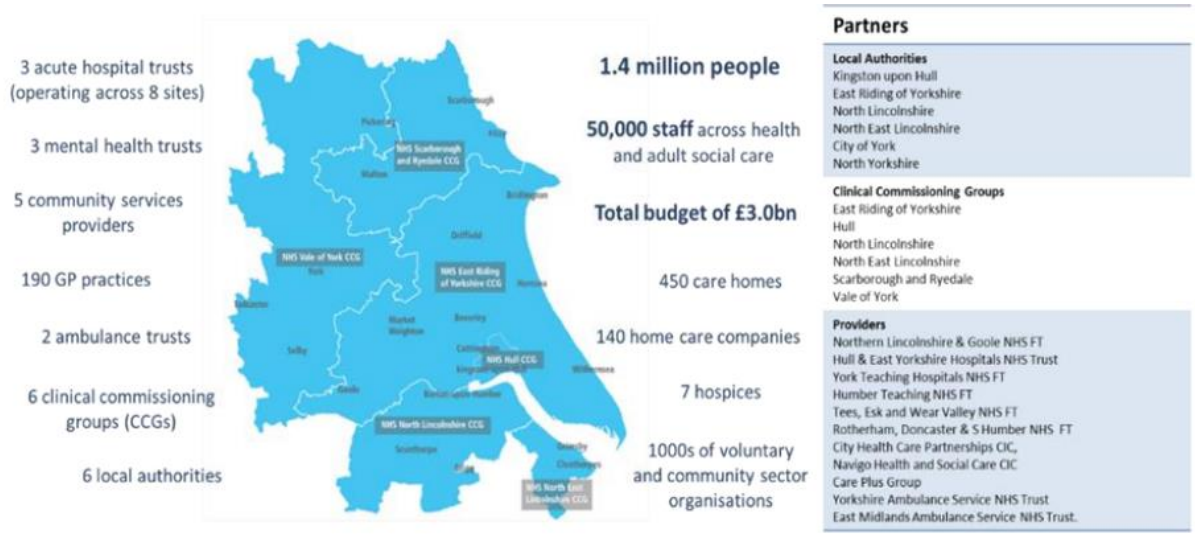


Figure 8 – HNYICS Footprint

In April 2020, Humber & North Yorkshire Health and Care Partnership become an ICS. The application for ICS status was ratified by NHSEI a year earlier than required by the NHS Long Term Plan. The HNY Partnership was one of only four sustainability and transformation partnerships (STPs) to achieve ICS status in April 2020, joining the 14 ICS already operating across England. HNY ICS organisations demonstrated that they share a common goal to improve health and wellbeing in their communities, supported by robust operational and financial plans, and proposals for collective leadership and accountability.

Although the Procurement Collaborative does not sit within the remit of HNY ICS, it operates with agreement of the NHS Acute Finance Directors in the ICS region.

The priorities of HNY ICS are:

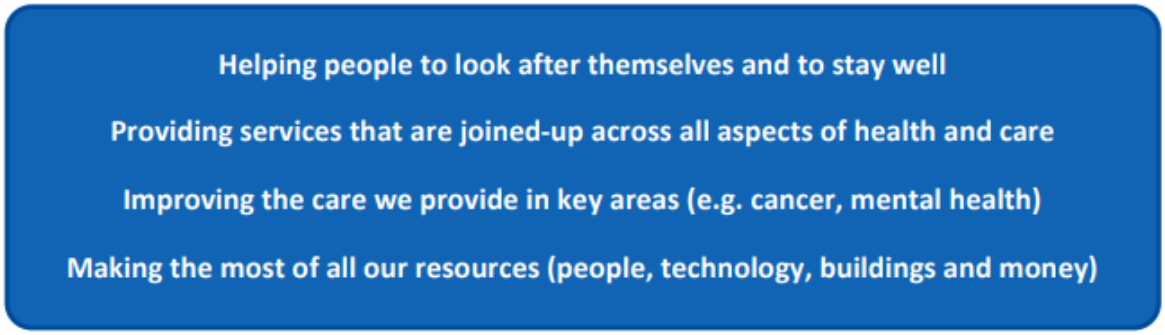


Figure 9 – HNYICS Priorities

The development of the HNYPC will support the delivery of the ICS vision by:

- Ensuring that the region has a single, aligned procurement function that reduces duplication therefore making the most of our people;
- Uses its collaborative power to influence the market, bringing innovative technologies to help improve clinical delivery and achieve best value for money;
- Supports clinical teams to deliver integrated and patient centred care, sharing best practice from across the region;
- Is seen as a great employer providing opportunities for people to learn and grow thereby attracting talent from across the region;
- Provides an efficient, effective and simple to use procurement service to all Partner Trusts.

2.3 Local Trust Strategic Aims and Values

The vision and mission for the new HNYPC will also be based on the vision and mission of the three acute Partner Trusts. The corporate priorities of each Partner Trust are listed below and it is reassuring to note that there is considerable convergence in terms of values and objectives. From a collaborative perspective, this means that the HNYPC has clear direction and a consistent message as to how it should align its activity to best support the corporate priorities.

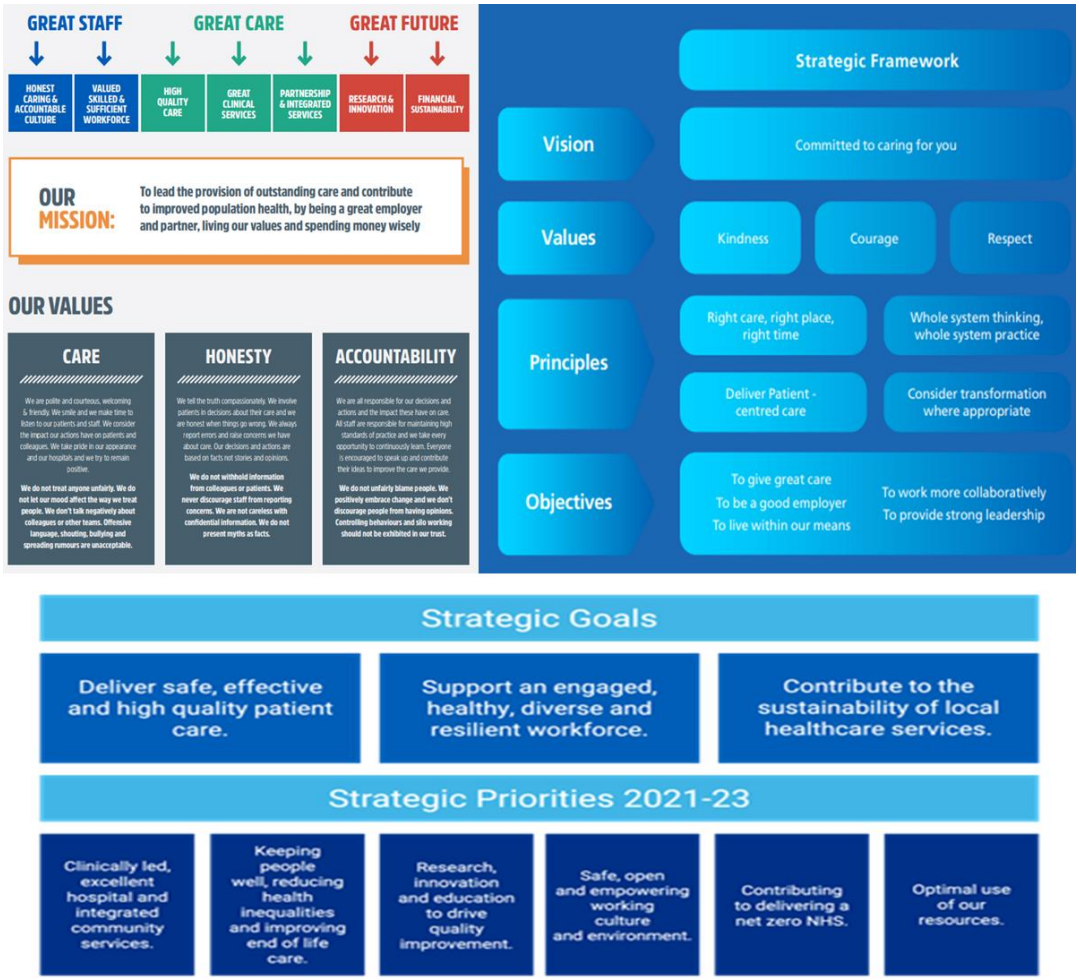


Figure 10 – Partner Trust Priorities

Procurement isn't explicitly mentioned in any Partner Trust strategy despite reference to other professional strategies (e.g. Estates/ Finance) or explicit mention to financial sustainability and getting more from every pound spent. There is also no clear link from the Partner Trusts visions and mission to the work procurement undertake which allows staff to link their work to the overall Trust strategy. This needs to be addressed as part of the HNYPC so that procurement is seen as a key enabler to each Partner Trust meeting their objectives and the golden thread can be followed from the Partner Trust aims and values through to the aims and objectives of those working in Procurement.

Going forward the values and behaviours listed above will be embedded into the values and behaviours of the HNYPC as well as incorporated into the procurement and supply chain strategy. In this way staff and customer groups will develop procurement and contracting strategies which work with suppliers to promote these ambitions.

The three Trust strategies overlap and can be combined into a single set of aims and values which will become the basis for HNYPC:

	Combined
Vision/ Strategic	• **Care** – ensure procurement promotes patient centred, high quality, great, safe, right place, right time care for all Partner Trusts;

Goals/ Principles	• **Staff** – encourage our staff to be the best they can who are collaborative leaders, engaged, healthy, and resilient; • **Future** – procurement to promote whole system thinking and practice encouraging Partner Trusts to consider transformation to deliver financial stability.
Mission	To deliver a procurement service which allows our Partner Trusts to offer great care, which supports people to start, live and age well. Being a great employer spending money wisely.
Values	• Respect/ Honest; • Caring; • Helpful/ Kind; • Listening, Courage to challenge, accountable.
Objectives/ Strategic Themes	• Ensuring Procurement supports our Partner Trusts to deliver high quality care through great clinically sustainable services with a home first approach; • To be a good employer who values and has a skilled & sufficient workforce who focus on improving our service; • Make best use of every pound to support Partner Trusts live within their means and deliver financial sustainability; • Work collaboratively in partnerships and integrated services/ alliances; • Embed an honest, caring and accountable culture with strong leadership; • Promote research & innovation.

Figure 11 – HNYPC Values and Mission

2.4 Procurement As-Is Assessment

The current procurement service model across the HNYPC is decentralised with three procurement teams supporting three acute trusts. Whilst there has been some cooperation during Covid-19 there is no joint working or formal collaboration undertaken demonstrating substantial opportunities for greater collaboration, efficiency, effectiveness in procurement operations and delivery of a multitude of incremental quantitative and qualitative benefits.

The key areas within the current procurement services identified as requiring improvement include:

- People – there are few high-calibre procurement managers able to drive major cross-ICS projects, a significant absence of supplier relationship management roles, data analytical roles and clinical engagement roles. The large element of procurement roles are transactional;
- Structure and Governance – does not enable the level of collaboration across HNYPC Partner Trusts required to unlock incremental value;
- Systems, Processes and Policies – fragmented systems across the ICS that hinder joined-up working; insufficient focus on Supplier Relationship Management and Contract Management; coupled with poor data visibility and management reporting. Improving these areas will enable the delivery of substantially greater savings through collectively leveraging the combined buying power of the HNYPC Partner Trust's annual addressable spend of £538m.

A summary of some of the key issues discovered as part of the as-is assessment are outlined below:

Data Transparency:

- Category and spend data analysis not effectively supporting strategic procurement / activity;
- Issues with quality of financial and procurement data;
- Lack of ICS view on supplier spend, performance, contracts, risks, and procurement operations in terms of transactions, performance, return on investment.

Lost Savings Opportunities:

- The system lacks the ability to identify and scope projects at an ICS level, due to capacity pressures, capability, conflicting Partner Trust priorities, and a lack of ICS mandated policy/ governance;
- ICS wide savings plan viewed as aspirational, limited collaboration and therefore lack of leverage across system wide suppliers, spend and delivery of savings;
- Lack of transparency and localised annual planning approach.

Inefficient Technology & Governance Landscape:

- Technology landscape inconsistent and deficient;
- Multitude of governance processes, policies and procedures;
- Inconsistent procurement approaches leads to a duplication of effort, lack of effective activity planning.

Inappropriate Team Structures:

- Team structures heavily weighted towards transactional procurement activities;
- Absence of procurement business managers and category plans to support procurement activities;
- Significant differences in access to qualified procurement staff, training, and development, coupled with culture of silo working approach;
- Limited automation and application of digital approaches.

Lack of Strategic Procurement Activity:

- Under resourced business partner capabilities, impacts effective procurement activity and wider stakeholder engagement;
- Absence of engagement with Trust stakeholders throughout the procurement process with stakeholders requesting more time with Procurement;
- Significant absence of supplier relationship management and engagement with strategic suppliers;
- Lack of long term planning.

Procurement & Supplier Risks:

- Immaturity of procurement operations increases risks to procurement delivery and supplier management;
- Little evidence of effective contract management, poor quality of contract register information;
- Reactive rather than proactive procurement approaches and basic procurement resource activity planning;
- Limited due diligence and supplier monitoring.

There are significant gaps in the skills required for a fully functional Procurement team with a high number of resources focussed toward transactional activities such as the processing of requisitions, replenishment of stock or tendering and sourcing activity. There are minimal resources focussed on strategic business partnering, stakeholder and market engagement. There is also an element of duplication in each Trust with similar roles being carried out, particularly at a management and transactional level that could be rationalised by centralising these resources. The size of each organisation means that some specialist resources are deemed as nice to have rather than essential.

Bringing staff up to a common standard of operating is key to ensuring that the organisation can deliver its goals. The concentration on annual savings targets has led to a narrow focus on achieving in-year savings rather than a strategic approach to the value opportunities which procurement can deliver.

All three trusts employ various methodologies regarding clinical engagement and product standardisation. Formal procurement/clinical meetings within the trusts can be sporadic or poorly attended. This is common with many trusts where standardisation groups suffer in terms of maintaining appropriate attendance levels and engagement.

There appears to be limited dialogue in terms of understanding the strategic plans of service groups and how procurement can work with customers to deliver their strategy. Despite clinical, medical and operational staff being the key customers there are no measures in place to understand customer satisfaction or allow clinical teams to contribute to governance or performance management. As part of the engagement with various members of staff across the three acute trusts the same asks were raised for any future service offering:

1. Support the trusts with their financial position;
2. Simplify the procurement process and eliminate confusion;
3. Standardise the use of products where possible;
4. Provide more face-to-face time with procurement staff, in particular staff who are authorised to make decisions;
5. The importance of attracting and retaining talent.

As part of the development of this business case supplier feedback was requested from the major suppliers to HNYPC. The key themes of this feedback were:

- Single Entity – it is a lot easier for the supplier to transact with a single entity rather than a front to three separate organisations. A single entity can achieve more in reductions of transaction cost but can also consider things such as bulk purchase that could deliver an additional 5%. Quite often collaborations between organisations don't go far enough and work as more of a bolt-on;
- Patient Pathways – Procurement should think and operate around patient pathways rather than product categories as this could deliver additional benefit rather than improving parts of a pathway. Operating on this basis could also see procurement influencing decisions around where care is provided by understanding what technology is available through suppliers;
- Value Based Procurement/ Strategic Relationships – Procurement should be undertaken to understand the added value suppliers can bring rather than just cost down of a product. These value add services need to be built into contracts and to hold suppliers to account. Suppliers have value add offerings such as pathway optimisation or technology offerings which can be offered as part of a joint contract. Other trusts have delivered theatre efficiencies of 10-15%. Quarterly business reviews should be held with key suppliers to measure performance and explore ideas for process efficiencies;
- Value of Data – clinical data is worth more to suppliers than the sale. How can procurement influence thoughts around the commercialisation of clinical data;
- Contract Terms – standard contract terms should be agreed across the ICS but there should be greater understanding within procurement as to how to manage risk within markets and to set this out in contracts which drive the right behaviours, for example how base wage rises and inflation is dealt with;
- Tender Documents – the quality of the tender documents and the process which is followed needs to be improved. Quite often specifications are not clear

around what is being procured and the evaluation documentation isn't followed. This makes it easy for the supplier to challenge the process. The view from the supplier is that this is down to capability issues within procurement;

- Pipeline Visibility – it would be beneficial to have regular catch-ups with procurement individuals to better understand the pipeline of opportunities but to also allow for supplier feedback on market trends and challenges so this can be included within any procurement exercise or as part of the contract management regime. The pipeline needs to consider ways of working and not rely on cash coming into the system at the end of the year. HUTH have recently bought Endoscopy scopes but haven't changed their ways of working to align with the additional technology and functionality. Start procurement exercises earlier, understand what is available from the market through innovation days and allow procurement documents to have the flexibility for innovation;
- Contract Management – Procurement need to be leading contract management to ensure that the supplier is delivering what was promised but also to provide the link between suppliers and customers. Recently suppliers have seen capital purchases completed where clinical staff do not know how to use the product and this has created issues. Both parties should be responsible for delivery of cost improvement;
- Supply Chain Resilience – improve supply chain resilience and minimise supply chain risk and disruption by identifying supplier networks rather than relying upon monopolies;
- Simplification of Process – the sign off process across the three organisations appears to be very different. As an example the process at NLAG appears smooth a quick whereas the sign off process for HUTH takes weeks and large orders are often delayed. Communication with HUTH can also go unanswered which is frustrating;
- Stakeholder Engagement – Procurement need to provide the link between the supplier, the clinical community and the ICB to ensure the best outcome for patients. There is a current visible lack of procurement engagement with the clinical community.

The respective establishment WTE headcount by function is shown below:

Function	HUTH	NLAG	YSTH	Total
Procurement	15.74	10.12	25.15	**51.01**
Systems & e-Commerce	0	0	1.9	**1.9**
Clinical Procurement Specialist	0	1	0	**1**
Receipt & Distribution	7	5.5	12.99	**25.49**
Materials Management	12.64	11	15.5	**39.14**
Total	**35.38**	**27.62**	**55.54**	**118.54**
Addressable Spend	£243m	£129m	£166m	£538m
£m per WTE	£6.8	£4.6	£3	£4.5

Figure 12 – WTE Headcount by Function

The above table shows a significant difference between the value of addressable spend per WTE with HUTH operating at £6.8m per WTE and York at £3m. Looking at other benchmarks, Manchester University NHS Foundation Trust have 132.92 WTE

with an addressable spend of £540m meaning an average of £4m per WTE. Working on £4m per WTE HNYPC would operate with a WTE headcount of 134.57.

In total 44 people work less than full time hours, this represents 33% of the total headcount working part time. There are also a number of grade gaps within the existing procurement structures which prevents individuals seeking careers internally.

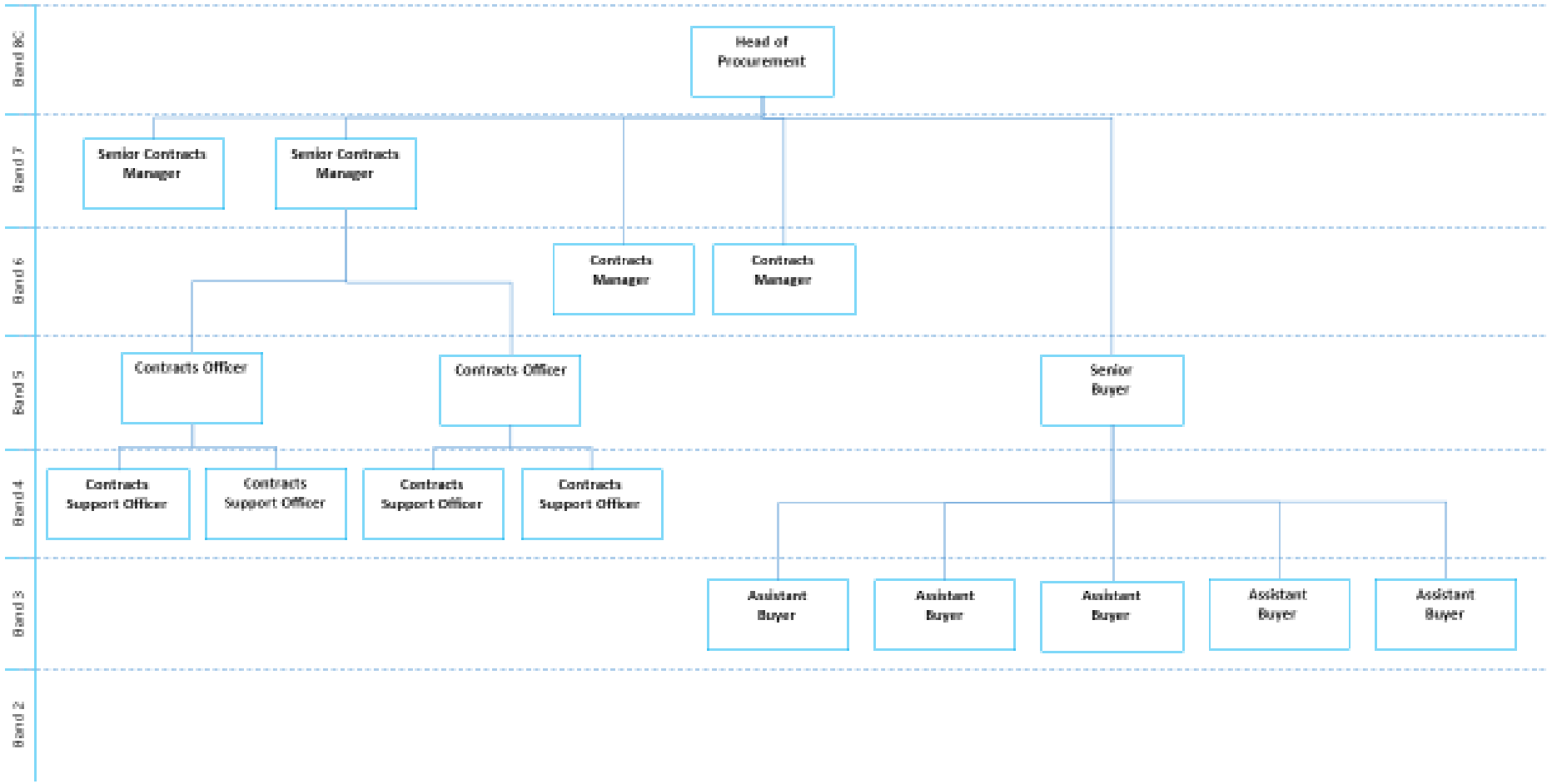


Figure 13 – HUTH Procurement Team

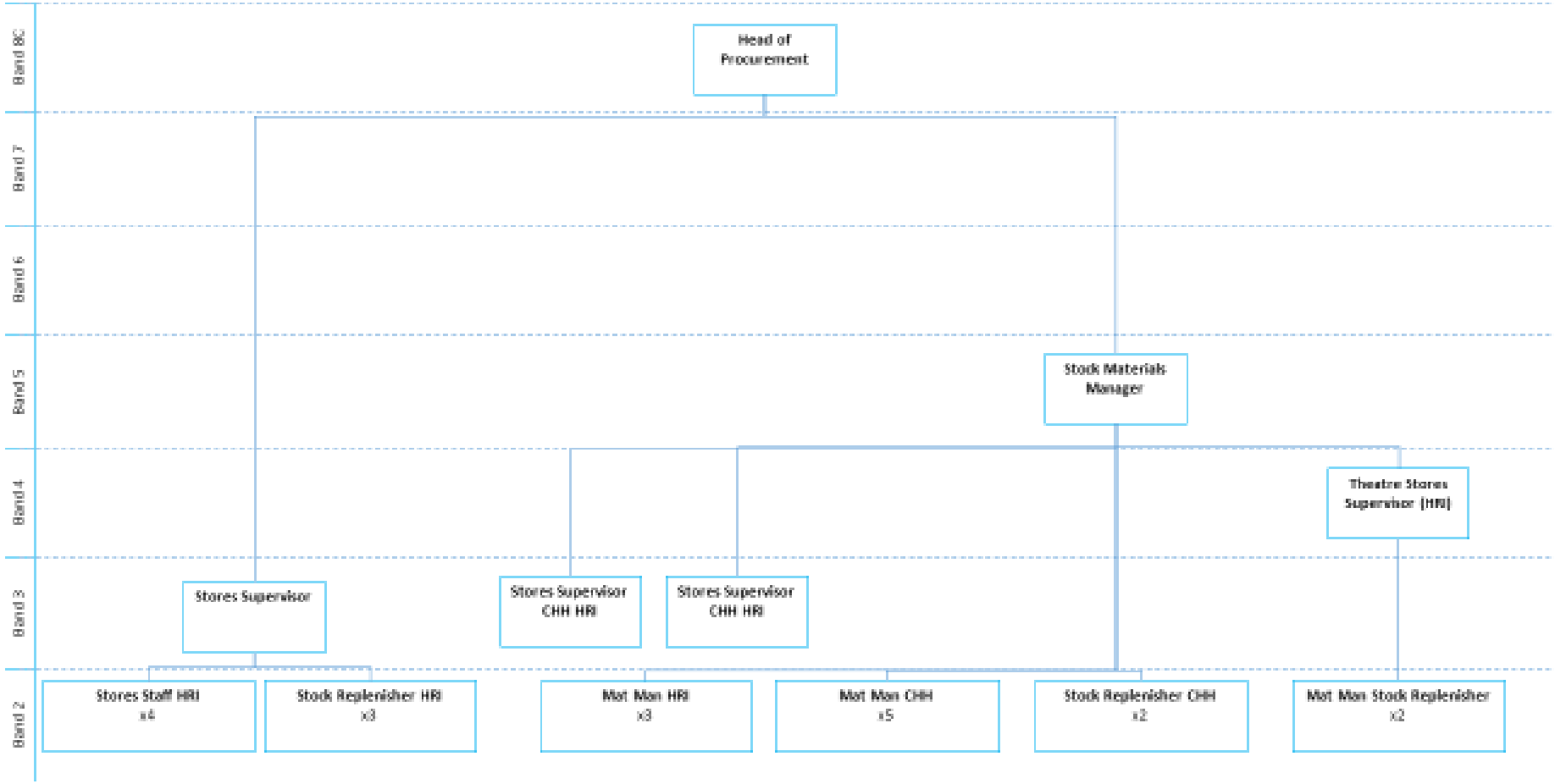


Figure 14 – HUTH Stores and Mat Man

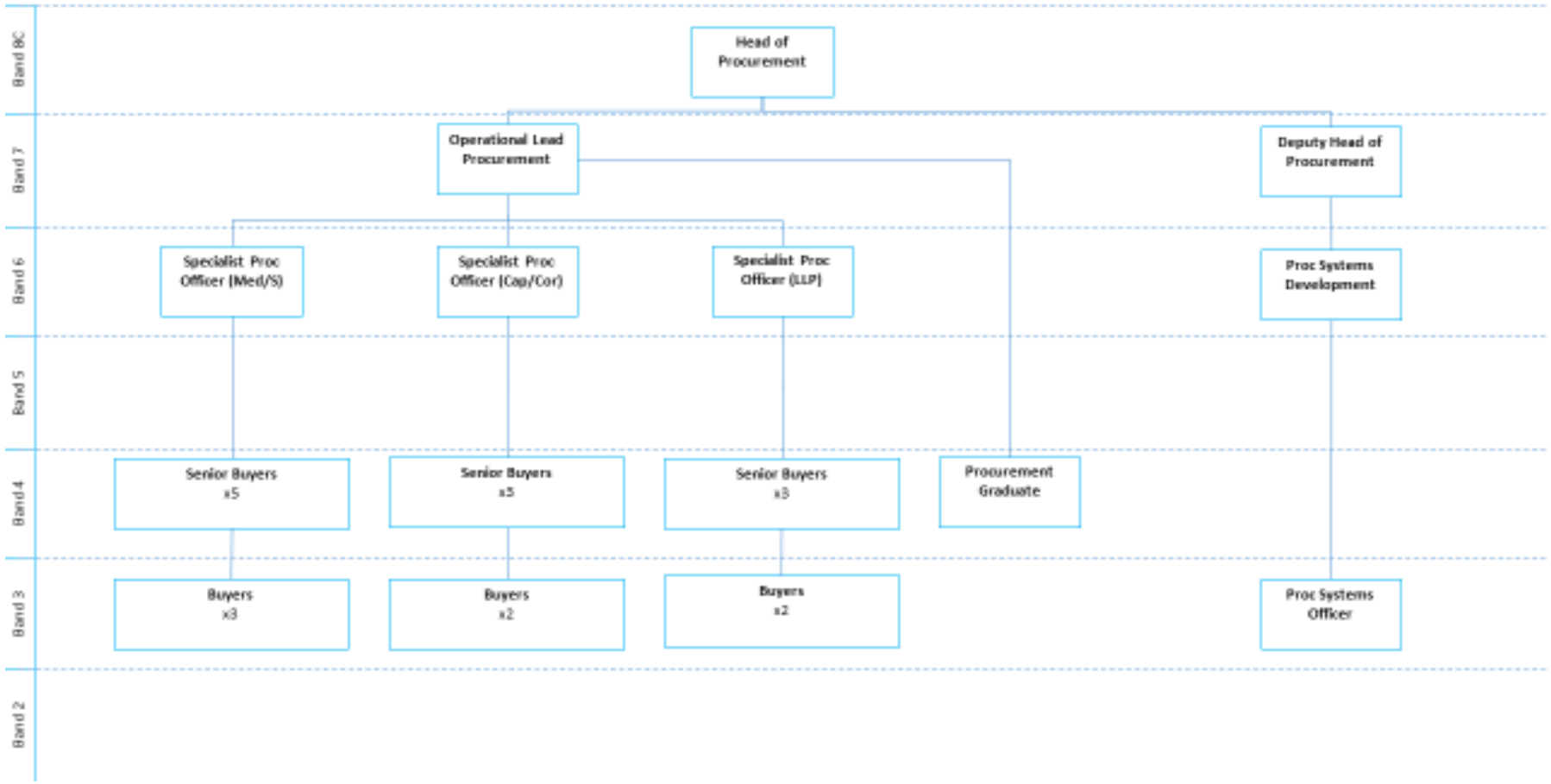


Figure 15 – YSTH Procurement Team

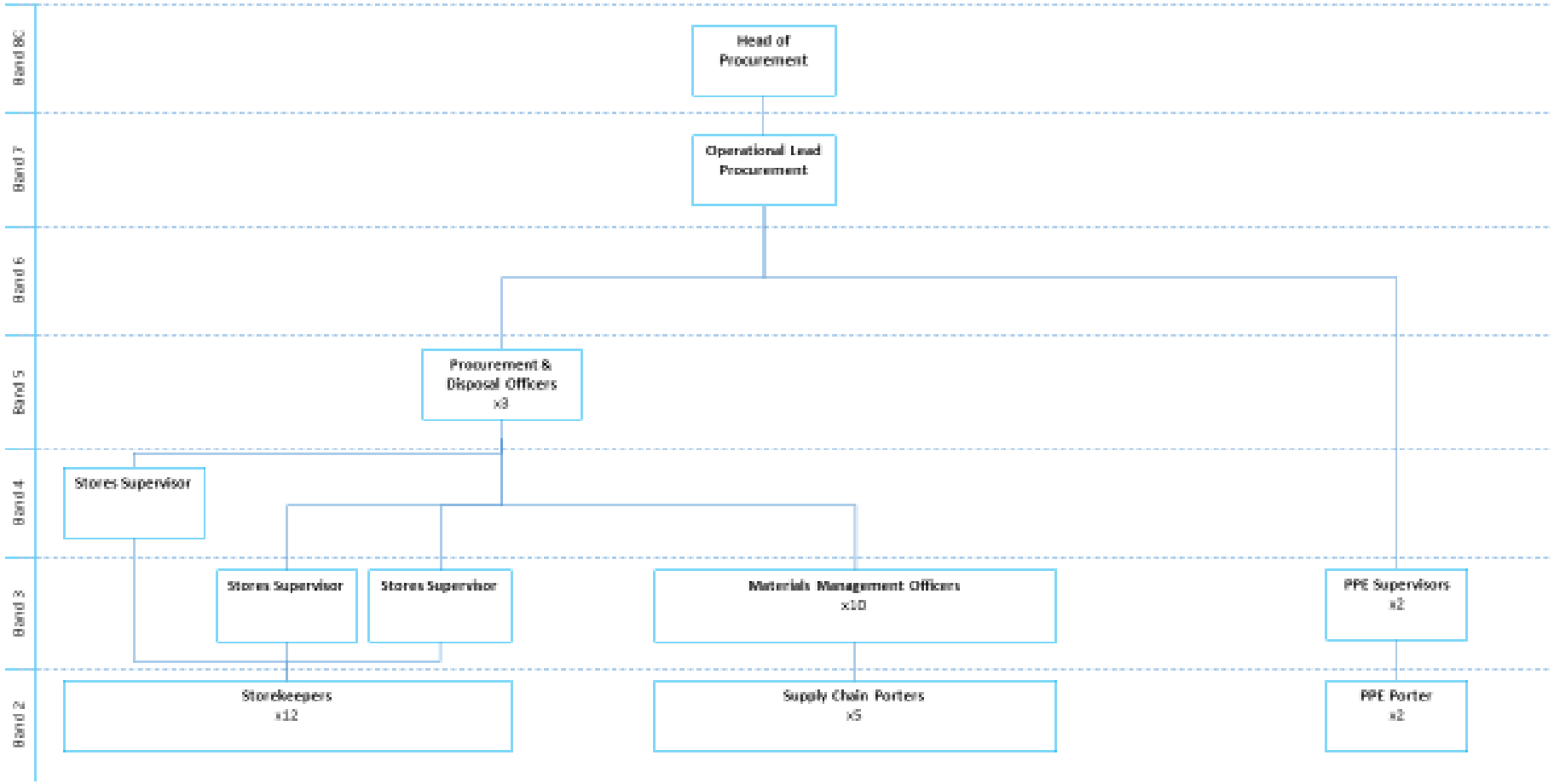


Figure 16 – YSTH Stores & Mat Man

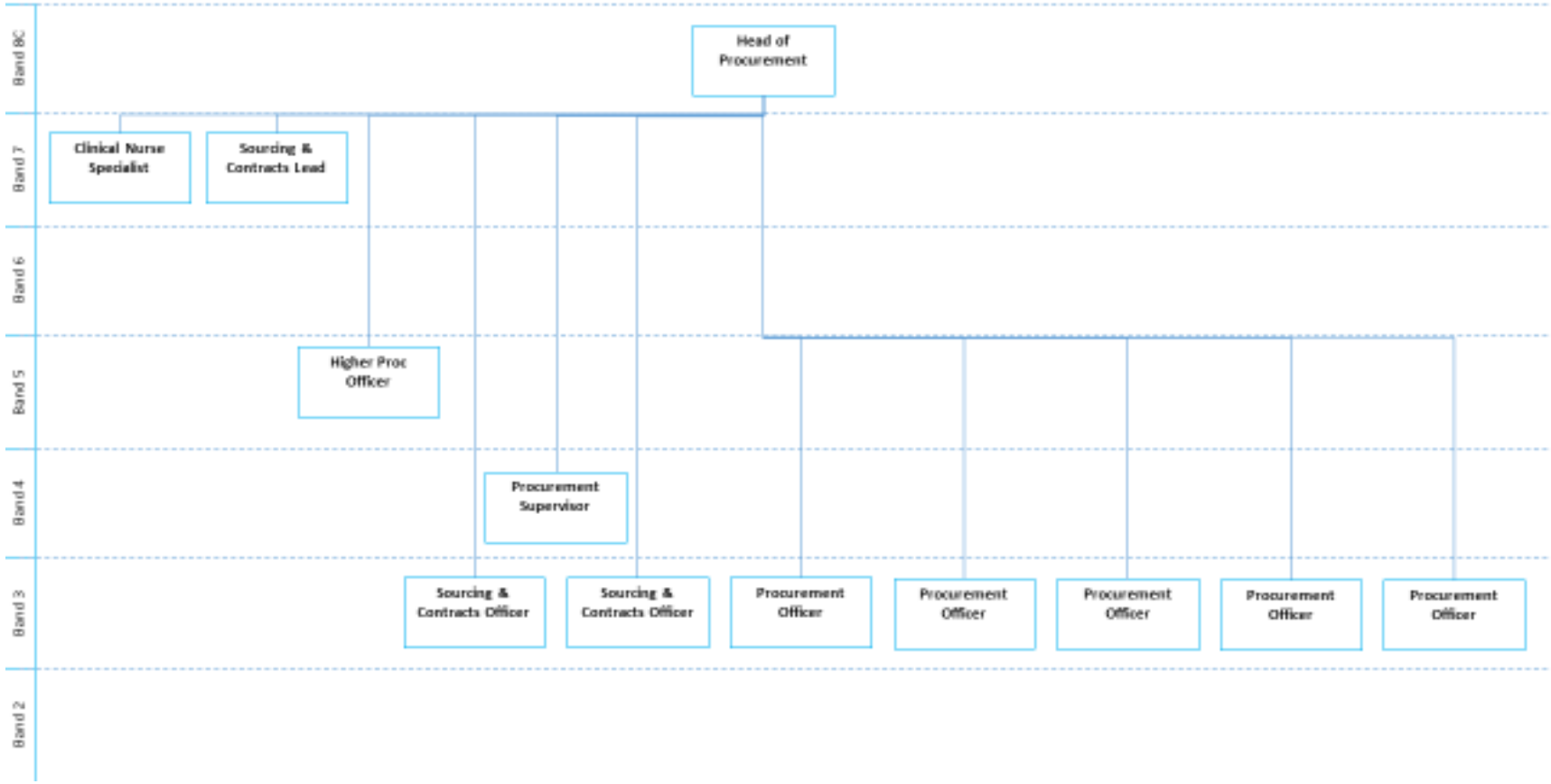


Figure 17 – NLAG Procurement Team

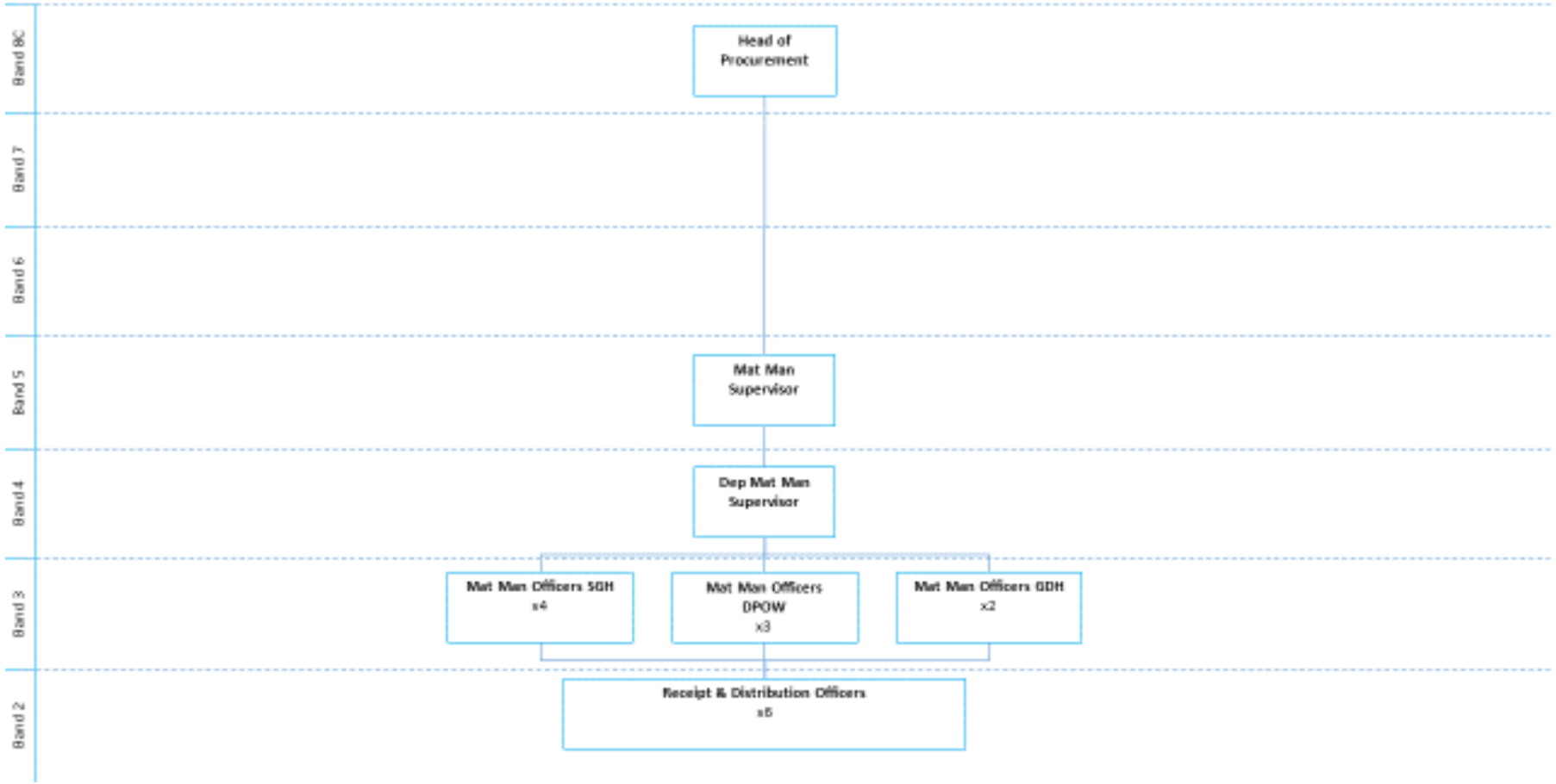


Figure 18 – NLAG Stores & Mat Man

2.5 Scope of Procurement Responsibility

Procurement currently has responsibility for non-pay spend in most areas however there are local exceptions such as:

- Pharmacy - the purchase of drugs;
- Estates & Facilities – not only capital expenditure;
- Purchased Healthcare/ Commissioning.

This leakage needs to be better understood as it will impact the data which sits in purchase order and invoice systems. Under the future procurement offering the HNYPC Board will be required to approve any change in scope of addressable non-pay spend.

3. Key Metrics & Baseline Data

3.1 Addressable Spend & Insights

Obtaining a single version of the truth on Partner Trust expenditure which should be managed by a procurement function has proved incredibly difficult. Addressable spend for Procurement has been calculated following a line by line review of all non-pay spend.

	HUTH	NLAG	YSTH	Total
Total Non-Pay Spend	£427.4m	£221.1m	£395.1m	£1,043.7m
Un-addressable Spend	£174.3m	£92.3m	£226.7m	£493.3m
Excluded Devices	£9.9m	£0	£2.2m	£12.1m
Addressable Spend	£243.2m	£128.8m	£166.2m	£538.2m

Figure 19 – Spend Profile

There is a lot of work that Partner Trusts need to undertake around who they spend their money with and how much they spend. HNYPC aims to put in place IT solutions that deliver one version of the truth on non-pay spend. For the purpose of evaluating expenditure to inform this business case accounts payable data has been used as this is broken down to line level detail allowing interrogation.

Following the receipt of spend, contracts and work-plan data, several reports were created to provide a high-level view of spend to illustrate procurement activity and identify consolidation opportunities. Total spend across the three HNYPC partners, during the baseline period (Jan 21 – Dec 21) was £1,043.7m. Any business fees and payments to government were removed as well as pass through costs from the total spend as these are not addressable by procurement, leaving £538.2m spend.

	HUTH	NLAG	YSTH	Total	Consolidated
Addressable with top 10 suppliers	£106.5m	£52.7m	£62.4m	£221.6	£185.6m
% with top 10 suppliers	43.8%	41%	37.5%	41.2%	34.4%
Number of Addressable Suppliers	2,857	1,706	2,708	7,271	3,812
£ per Supplier	£88.5k	£75.6k	£61.3k	£75.4k	£143.8k
Invoices per annum	102,006	59,570	104,406	265,982	
Invoices without PO	21.47%	56.92%	53.92%	42.15%	
Tier 1 Invoices (£1m+)	21 (£123m)	34 (£85.1m)	40 (£200.6m)	95 (£408.7m)	
Tier 2 Invoices (£100k-£1m)	448 (£127.6m)	178 (£55.5m)	186 (£52.2m)	812 (£235.3m)	
Tier 3 Invoices (£10k-£100k)	3,686 (£100.9m)	1,546 (£39.8m)	2,704 (£71.4m)	7,936 (£212.1m)	
Tier 4 Invoices (<£10k)	97,851 (£75.9m)	57,812 (£40.7m)	101,476 (£70.7m)	257,139 (£187.3)	
Number of Purchase Orders	28,769	28,305	28,042	85,116	

Value of Purchase Orders	£2,119m	£76.5m	£198.1m	£2,394m	

Figure 20 – Spend Breakdown

Where it is possible to provide a consolidated view of the data, for example the three Partner Trusts share a number of suppliers, this has been stated separately above.

Key insights from the analysis of the addressable spend include opportunities for:

- Supplier management consolidation – 3,459 suppliers are currently being managed by two or more Partner Trusts;
- Tail management – 60% / 2,279 of suppliers have a spend of less than £10k;
- Strategic contract management – 60% of the addressable spend is identified as being under contract;
- Reductions in transactional processing – some suppliers are submitting thousands of invoices per year. Consolidating these invoices would save transaction costs as well as contract costs with the outsourced payments provider. As an example, Stryker submitted 2,194 invoices to Hull of which 80% were less than £1,000.

The £538m addressable spend was categorised by e-Class and mapped to each organisations' care groups to understand the resource required for effective business partnering. The figures in the table below do not exactly match the addressable spend set out in the table above as it has not been possible to take out excluded devices at a line level and due to some spend being costed against care groups marked "n/a":

Care Group	Non-Pay Spend	% of Spend
Family Health	£8,217,905.85	2.78%
Surgery & Critical Care	£15,558,059.42	5.26%
Clinical Support Services	£143,345,510.96	48.47%
Specialist Medicine	£29,904,436.01	10.11%
Community & Therapies	£2,613,052.70	0.88%
Emergency & Elderly Medicine	£6,965,947.51	2.36%
Corporate	£89,164,186.14	30.15%
Sub-Total	**£295,769,098.59**	
Capital and Charitable	£243,193,849.50	
Total	**£538,962,948.09**	

Figure 21 – Care Group Non-Pay Spend

The top 20 suppliers to the three trusts are:

Normalised Supplier	Non-Pay Spend	% Share
NHS Supply Chain	£55,905,267.99	10.39%
Kier Construction Ltd	£21,671,539.62	4.03%
Bayer Plc	£18,509,466.99	3.44%
Lloyds Pharmacy Ltd	£17,265,141.00	3.21%
BOOTS UK LTD	£16,173,527.67	3.00%
Roche Diagnostics Ltd	£14,649,347.60	2.72%

HEALTHCARE AT HOME LTD	£13,522,766.61	2.51%
Ocs Group Uk Ltd	£10,091,430.08	1.87%
Lloyds Pharmacy Clinical Homecare Ltd	£9,145,787.05	1.70%
Baxter Healthcare Ltd	£8,724,389.68	1.62%
Fresenius Kabi Ltd	£8,516,282.64	1.58%
Healthcare Solutions (Hull) Ltd	£7,749,394.76	1.44%
SYNERGY LMS	£7,339,843.11	1.36%
Nimbuscare Ltd	£7,296,773.00	1.36%
Alliance Healthcare Distribution Ltd	£7,152,046.54	1.33%
Helix-Cms Ltd	£7,055,580.39	1.31%
Healthnet Homecare Uk Ltd	£6,572,734.75	1.22%
Alloga Uk Ltd	£6,474,135.67	1.20%
Qualasept Ltd	£6,415,888.18	1.19%
Ashcourt Contracts Ltd	£6,228,317.32	1.16%

Figure 22 – Top 20 Suppliers

3.2 Model Hospital Data

The Model Health System is a data-driven improvement tool that supports health and care systems to improve patient outcomes and population health. It provides benchmarked insights across the quality of care, productivity and organisational culture to identify opportunities for improvement. The Model Health System incorporates the Model Hospital, which provides hospital provider-level benchmarking.

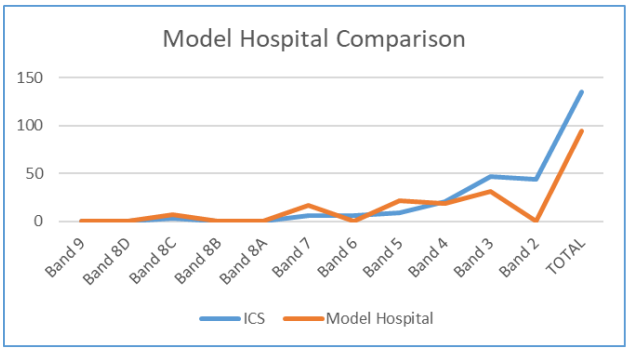
Model Hospital data allows the comparison of back office functions across the NHS based on their as-is operations, it does not provide a 'should-be' status as the NHS moves to working in ICS structures.

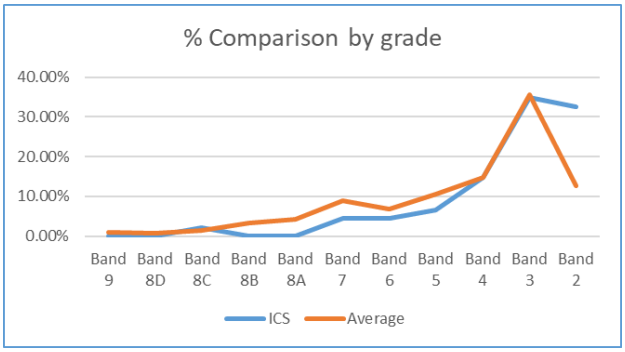
It is still important to compare the performance of the three acute trusts to understand how they perform compared to other NHS providers. Key findings from Model Hospital show:

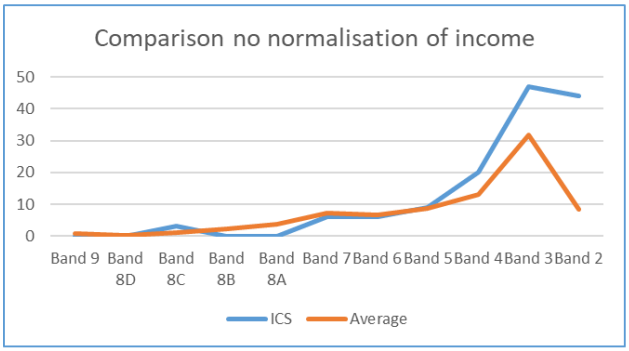
- The national average pay cost of the function is £3.7m against an actual cost of £3.69m;
- The national average FTE in Model Hospital is 95 against an actual FTE return from the Partner Trusts of 118.44;
- Average national cost per post is £39k against an actual cost per post of £34k;
- The majority of the additional posts sits in Materials Management (6 posts) and Receipt & Distribution (13 posts);
- Strategy & Leadership and Procurement Systems are both below the national average;
- Investment in training and development is below the national average of £216 per person per annum with a Partner Trust average of £98;
- Non-pay spend on contract is at 60% against a national average of 85%;
- Transactions on catalogue is in line with the national average;
- Stock holding is almost double of the national average;
- Materials management coverage in clinical areas is 73%, below the national average of 83%;
- Items covered by Materials Management is significantly higher than the national average.

Using the department descriptions and average wage costs provided within the Model Hospital data it is possible to create a 'should-be' structure based on the national

average. This structure includes more posts at the higher grades in Strategy & Leadership and less resource in the lower grades of Materials Management and Receipt & Distribution:







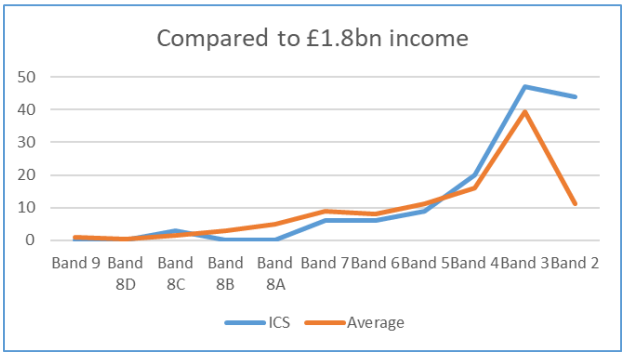


Figure 23 – Model Hospital Grade Data

To check the findings within the Model Hospital data comparisons have been undertaken against 6 other NHS trusts where it was possible to get their structures by grade. Cutting the data in various ways all tells the same story, the three Partner Trusts have significantly more resource at band 2 and less resource at band 5-8b.

Model Hospital uses Trust income as the key comparator. Between the three Partner Trusts the annual income is £1.8bn. Normalising the comparator trusts to the same income doesn't change the key findings around numbers of staff by grade.

Taking Model Hospital data to compare Procurement against other back-office functions across the three Partner Trusts shows it is the second to last area for investment in both pay and non-pay:

Pay	Investment as a % of Income	Investment as a % of non-pay
IM&T	1.13%	3.82%
HR	0.72%	2.43%
Gov & Risk	0.54%	1.83%
Finance	0.43%	1.46%
Procurement	0.20%	0.69%
Payroll	0.10%	0.34%

Non-Pay	Investment as a % of Income	Investment as a % of non-pay
IM&T	1.16%	3.91%
HR	0.25%	0.84%
Finance	0.11%	0.38%
Gov & Risk	0.04%	0.13%
Procurement	0.01%	0.03%
Payroll	0.00%	0.01%

Figure 24 – Corporate Services Investment

IM&T figures are significantly higher than all other back-office areas, the assumption is that this has been impacted by Covid-19. Removing IM&T from the average investment by income and non-pay spend gives an average for pay of 0.4% against income and 1.35% against non-pay. For non-pay function spend the average is 0.08% against income and 0.28% of non-pay spend.

If the average is applied to procurement then the pay budget would increase to £7.2m and non-pay to £1.5m which is an increase of £3.5m in pay and £1.3m non-pay.

Comparison of the Procurement grade split shows procurement to be under resourced between band 4 and 8b compared to other corporate service areas:

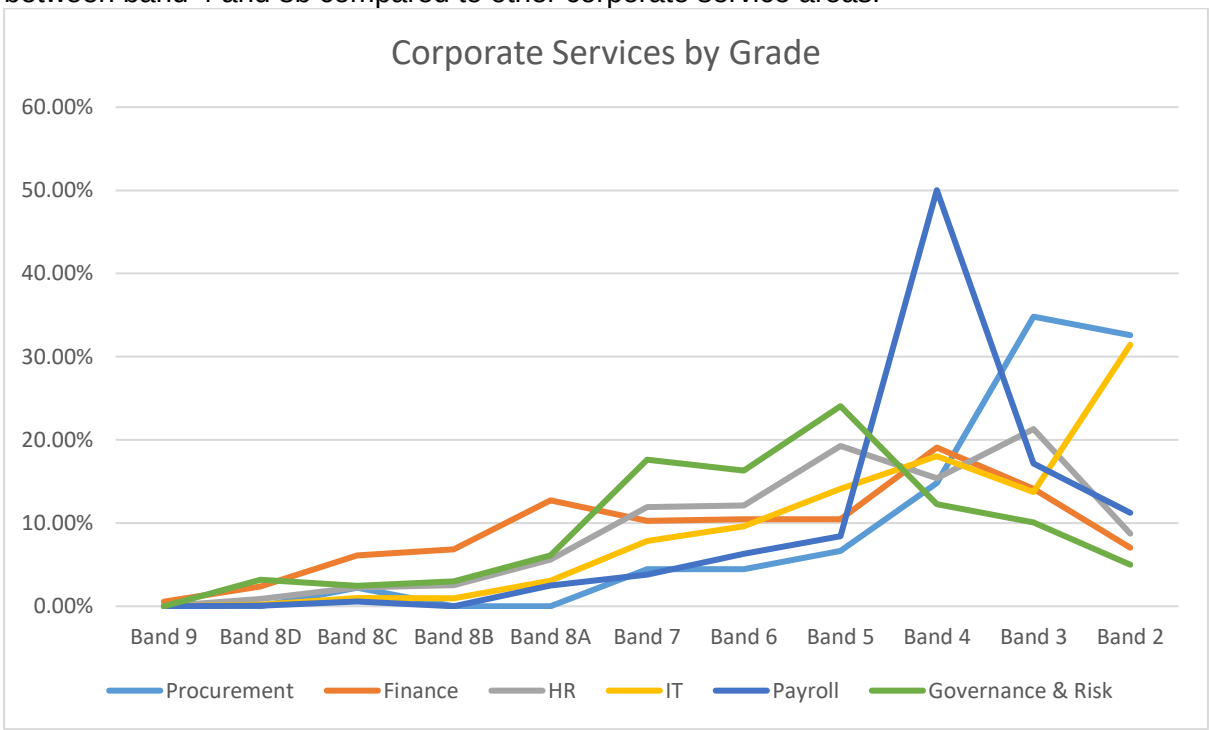


Figure 25 – Corporate Services by Grade

3.3 NHS Spend Comparison Service

The NHS Spend Comparison Service (SCS) was commissioned by NHS Improvement and is provided by NHS Digital on behalf of providers. It provides users with price benchmarking and spend analysis of procurement data for all NHS trusts within NHS England.

All NHS trusts are required to upload their purchase order and accounts payable data to NHS Digital's Strategic Data Collections Service (SDCS). Purchase Order data is collected on a weekly basis and Accounts Payable data is collected monthly. The raw Trust data is then aggregated and cleansed by NHS Digital, and this aggregate database then forms the foundation of the different visualisations and analysis found within the SCS analytics dashboards.

The service enables users to view the underlying data within several different formats, allowing for different methods of analysis, including benchmarking prices paid for goods and services, identifying alternative suppliers and products that may offer better value, as well as identifying inflation, possible sources of alternative stock, and insight into and trends within supply markets.

All three Partner Trusts are now putting their data into the SCS. By its nature, the PO analysis and AP analysis provide slightly different outputs but there are key themes which exist.

	HUTH	NLAG	YSTH	YSTH FM
Spend	£56.3m	£18.9m	£59.8m	£1.1m
% NHS Supply Chain	67.6%	64.7%	32.4%	100%
Suppliers	1,907	1,233	2,100	163
Product Codes	27,062	15,836	24,931	1,360
Variance to Median (£) (Opportunity)	£1.7m	£467k	£880k	£5k
Variance to Median (%) (Opportunity)	3%	2.5%	1.5%	0.4%
Variance to Min (£) (Opportunity)	£5.7m	£1.8m	£3.3m	£23.5k
Variance to Min (%) (Opportunity)	10.2%	9.7%	£5.6%	2%

Figure 26 – Spend Comparison Service Data

The data within the SCS suggests savings between £3m (variance to median) and £10m (variance to minimum). Each of the presented saving opportunities would need to be validated to ensure that the opportunity is achievable.

3.4 Contract Data & Work Plan 2022/23

The three Heads of Procurement were asked to share their contract databases and work plan for 2022/23. The work plans derive from contracts that need to be re-procured as well as new requirements raised through engagement with the business. The information provided shows that:

- There are 3,008 contracts in place across the three Partner Trusts;
- £445.6m is currently registered against these contracts however it should be noted a number of contracts (20%) have no value against them;
- 1,118 (37%) of the contracts have expired but these only represent 8% of the total contract value (£39m);
- The work plan for 2022/23 has 1,425 projects with a procurement value of £247m;

- There are significant opportunities for collaboration with either 2 or all 3 Partner Trusts having the same contracts on the work plan;
- Around 805 of the contracts on the work plan could be procured through a NHSSC framework;
- Around 236 of the contracts on the work plan could be procured through a NOECPC framework;
- 477 contracts are not covered by NHSSC or NOECPC frameworks.

The recommendation set out within this paper would not be able to immediately address the backlog of contracts which need to be renewed but these would need to be prioritised with the total number of projects also being reduced through collaboration.

3.5 Key Performance Indicators

The three procurement teams' performance is currently managed and monitored through the following key performance indicators:

3.5.1 Model Hospital Key Performance Indicators

KPI	HUTH	NLAG	YSTH	Peer
Clinical areas serviced by the Procurement function	75%	80%	64.9%	81%
Items covered by Materials Management	9,228	18,000	21,512	2,834
Purchase orders raised via top-up through Materials Management	12,729	5,000	24,279	11,056
Procurement function professional development spend per 'Procurement' function FTE	£43	£149	£101	£215
Apprenticeship levy drawdown for Procurement as percentage of 'Procurement' function pay cost	0%	0%	0%	1%
Number of 'Procurement' function staff accessing the apprenticeship levy drawdown for training as percentage of 'Procurement' function FTEs	4%	4%	0%	9%
Number of apprentices recruited in year for Procurement as percentage of 'Procurement' function FTEs	0%	4%	0%	7%
Non-pay spend on contract (%)	63.8%	31.5%	83.3%	85.7%
Transactions on eCatalogue (%)	95.4%	72.5%	96.5%	93.9%
Invoices matched to an e-PO (% by value)	87%	68.1%	85.1%	88.4%
Invoices matched to an e-PO (% by count)	91.6%	92%	91.9%	91.1%
PO lines transmitted through EDI (% by count)	88.4%	72.5%	74.1%	86.5%
Invoice lines transmitted through EDI (% by count)	88.%	72.5%	96.8%	73.6%
Supplies and services cost per WAU	£225	£282	£288	£236
Influenceable non-pay spend on PO (%)	73.2%	59.7%	61.8%	67.4%
Total non-pay spend on PO (%)	11.8%	11.6%	13.8%	10.7%
Supply chain expenditure as a proportion of non-pay expenditure (%)	7%	7.7%	7.7%	4%
Supply chain expenditure as a proportion of influenceable expenditure (%)	13.3%	13.10%	18.3%	9.5%
Supply chain expenditure as a proportion of clinical and general supply expenditure (%)	17.6%	26.2%	22.6%	16.4%
Dynamic days of stock cover			60.4	100.5
Static days of stock cover*	67.2	69.1	30.8	36.1

Variance from minimum price (%)	23.1%	23%	21.7%	20.6%
Variance from median price (%)	5.6%	4.7%	4.9%	4.5%
Variance for top 100 products (%)	13.5%	14.1%	15%	12.5%
Variance for top 500 products (%)	14.2%	14.5%	14.6%	12.5%
Products achieving best price in Top 500 products (%)	26.4%	28.4%	28%	29.2%
Blank MPCs (%)	1.3%	3.7%	5.6%	2.1%
Blank unit of measures (%)	0%	0%	0%	0%
Single organisation MPC (%)	0%	0%	0%	0%
Blank E-Class code (%)	9.7%	11.1%	19.9%	11.4%
Blank contract references (%)	6.9%	6.5%	21.7%	5.9%

Figure 27 – KPI Data

* Static days of stock cover are calculated by taking the inventory value of clinical and general supplies at year end (the year end stock take) and divided by to spend during year on clinical and general supplies and then multiplied by 365.

3.5.2 Trust Specific KPIs

Procurement within the three Partner Trusts is not measured on performance using KPIs which are Trust specific. Reporting of performance is linked to the model hospital key dataset above. To ensure that procurement, and those working in procurement, can evidence how they support their organisations to meet their aims and objectives, clear KPIs should be set out for procurement and reflected within individual's performance management documents.

NHS Procurement KPIs tend to measure the transactional performance of the team rather than the strategic achievements. Examples from other trusts include:

- Percentage Authorisation Transfers – reducing the number of requisition or purchase order approvals which are delegated from the nominated individual;
- Number of Contracts – reducing the number of contracts which have expired;
- Price Variance – reducing the number of invoices on hold as the price does not match the price of the purchase order;
- Processed Invoices – reducing the number of invoices processed without a purchase order;
- Purchase Order Buyer Intervention – reducing the need for buyers to intervene in purchase order raising through automation and better catalogue management;
- Purchase Order Three-Way Auto Matched – increasing the number of invoices that can be auto matched as the quantity and cost is correct;
- Percentage of Purchase Order Lines on Catalogue – increasing the number of purchase orders covered by catalogue;
- Savings Achievement – tracking savings achieved against target;
- Single Tender Waivers – reducing the number of single tender waivers received;
- Absence Rates – tracking staff absence rates;
- Appraisals Achieved – tracking the status of staff appraisals;
- Staff Professional Membership – increasing the number of staff who are members of a profession;
- Staff Turnover Rate – reducing the turnover rate;
- Vacant Positions – reduction in the number of vacant positions within the organisation;
- Continual Professional Development – tracking mandatory training rates;

- Speed of Procurement Transaction – increasing the speed for requisitions to be processed and orders to be receipted;
- Expenditure through Procurement – spend covered by contract or PO raised by procurement compared to total non-pay spend;
- Average Shelf Life – reducing the amount of stock held;
- Inventory Waste – reducing the amount of stock which is wasted through damaged, lost or beyond date.

4. Options Appraisal

4.1 Organisational Form

In developing this business case consideration has been given to the range of delivery vehicles potentially open to the Partner Trusts. The options considered are listed below with the recommendations produced as a result of engagement with Trust Executive Leads.

Each of the options is scored against the following criteria which was set out by the Trust Executive Leads:

- Supports the aims and vision of the ICS and collaborative members;
- Creates a single procurement function which will help support the sustainable provision of clinical and non-clinical services;
- Establishes the collaborative as a centre of procurement and commercial excellence which provides procurement and commercial services to its member organisations;
- Supports supplier rationalisation and cost savings;
- Ensures standardised robust product selection and range management practices are in place;
- Ensures that policies, practices and procedures are standardised and provide for the effective provision of procurement to the collaborative trusts;
- Ensures innovative and robust Supplier Relationship Management (SRM);
- Develops P2P e-commerce processes and systems to ensure smooth and efficient processing for all purchasing requirements;
- Enables effective partnering with senior stakeholders, internal customers and suppliers;
- Ensures all staff are given the opportunity to develop their potential.

4.2 Option 1 – Business as Usual (BAU)

4.2.1 Description

Maintain the procurement structures as-is under the current Partner Trusts with each procurement team providing dedicated procurement support to their own Trust.

4.2.2 Net Costs

The existing cost to running the procurement teams would remain:

	HUTH	NLAG	YSTH	Total
Annual Pay Budget	£1,152,509	£941,600	£1,636,461	**£3,730,570**
Annual Non-Pay Budget	£58,800	£31,700	£69,470	**£159,970**
Other Non-Pay Adjustments	£0.00	£0.00	(£154,773)	**(£154,773)**
Total Cost	**£1,211,309**	**£973,300**	**£1,551,158**	**£3,735,767**

Figure 28 – Option 1 Cost

The other non-pay adjustments refer to an income target at YSTH from selling equipment which is no longer required within the Trust.

4.2.3 Return on Investment

The return on investment for option 1 maintains the existing savings delivery and assumes no further improvement is made on the existing savings targets:

	Year 1	Year 2	Year 3	Year 4	Year 5
Cash Releasing Savings	£2,185,806	£2,185,806	£2,185,806	£2,185,806	£2,185,806
Cost Avoidance Savings	£0.00	£0.00	£0.00	£0.00	£0.00
Total Benefit	£2,185,806	£2,185,806	£2,185,806	£2,185,806	£2,185,806
Cumulative Benefit	£2,185,806	£4,371,612	£6,557,418	£8,743,224	£10,929,030
Total Cost	£3,735,767	£3,735,767	£3,735,767	£3,735,767	£3,735,767
Return on Investment	0.59	0.59	0.59	0.59	0.59

Figure 29 – Option 1 ROI

At present Partner Trusts do not calculate or record cost avoidance savings which is why these are zeroed.

4.2.4 Advantages

The advantages of the BAU option are:

- If the operations of the existing teams are reviewed this option could meet the aims and visions of each Trust individually;
- If the way in which each of the Partner Trust procurement teams is reviewed it could lead to standardised robust product selection and range management practices being in place in each individual Trust;
- It would only ensure that policies, practices and procedures are standardised and provide for the effective provision of procurement to each individual Partner Trust if each of these are reviewed in isolation;
- If each of the existing Partner Trust e-commerce processes are reviewed independently it could develop P2P e-commerce processes and systems to ensure smooth and efficient processing for all purchasing requirements on a per Trust basis;
- It could enable effective partnering with senior stakeholders, internal customers and suppliers on a per Trust basis if each Partner Trust procurement team increased their stakeholder engagement independently.

4.2.5 Disadvantages

This option does not address the following concerns with the current service:

- It would not meet the aims and vision of the ICS;
- It does not create a single procurement function which will help support the sustainable provision of clinical and non-clinical services;
- It will not establish the collaborative as a centre of procurement and commercial excellence which provides procurement and commercial services to its member organisations;
- It does not support supplier rationalisation and cost savings;
- It does not ensure innovative and robust Supplier Relationship Management;
- It doesn't ensure all staff are given the opportunity to develop their potential as the full range of roles and opportunities are open to all.

4.2.6 Conclusion

This option is discounted on the basis it does not meet the objectives set for collaborative procurement as set out in 4.9 below.

4.3 Option 2 – Do Minimum (Soft Collaboration)

4.3.1 Description

Maintain procurement as is in separate Partner Trusts but have a more formal arrangement around working together. This could be undertaken by adapting the MOU as to how to work together which has already been agreed by the three Partner Trusts. This could see the three Partner Trusts agree their joint work plans at the start of the year and how resource would be equally released to deliver joint procurement. It would however result in the awarding of separate contracts, therefore not delivering volume benefits.

4.3.2 Net Costs

It is assumed that the existing running costs remain as there will be no additional cost to soft collaboration, there could however be an increase in non-pay savings:

	HUTH	NLAG	YSTH	Total
Annual Pay Budget	£1,152,509	£941,600	£1,636,461	**£3,730,570**
Annual Non-Pay Budget	£58,800	£31,700	£69,470	**£159,970**
Other Non-Pay Adjustments	£0.00	£0.00	(£154,773)	**(£154,773)**
Total Cost	**£1,211,309**	**£973,300**	**£1,551,158**	**£3,735,767**

Figure 30 – Option 2 Cost

4.3.3 Return on Investment

The return on investment for option 2 increases year-on-year with Procurement becoming self-sufficient in year 2. Some additional marginal benefits are delivered through soft collaboration:

	Year 1	Year 2	Year 3	Year 4	Year 5
Cash Releasing Savings	£2,453,543	£5,714,830	£5,714,830	£8,406,264	£8,406,264
Cost Avoidance Savings	£0.00	£0.00	£0.00	£0.00	£0.00
Total Benefit	£2,453,543	£5,714,830	£5,714,830	£8,406,264	£8,406,264
Cumulative Benefit	£2,453,543	£8,168,373	£13,883,204	£22,289,467	£30,695,731
Total Cost	£3,735,767	£3,735,767	£3,735,767	£3,735,767	£3,735,767
Return on Investment	0.66	1.53	1.53	2.25	2.25

Figure 31 – Option 2 ROI

4.3.4 Advantages

The advantages of the soft collaboration option are:

- If the operations of the existing teams are reviewed this option could meet the aims and visions of each Partner Trust individually;
- Soft collaboration between the Partner Trusts could lead to standardised robust product selection and range management practices being in place across the Partner Trusts on a case-by-case basis;
- It would only ensure that policies, practices and procedures are standardised and provide for the effective provision of procurement to each individual Partner Trust if each of these are reviewed in isolation;
- It could support supplier rationalisation and cost savings on a case-by-case basis;

- If each of the existing Partner Trust e-commerce processes are reviewed independently it could develop P2P e-commerce processes and systems to ensure smooth and efficient processing for all purchasing requirements on a per Trust basis;
- It could enable effective partnering with senior stakeholders, internal customers and suppliers on a per Trust basis if each Partner Trust procurement team increased their stakeholder engagement independently.

4.3.5 Disadvantages

This option does not address the following concerns with the current service:

- It would not meet the aims and vision of the ICS;
- It does not create a single procurement function which will help support the sustainable provision of clinical and non-clinical services;
- It will not establish the collaborative as a centre of procurement and commercial excellence which provides procurement and commercial services to its member organisations;
- It does not ensure innovative and robust Supplier Relationship Management;
- It doesn't ensure all staff are given the opportunity to develop their potential as the full range of roles and opportunities are open to all.

4.3.6 Conclusion

This option is discounted on the basis it does not meet the objectives set for collaborative procurement as set out in 4.9 below.

4.4 Option 3 – Establish Outsourced Shared Service

4.4.1 Description

Establish a separate strategic procurement function which each Trust pays into based on spend/use. The establishment of the function would be similar to the YSTH Facilities Management LLP, whereby the shared service provides services to its members but can also attract commercial income from selling procurement services to other organisations.

4.4.2 Net Costs

As this option is unlikely to be approved a cost model has not been complete for this option.

4.4.3 Advantages

The advantages of establishing an outsourced shared service option are:

- Supports the aims and vision of the ICS and collaborative members for strategic procurement;
- Creates a single strategic procurement function which will help support the sustainable provision of clinical and non-clinical services;
- Establishes the collaborative as a centre of strategic procurement and commercial excellence which provides procurement and commercial services to its member organisations;
- Supports supplier rationalisation and cost savings;
- Ensures standardised robust product selection and range management practices are in place;
- Ensures that policies, practices and procedures are standardised and provide for the effective provision of strategic procurement to the collaborative trusts;

- Ensures innovative and robust Supplier Relationship Management centrally;
- Develops P2P e-commerce processes and systems to ensure smooth and efficient processing for all strategic purchasing requirements;
- Enables effective partnering with senior stakeholders, internal customers and suppliers;
- Ensures strategic staff are given the opportunity to develop their potential.

4.4.4 Disadvantages

This option does not address the following concerns with the current service:

- This option does not support the aims and vision of the ICS and collaborative members for operational procurement;
- There is a risk with this option that operational procurement is not seen as a centre of procurement excellence and this has an adverse impact on the strategic procurement function;
- There is a risk that policies, practices and procedures are not standardised for operational procurement which impact on the strategic procurement function;
- There is a risk that operational procurement e-commerce processes and systems are not developed which undermine the work of the strategic procurement team;
- Operational procurement staff would not have the same opportunity to develop their potential;
- This option would be considered a significant transaction and would require NHSEI and HMRC approval.

4.4.5 Conclusion

This option is discounted on the basis that it would require special approval from NHSEI and HMRC as it would be considered a significant transaction which would require the tax treatment of such an agreement to be approved. It is not believed that this approval would be given.

4.5 Option 4 – Single Procurement Organisation/ Separate Finances

4.5.1 Description

Centralise the existing Trust procurement teams but leave the operational elements of Procurement (PO raising and invoice management) at a Partner Trust level.

4.5.2 Net Costs

There would be development costs for establishing the shared service and triple running costs for maintaining three separate finance/e-procurement systems:

	HUTH	NLAG	YSTH	Total
Baseline Pay Budget	£1,152,509	£941,600	£1,636,461	**£3,730,570**
Increase/Investment	£425,916	£425,916	£425,916	**£1,277,747**
Option 4 Annual Pay Budget	£1,578,425	£1,367,516	£2,062,377	**£5,008,317**
Baseline Non-Pay Budget	£58,800	£31,700	£69,470	**£159,970**
Increase/Investment	£86,543	£86,543	£86,543	**£259,628**
Option 4 Non-Pay Budget	£145,343	£118,243	£156,013	**£419,598**
Capital Spend	£44,300	£44,300	£44,300	**£132,900**

Other Non-Pay Adjustments	£0	£0	(£154,773)	**(£154,773)**
Baseline Total Cost	**£1,211,309**	**£973,300**	**£1,551,158**	**£3,735,767**
Total Cost	**£1,768,068**	**£1,530,059**	**£2,107,915**	**£5,406,042**

Figure 32 – Option 4 Cost

4.5.3 Return on Investment

The return on investment for option 4 increases year-on-year with Procurement becoming self-sufficient in year 2. Some additional marginal benefits are delivered through soft collaboration:

	Year 1	Year 2	Year 3	Year 4	Year 5
Cash Releasing Savings	£2,668,618	£6,131,528	£9,252,042	£12,163,325	£15,074,608
Cost Avoidance Savings	£600,000	£2,150,000	£5,100,000	£10,737,002	£10,697,002
Total Benefit	£3,268,618	£8,281,528	£14,352,042	£22,900,328	£25,771,611
Cumulative Benefit	£3,268,618	£11,550,146	£25,902,188	£48,802,515	£74,274,126
Total Cost	£5,406,042	£5,263,142	£5,263,142	£5,263,142	£5,263,142
Return on Investment	0.60	1.57	2.73	4.35	4.90

Figure 33 – Option 4 ROI

4.5.4 Advantages

The advantages of the single procurement organisation/separate finances option are:

- To some extent this option supports the aims and vision of the ICS and collaborative members;
- To some extent this option creates a single procurement function which will help support the sustainable provision of clinical and non-clinical services;
- Establishes the collaborative as a centre of procurement and commercial excellence which provides procurement and commercial services to its member organisations;
- Supports supplier rationalisation and cost savings;
- Ensures standardised robust product selection and range management practices are in place;
- This option ensures that to some extent policies, practices and procedures are standardised and provide for the effective provision of procurement to the collaborative trusts;
- To some extent this option ensures innovative and robust Supplier Relationship Management;
- Enables effective partnering with senior stakeholders, internal customers and suppliers;
- Ensures all staff are given the opportunity to develop their potential.

4.5.5 Disadvantages

This option does not address the following concerns with the current service:

- Separate systems for purchase orders and invoicing based on Trust finance systems will lead to procurement teams having to enter one contract onto multiple systems. This will not lead to efficiencies for the supplier and their back-office costs which could be passed onto HNYPC and would not be seen as effective SRM;

- There is a risk with this option that if the collaborative procurement function is using different systems they will be following the separate policies and processes of each of the trusts finance teams;
- P2P e-commerce processes and systems would remain separate for each organisation and would therefore require additional administration as the same information is re-keyed into separate systems. This is not a smooth and efficient processing for all purchasing requirements;
- Reporting and data management would be impacted as spend information would continue to sit in three systems which would impact Contract Management;
- Depending upon the organisational structure, the Partner Trust who hosts HNYPC may act as the Contracting Authority for all three trusts but does not control the payment of invoices. Any late payment of an invoice by another Partner Trust could see the host organisation receive a challenge or claim for costs.

4.5.6 Conclusion

This option is discounted as it does not deliver all of the efficiencies that a fully collaborative procurement function can bring.

4.6 Option 5 – Single Procurement Organisation and Finances

4.6.1 Description

Centralise the existing Trust procurement teams as well as non-pay spend so only one system for PO/invoice is required for each contract awarded.

4.6.2 Net Costs

The alternative resourcing structure would require funding for the specialist roles which cannot be resourced from elsewhere e.g. Clinical Procurement Specialists and more senior roles required to deliver change:

	HUTH	NLAG	YSTH	Total
Baseline Pay Budget	£1,152,509	£941,600	£1,636,461	**£3,730,570**
Increase/Investment	£253,436	£253,436	£253,436	**£760,307**
Option 5 Annual Pay Budget	£1,405,945	£1,195,036	£1,889,897	**£4,490,878**
Baseline Non-Pay Budget	£58,800	£31,700	£69,470	**£159,970**
Increase/Investment	£110,107	£110,107	£110,107	**£330,322**
Option 5 Non-Pay Budget	£168,907	£141,807	£179,577	**£490,292**
Capital Spend	£44,300	£44,300	£44,300	**£132,900**
Other Non-Pay Adjustments	£0	£0	(£154,773)	**(£154,773)**
Baseline Total Cost	**£1,211,309**	**£973,300**	**£1,551,158**	**£3,735,767**
Total Cost	**£1,619,152**	**£1,381,143**	**£1,959,001**	**£4,959,297**

Figure 34 – Option 5 Cost

4.6.3 Return on Investment

The return on investment for option 5 increases thought to year 5 when the benefits of supplier rationalisation reduce as they have been delivered during previous years:

	Year 1	Year 2	Year 3	Year 4	Year 5
Cash Releasing Savings	£6,248,378	£9,248,662	£12,369,175	£15,110,608	£18,064,892
Cost Avoidance Savings	£700,000	£2,250,000	£5,150,000	£10,757,003	£10,707,002
Total Benefit	£6,948,378	£11,498,662	£17,519,175	£25,867,611	£28,771,894
Cumulative Benefit	£6,948,378	£18,447,040	£35,966,215	£61,833,826	£90,605,720
Total Cost	£4,959,297	£4,816,397	£4,816,397	£4,816,397	£4,816,397
Return on Investment	1.40	2.39	3.64	5.37	5.97

Figure 35 – Option 5 ROI

4.6.4 Advantages

The advantages of the single procurement organisation and finances option are:

- Supports the aims and vision of the ICS and collaborative members;
- Creates a single procurement function which will help support the sustainable provision of clinical and non-clinical services;
- Establishes the collaborative as a centre of procurement and commercial excellence which provides procurement and commercial services to its member organisations;
- Supports supplier rationalisation and cost savings;
- Ensures standardised robust product selection and range management practices are in place;
- Ensures that policies, practices and procedures are standardised and provide for the effective provision of procurement to the collaborative trusts;
- Ensures innovative and robust Supplier Relationship Management;
- Develops P2P e-commerce processes and systems to ensure smooth and efficient processing for all purchasing requirements;
- Enables effective partnering with senior stakeholders, internal customers and suppliers;
- Ensures all staff are given the opportunity to develop their potential.

4.6.5 Disadvantages

This option meets all of the criteria set out so no disadvantages have been listed.

4.6.6 Conclusion

This option is supported as it meets all of the criteria in table 4.9 below as agreed by the trust's executive leads and contained in the HNYPC Procurement Strategy. However, it is recognised that this option is requesting a significant investment in back office expenditure at a time when finances across the NHS are stretched and inflation is pushing the costs higher. Not addressing opportunities in procurement however will mean that both cost and cost avoidance savings will be missed. This case evidences significant improvement and opportunity for the Partner Trusts.

The capability and grade mix of existing resource provides significant challenge to deliver a transformation in the way procurement operates and the way it is perceived by customers across the three Partner Trusts. New resource will be required to deliver change but equally importantly, new resource will be required to help change the

culture of the existing resources. This business case will fundamentally change the way procurement operates in the Partner Trusts making it much more engaging, proactive and will reduce unnecessary paper-based bureaucracy.

4.7 Option 6 – Join Another ICS Procurement Collaborative

4.7.1 Description

Speak to other ICS Procurement collaborative organisations who may be further advanced to add HNY strategic procurement requirements to their existing structures and plans. Use the existing operational procurement workforce to manage local engagement as business managers.

4.7.2 Net Costs

The cost of this option would need to be scoped up with another collaborative based on a specification of services.

4.7.3 Advantages

The advantages of the join another ICS procurement collaborative option are:

- So long as the specification of requirements clearly sets out the requirements this option could support the aims and vision of the ICS and collaborative members;
- Creates a single procurement function which will help support the sustainable provision of clinical and non-clinical services;
- Supports supplier rationalisation and cost savings;
- Ensures standardised robust product selection and range management practices are in place;
- Ensures that policies, practices and procedures are standardised and provide for the effective provision of procurement to the collaborative trusts;
- Ensures innovative and robust Supplier Relationship Management;
- Develops P2P e-commerce processes and systems to ensure smooth and efficient processing for all purchasing requirements;
- Enables effective partnering with senior stakeholders, internal customers and suppliers.

4.7.4 Disadvantages

This option does not address the following concerns with the current service:

- As this would be outsourced it does not establish the collaborative as a centre of procurement and commercial excellence which provides procurement and commercial services to its member organisations;
- Depending on where this service is provided it would not ensure all staff are given the opportunity to develop their potential.

4.7.5 Conclusion

This option is discounted as following discussion with NHSEI there are no other ICS procurement teams far enough advanced to be able to provide this service.

4.8 Option 7 – Outsource Procurement

4.8.1 Description

Run a competition to outsource the procurement function to a standalone provider.

4.8.2 Net Costs

The cost of this option would need to be scoped up with an outsourced provider based on a specification of services.

4.8.3 Advantages

The advantages of the outsource procurement option are:

- So long as the specification of requirements clearly sets out the requirements this option could support the aims and vision of the ICS and collaborative members;
- Creates a single procurement function which will help support the sustainable provision of clinical and non-clinical services;
- Supports supplier rationalisation and cost savings;
- Ensures standardised robust product selection and range management practices are in place;
- Ensures that policies, practices and procedures are standardised and provide for the effective provision of procurement to the collaborative trusts;
- Ensures innovative and robust Supplier Relationship Management;
- Develops P2P e-commerce processes and systems to ensure smooth and efficient processing for all purchasing requirements;
- Enables effective partnering with senior stakeholders, internal customers and suppliers.

4.8.4 Disadvantages

This option does not address the following concerns with the current service:

- As this would be outsourced it does not establish the collaborative as a centre of procurement and commercial excellence which provides procurement and commercial services to its member organisations;
- Depending on where this services is provided it would not ensure all staff are given the opportunity to develop their potential;
- The three Partner Trusts would need to agree how to manage the contract for the outsourced service. At present contract management is identified as an activity requiring improvement.

4.8.5 Conclusion

This option is discounted as it does not establish a commercial centre of excellence nor ensure that all staff are given the opportunity to develop.

4.9 Option Appraisal

The options which were not discounted as part of the long list have been scored against the 10 criteria as agreed by the trust's executive leads and contained in the HNYPC Procurement Strategy:

	Option 1	Option 2	Option 4	Option 5
Supports the aims and vision of the ICS and collaborative members.				

Creates a single procurement function which will help support the sustainable provision of clinical and non-clinical services.				
Establishes the collaborative as a centre of procurement and commercial excellence which provides procurement and commercial services to its member organisations.				
Supports supplier rationalisation and cost savings.				
Ensures standardised robust product selection and range management practices are in place.				
Ensures that policies, practices and procedures are standardised and provide for the effective provision of procurement to the collaborative trusts.				
Ensures innovative and robust Supplier Relationship Management (SRM).				
Develops P2P e-commerce processes and systems to ensure smooth and efficient processing for all purchasing requirements				
Enables effective partnering with senior stakeholders, internal customers and suppliers.				
Ensures all staff are given the opportunity to develop their potential.				
Total	**5**	**6**	**15**	**20**

Figure 36 – Options Appraisal

The ROI has also been compared across the options which were shortlisted for costing which shows option 5 outperforms other options. The as-is option is the only one which does not increase the ROI above 1:

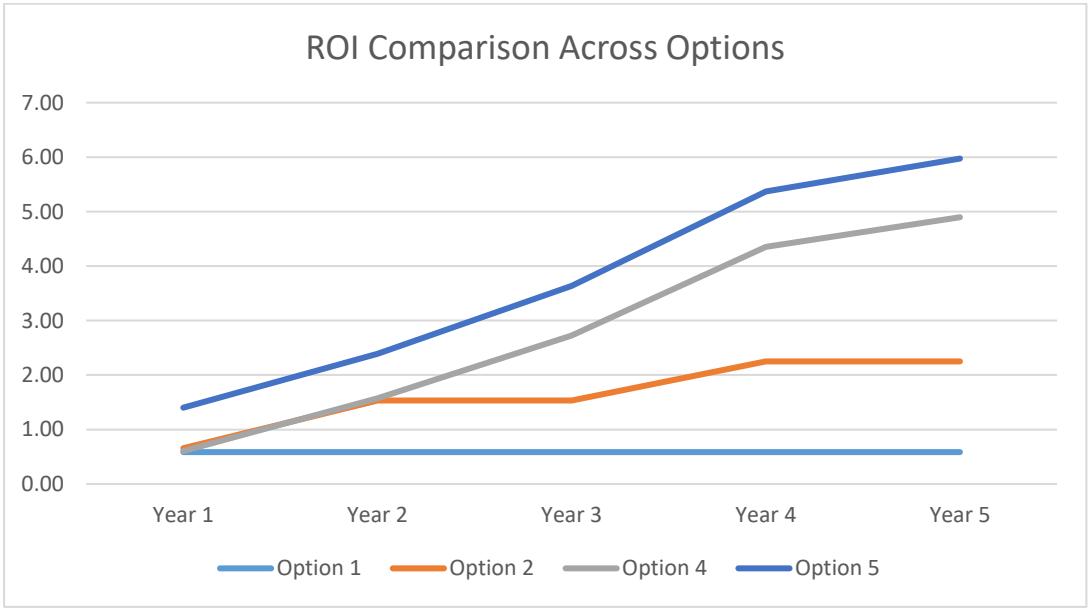


Figure 37 – ROI Comparison

The savings predictions have also been plotted over the five year period with the current estimated inflation figures included. The Bank of England expects inflation to peak at 11% during the next 12 months reducing to 2% in a couple of years' time. Only options 4 and 5 deliver financial benefit above inflation after three years:

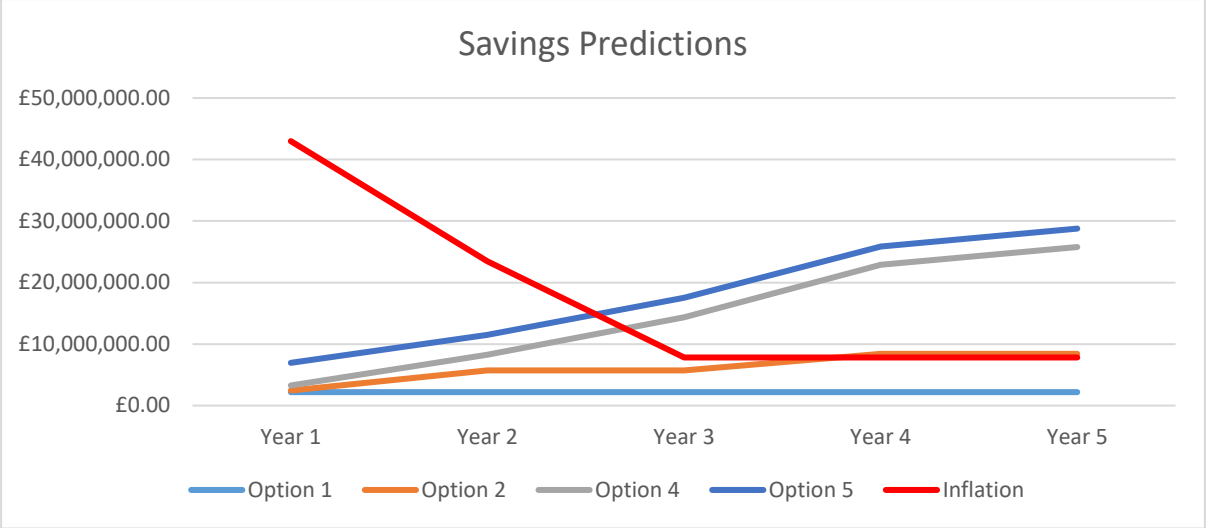


Figure 38 Savings Predictions

Based on the assessment against the criteria in table 4.9, as agreed by the trust's executive leads and contained in the HNYPC Procurement Strategy, the ROI and savings prediction, option 5 is identified as the preferred option and therefore explored in further detail in the following sections.

5. Preferred Option – Organisation Form & Governance Structure

5.1 Formal Establishment of the HNYPC

Three options have been considered as part of the organisational form in terms of how the procurement collaborative will be established and managed moving forward. Consideration is also given as to how to manage new organisations wishing to join the collaborative in the future. This ensures that a fair and transparent approach is set out at the beginning. The three options considered are:

- As-Is – individuals and costs will remain as per the current Partner Trust structures;
- Full Centralisation – all resource is moved to one Partner Trust and managed centrally;
- Transitional – centralisation happens over a period of time with elements of cost and risk being shared between Partner Trusts.

Governance processes were set out for the HNYPC as part of the MoU signed by all Trusts in June 2022. At a meeting of the Procurement Board in October 2022 it was agreed that the procurement function should be centralised under HNYPC which should be hosted by HUTH. To assure the HUTH Board around the risks and mitigating actions of this, a formal legal agreement will be established to ratify these arrangements. The development of the legal arrangement will include work with legal and finance colleagues across the HNYPC to legally formalise the governance behind the shared service (in particular with reference to the requirements of Regulation 12(7) of the Public Contracts Regulations 2015). This is also important so that suppliers are aware that HNYPC employees represent all Partner Trusts. Development of this business case has been delayed by the reluctance of suppliers to share individual Trust data with the DoP who is perceived as only acting on behalf of one Trust.

It is proposed that the agreement will set out how the three Partner Trusts will cooperate between themselves for purchasing and supplies activity. The HNYPC Board will be responsible for managing the performance of the DoP in fulfilling the service obligations. The HNYPC will provide a collaborative framework where-by purchasing and supplies activities can be delivered by and on behalf of the Partner Trusts. The remit will include recommendations as to the best commercial solution or route to market and where appropriate may include challenge to service leads in terms of demonstrating best value.

5.2 Establishment Costs

The current key financial figures per Partner Trust which could impact the decision as to how establishment costs are apportioned are:

Expenditure	HUTH	NLAG	YSTH	Total
Pay	£1,152,509	£941,600	£1,636,461	**£3,730,570**
Non-Pay	£58,800	£31,700	£69,470	**£159,970**
Total	**£1,211,309**	**£973,300**	**£1,705,931**	**£3,890,540**
Proportion	31.13%	25.02%	43.85%	
Headcount	35.38	27.62	55.54	**118.54**
Proportion	30%	23%	47%	
Organisational Income	£727m	£478m	£616m	**£1.8bn**
Proportion	40%	26%	34%	
Addressable Non-Pay Spend	£243.2m	£128.8m	£166.2m	**£538.2m**

Proportion	45.19%	23.94%	30.88%	

Figure 39 – Establishment Costs

It is therefore possible to apportion costs for HNYPC in five different ways:

- As a proportion of existing establishment cost;
- As a proportion of existing headcount;
- As a proportion of organisational income;
- As a proportion of non-pay spend;
- Equally split between each Partner Trust.

The benefits and constraints of each approach is set out below:

Approach	Benefits	Constraints
Proportion of existing establishment cost	Each Partner Trust proportionately increases its existing establishment cost equally	Partner Trusts who have funded the Procurement function to a higher level historically cover the cost of Partner Trusts who have historically underfunded the function
Proportion of existing headcount	Each Partner Trust proportionately increases its cost in line with existing headcount equally	Partner Trusts who have had a higher headcount historically cover the cost of Partner Trusts who have historically had a lower headcount
Proportion of organisational income	Partner Trusts with the greatest income from offset the cost of the procurement function	Organisational income is not linked to procurement activity so is not a fair baseline
Proportion of non-pay spend	Procurement activity is driven by non-pay expenditure so is a fair baseline on which to apportion the cost of the function	Partner Trusts who have historically underfunded Procurement activity in comparison to non-pay spend will have a greater cost to pick up
Equal between all Partner Trusts	Each Partner Trust is equally invested in the new Procurement collaborative	Partner Trusts who have funded the Procurement function to a higher level historically cover the cost of Partner Trusts who have historically underfunded the function

Figure 40 – Benefits of Scoring Approach

At the Procurement Board in October 2022 all options were reviewed and it was agreed that Procurement establishment costs (pay and non-pay) are apportioned equally between the three Partner Trusts.

5.2.1 As-Is

All current pay and non-pay costs stay with each Partner Trust. Any additional investment in establishment costs are funded by the Partner Trusts equally.

Using the costs set out in Option 5 above there is a request to increase pay spend by £760,307 and non-pay by £330,322 for HNYPC. Splitting the increase equally across the three Partner Trusts would increase existing budgets:

Expenditure	HUTH	NLAG	YSTH
Pay Budget	£1,152,509	£941,600	£1,636,461
Additional Pay	£253,436	£253,436	£253,436
Non-Pay Budget	£58,800	£31,700	£69,470
Additional Non-Pay	£110,107	£110,107	£110,107
Income Target	£0	£0	(£154,773)

Total	**£1,574,852**	**£1,336,843**	**£1,914,701**
Total Increase	**£363,543**	**£363,543**	**£363,543**

Figure 41 – As-Is Pay & Non-Pay

The benefits of the as-is approach is that it uses existing Partner Trust processes and procedures and will allow for performance reporting at a budget line and organisational level. The constraints of this approach is that it drives duplication into the system with three different budgets to manage for a single central function. Non-pay costs would need to be split in such a way that each Partner Trust picks up its proportionate cost where the requirement may be single and central e.g. a single e-commerce IT system across HNYPC.

5.2.2 Full Centralisation

All current pay and non-pay costs are centralised to a single Partner Trust and to a single budget line. Any additional investment on establishment costs are funded by the Partner Trusts equally with the additional funding transferred to the single Partner Trust and central budget.

Using the same example as above:

Expenditure	HUTH	NLAG	YSTH
Additional Pay	£253,436	£253,436	£253,436
Additional Non-Pay	£110,107	£110,107	£110,107
Pay Budget (inc. transferred)	£4,490,878	£0	£0
Non-Pay Budget (inc. transferred)	£490,292	£0	£0
Income Target	(£154,773)	£0	£0
Total	**£4,826,397**	**£0**	**£0**

Figure 42 – Full Centralisation Pay & Non-Pay

The benefits of the centralisation approach is that it brings all pay and non-pay budget responsibility for HNYPC into one reporting structure making financial reporting and management easier. The constraints of this approach is that it requires financial transfers between organisations and could leave HUTH with the risk of any non-payment or late payment by other Partner Trusts. This risk is considered as low.

5.2.3 Transitional

All current pay costs are retained in their existing Partner Trusts with non-pay and new additional costs centralised to HUTH. As pay costs are reduced at Partner Trusts through individuals leaving posts these funds would then be centralised to HUTH and a single budget line.

Using the same example as above:

Expenditure	HUTH	NLAG	YSTH
Additional Pay	£760,308	£0	£0
Additional Non-Pay	£330,321	£0	£0
Pay Budget	£1,152,509	£941,600	£1,636,461
Non-Pay Budget	£159,970	£0	£0
Income Target	(£154,773)	£0	£0
Total	**£2,248,335**	**£941,600**	**£1,363,461**

Figure 43 – Transitional Pay & Non-Pay

The benefits of this approach are that it allows existing pay costs to remain within existing budget lines and to only transfer pay costs at the point in which additional cost is approved or existing cost is released. The constraints of this approach are that it will be difficult to continually monitor and manage and will require multiple budget transfers between Partner Trusts.

The recommendation is that the transitional approach is followed with all non-pay and additional cost centralised to HUTH. Existing pay costs will stay with the current employing Trust until the post becomes vacant, at which point the vacant post funds will be transferred to HUTH. Budget responsibility for all pay and non-pay costs transfers to the HNYPC DoP.

5.3 HR & Employment

Although not essential, it would make sense for the HR and Employment options to mirror the establishment cost approach to ensure parity and fairness. Each option is however set out below.

5.3.1 As-Is

All staff remain employed by their existing Partner Trust and work collaboratively under a single management structure. New posts and roles are advertised on a rotational basis between Partner Trusts based on the agreed establishment using existing headcount.

Using Option 5 the requirement is for £760,307 pay cost which represents an additional 14 FTE these would be employed on the following basis:

Expenditure	HUTH	NLAG	YSTH
Headcount	39.15	27.12	52.17
Proportion	33.05%	22.90%	44.05%
Additional to recruit	4.63	3.21	6.17
Total	**43.78**	**30.33**	**58.34**

Figure 44 – As-Is HR & Employment

The benefit of this approach is that each Partner Trust increases its headcount proportionately to meet the needs of HNYPC. The constraints of this approach are that it becomes messy when dealing in decimal points of a FTE and that it will not promote any single team ethos across the different Partner Trusts.

5.3.2 Full Centralisation

All staff transfer to a single Trust for their employment and pay. All new roles are appointed by the single Partner Trust with funding transferred as per the agreed establishment cost set out above.

Using Option 5:

Expenditure	HUTH	NLAG	YSTH
Proportion	33.05%	22.90%	44.05%
Additional to recruit	14	0	0
Centralised headcount	118.54	0	0
Total	**132.54**	**0**	**0**

Figure 45 – Full Centralisation HR & Employment

The benefits of this approach is it provides better team cohesion as well as greater clarity to applicants around the organisation they are employed by and who they are working for. The only constraint is for HUTH to ensure that the finances flow to support the additional cost and that there is no risk of any non-payment or late payment by other Partner Trusts. There is also a considerable and unsettling HR process to go through where staff TUPE to HUTH.

5.3.3 Transitional

Existing staff stay employed with their current Partner Trust, with all new employments made by HUTH. This would include both additional resource as well as new recruitment for existing posts that are vacant.

Using Option 5:

Expenditure	HUTH	NLAG	YSTH
Headcount	39.15	27.12	52.17
Proportion	33.05%	22.90%	44.05%
Additional to recruit	14	0	0
Total	**53.15**	**27.12**	**52.17**

Figure 46 – Transitional HR & Employment

The benefit of this approach is it minimises HR process and support required to move people from one Partner Trust to HUTH. This could provide a quicker and smoother transition to the new organisation. The constraints of this approach are that it could generate the view of a split workforce.

Based on the above, the recommendation is that the transactional approach is followed. All staff will remain employed by their existing Partner Trust and would only transfer if they applied for a new role within HNYPC. All new roles and vacant roles would be recruited by HUTH with budget adjustments made as appropriate. Each Partner Trust also retains their own HR risk around any future structure.

5.4 Contracting Authority & Risk Management

Every contract entered into by HNYPC will need to be entered into by an organisation with legal standing - a Contracting Authority. HNYPC aims to generate benefit through procurement by centralising procurement, maximising the use of our resources and delivering value for money to our Partner Trusts. A collaborative procurement exercise could result in one or more contracts being awarded.

5.4.1 As-Is

Each Partner Trust will maintain its current contracts and will award its own contracts after a collaborative procurement exercise is completed. This will then lead to separate purchase orders, invoices and payments, it is therefore important this aligns to non-pay spend management set out below. The fact that separate contracts will be entered into after the procurement exercise will need to be clearly set out to bidders in advance.

As an example HNYPC undertake ten collaborative procurement exercises within the first 12 months:

Contract	HUTH	NLAG	YSTH
Waste Services	£8,000,000	£44,000	£3,700,000
Laundry Services	£3,700,000	£1,000,000	£5,200,000
e-Rostering	£1,077,964	£1,218,180	£1,002,000

Interpretation	£1,857,117	£350,000	£275,373
Car Parking Services	£6,014,385	£1,377,890	£58,000
Temporary Staffing	£6,348,780	£5,000,000	£8,000,000
Orthotics	£2,000,000	£66,500	£1,600,000
Hips & Knees	£4,075,505	£1,000,000	£1,000,000
Procedure Packs	£694,000	£450,000	£560,000
Mesh	£150,000	£80,000	£120,000
Total	**£33,917,751**	**£10,586,570**	**£21,515,373**

Figure 47 – As-Is Contracting Authority

Although £66m of contracts will have been entered into, each Partner Trust would act as the Contracting Authority and underwrite the risk of their proportion of the contract entered into.

The benefits of this approach is that it keeps ownership and responsibility of risk as is with each Partner Trust. The constraint of this approach is that it does not achieve the ambition for collaborative procurement across HNYPC. Although a collaborative procurement exercise will be undertaken, separate contracts will still be awarded and the cost of business to the supplier will not change. This could also lead to complications in contract management especially if this is not consistent between Partner Trusts.

5.4.2 Full Centralisation

All existing contracts are novated to a single Partner Trust who also acts as the Contracting Authority and takes the risk associated with future procurement activity. This is then managed through finance transfers in line with the establishment costs set out above.

Using the example above this would mean that HUTH would underwrite the risk of all £66m of contracts entered into by HNYPC:

Contract	HUTH	NLAG	YSTH
Waste Services	£11,744,000	£0	£0
Laundry Services	£9,900,000	£0	£0
e-Rostering	£3,298,144	£0	£0
Interpretation	£2,482,490	£0	£0
Car Parking Services	£7,450,275	£0	£0
Temporary Staffing	£19,348,780	£0	£0
Orthotics	£3,666,500	£0	£0
Hips & Knees	£6,075,505	£0	£0
Procedure Packs	£1,704,000	£0	£0
Mesh	£350,000	£0	£0
Total	**£66,019,694**	**£0**	**£0**

Figure 48 – Centralised Contracting Authority

The benefits of this approach are that this achieves the ambition of centralising procurement activity across HNYPC and that the cost of doing business can be reduced. This will also support contract management activity as there will only be one contract to manage, rather than three. The constraints of this approach are that HUTH takes all of the risk associated with contracting.

This however could be covered by an agreement by all Partner Trusts to underwrite the risk of their element of the contract in the background either undertaken on a

contract-by-contract basis or through a blanket approach based on income of each organisation which links to their financial ability to cover risk.

Using this approach the risk underwriting £66m as a basket would be:

Expenditure	HUTH	NLAG	YSTH
Proportion	40%	26%	34%
Total	**£26,407,877**	**£17,165,120**	**£22,446,696**

Figure 49 – Risk Underwriting

5.4.3 Transitional

Each Partner Trust will maintain its current contracts and all new contracts are entered into on a rotational basis between the Partner Trusts. This means that the risk is shared between each of the Partner Trusts on a rotational basis and it would be agreed as part of the procurement strategy which Contracting Authority would manage each contract. This would be linked as closely as possible to the proportions set out above.

Using the example above this would mean:

Contract	HUTH	NLAG	YSTH
Proportion	40%	26%	34%
Total	**£26,407,877**	**£17,165,120**	**£22,446,696**
Waste Services	£0	£11,744,000	£0
Laundry Services	£9,900,000	£0	£0
e-Rostering	£0	£0	£3,298,144
Interpretation	£2,482,490	£0	£0
Car Parking Services	£7,450,275	£0	£0
Temporary Staffing	£0	£0	£19,348,780
Orthotics	£3,666,500	£0	£0
Hips & Knees	£0	£6,075,505	£0
Procedure Packs	£1,704,000	£0	£0
Mesh	£350,000	£0	£0
Total	**£25,553,265**	**£17,819,505**	**£22,646,924**
Proportion	38.7%	27%	34.3%

Figure 50 – Transitional Contracting Authority

The benefit of this approach is that all organisations take a share of the risk of being a Contracting Authority, both the procurement risk but also subsequent contract management risk. The constraints of this approach are that it assumes all contracts cover equal risk, which they don't, and it requires ongoing management to ensure contracts fit the agreed proportion. As evidenced above the outcome is slightly different to the agreed proportion so some level of tolerance would need to be agreed in advance.

Based on the above, the recommended approach would be that HUTH acts as Contracting Authority however existing contracts are not novated to HUTH, it is only for future contracts. The reason for this is that HUTH would need to undertake due diligence on the contracts to novate which would take time and incur cost. These legacy contracts would still be managed by HNYPC on behalf of each Partner Trust. Additional legal guidance is provided to HUTH around risk and mitigations of this approach.

5.5 Non-Pay Spend Management

Spend management refers to the way in which the administration element of procurement is undertaken. Once the contracts are awarded, purchase orders will need to be raised to allow the supplier to raise an invoice and payment to be made once confirmation the goods, works or services have been received to the expected quality. Consistent feedback from supplier engagement is that spend management, the cost of doing business, needs to be considered rather than expecting savings just from saying collaboration is happening. This element is closely linked to the decision around Contracting Authority.

5.5.1 As-Is

Each Partner Trust will raise a purchase order on their own e-financial system based on the contract that has been awarded. This will allow each Partner Trust to receive an invoice and charge this to the local ledger.

Using the example above, once the contracts are awarded each Partner Trust will raise a purchase order for the contract:

Contract	HUTH	NLAG	YSTH
Waste Services	£8,000,000	£44,000	£3,700,000
Laundry Services	£3,700,000	£1,000,000	£5,200,000
e-Rostering	£1,077,964	£1,218,180	£1,002,000
Interpretation	£1,857,117	£350,000	£275,373
Car Parking Services	£6,014,385	£1,377,890	£58,000
Temporary Staffing	£6,348,780	£5,000,000	£8,000,000
Orthotics	£2,000,000	£66,500	£1,600,000
Hips & Knees	£4,075,505	£1,000,000	£1,000,000
Procedure Packs	£694,000	£450,000	£560,000
Mesh	£150,000	£80,000	£120,000
Total	**£33,917,751**	**£10,586,570**	**£21,515,373**

Figure 51 – As-Is Non-Pay Management

The benefit of this approach is that there is no change to the current finance ways of working. The constraint of this approach is that it does not reduce the cost of business to the supplier so could impact the value for money achieved. Depending upon the decision around Contracting Authority there would also be additional risk for the Contracting Authority if they were not in control of the payment process as well. Should a decision be made to either centralise or have a transitional arrangement around the Contracting Authority but retain the as-is payment process, the Contracting Authority could find themselves in breach of contract should another Partner Trust not pay an invoice on time.

5.5.2 Full Centralisation

Non-pay spend is centralised under HUTH with purchase orders, invoices and payments managed by HUTH. This approach would require each Partner Trust to agree to transfer its non-pay budget to HUTH.

Using the example above the payment process would be:

Contract	HUTH	NLAG	YSTH
Proportion	40%	26%	34%
Budget to transfer	**£26,407,877**	**£17,165,120**	**£22,446,696**

Waste Services	£11,744,000	£0	£0
Laundry Services	£9,900,000	£0	£0
e-Rostering	£3,298,144	£0	£0
Interpretation	£2,482,490	£0	£0
Car Parking Services	£7,450,275	£0	£0
Temporary Staffing	£19,348,780	£0	£0
Orthotics	£3,666,500	£0	£0
Hips & Knees	£6,075,505	£0	£0
Procedure Packs	£1,704,000	£0	£0
Mesh	£350,000	£0	£0
Total	**£66,019,694**	**£0**	**£0**

Figure 52 – Centralised Non-Pay Management

The benefit of this approach is that the cost of doing business for the supplier would reduce as there would only be HUTH to engage with and this should lead to greater value for money. This would also allow the risk for any centralised Contracting Authority to be managed as they would also manage the payment process. The constraint of this option is that HUTH would hold the risk around contract variations which lead to price changes. Other Partner Trusts may see an opportunity to increase the scope of the contract as they perceive this to be free on the basis they are not paying. This would have to be managed through the contract management function by HNYPC.

5.5.3 Transitional

All non-pay spend is funded by HUTH with budget transfers completed in the background back to individual Partner Trust budget lines. Rather than the non-pay budget being centralised at the start of the year HUTH would recharge each Partner Trust their proportion of the contract cost.

Using the example above the budget transfer process moves to the end of the process and would allow finance teams to recharge each cost centre at a Partner Trust level:

Contract	HUTH	NLAG	YSTH
Waste Services	£11,744,000	£0	£0
Laundry Services	£9,900,000	£0	£0
e-Rostering	£3,298,144	£0	£0
Interpretation	£2,482,490	£0	£0
Car Parking Services	£7,450,275	£0	£0
Temporary Staffing	£19,348,780	£0	£0
Orthotics	£3,666,500	£0	£0
Hips & Knees	£6,075,505	£0	£0
Procedure Packs	£1,704,000	£0	£0
Mesh	£350,000	£0	£0
Total	**£66,019,694**	**£0**	**£0**
Proportion	40%	26%	34%
Trust recharge	**£26,407,877**	**£17,165,120**	**£22,446,696**

Figure 53 – Transitional Non-Pay Management

The benefit of this approach is that it allows finance teams at each Partner Trust to charge non-pay spend to local cost centres. This may lead to better local management of resources. The constraints of this approach are that it adds additional cost to finance

in managing the recharging process and only allows for non-pay spend to be reconciled at the end of the commitment.

Based on the above the recommendation is that non-pay spend is centralised to HUTH and recharged to each Partner Trust to be charged at a cost centre and budget holder level so they can take ownership of all expenditure. HUTH will establish a cash account that will need to be cleared at the end of each month to ensure the transactions do not impact the financial accounts of HUTH.

5.6 Addition of New Partner Trusts

Should other trusts wish to become a Partner Trust of HNYPC then the chosen proportionality calculations will be recalculated and adjusted for at the begging of the next financial year and approved by the Procurement Board.

A decision will also need to be made around any additional cost incurred by Partner Trusts prior to a new Partner Trust joining. For example, if the Partner Trusts agree additional pay and non-pay expenditure which is funded between the three original Partner Trusts and a new Partner Trust joins within the first 12 months a decision needs to be made as to whether they should be charged a proportion of the additional establishment cost.

5.6.1 Establishment Costs

The recommendation is that all non-pay costs are fully centralised to HUTH with pay costs remaining with the existing Trust. Additional future costs are then proportioned across Partner Trusts and budget transferred to HUTH.

For simplicity the recommendation is that any new member will only be charged for the proportionate cost at the start of each financial year. They may transfer their non-pay budget to HUTH part way through a financial year on a proportionate basis.

For example, if a new Partner Trust were to join on 1st October they would budget transfer 50% of non-pay costs to HUTH. On 1st April of the following year their non-pay spend would be included as part of the calculation of the proportionate charge. This new proportionate charge would also be used for any additional funding requested by HNYPC.

5.6.2 HR & Employment

The recommendation is that the transitional approach is followed. All staff will remain employed by their existing Partner Trust and would only transfer if they applied for a new role within HNYPC. All new roles and vacant roles would be recruited by HUTH with budget adjustments made as appropriate.

Following this approach the new Partner Trust would transfer vacant posts to HUTH either to recruit into or to be subsumed in the current structure. All existing staff from the new Partner Trust would remain on their employment until applying for another role within HNYPC or leaving their post.

5.6.3 Contracting Authority & Risk

The recommended approach is that HUTH acts as the Contracting Authority however existing contracts are not novated to HUTH, it is only for future contracts. The reason for this is that HUTH would need to undertake due diligence on the contracts to novate

which would take time and incur cost. These legacy contracts would still be managed by HNYPC on behalf of each Partner Trust.

The new Partner Trust would need to accept HUTH acting as the Contracting Authority for all future collaborative contracts.

5.6.4 Non-Pay Spend Management

Based on the above the recommendation is that non-pay spend is centralised to HUTH and recharged to each Partner Trust to be charged at a cost centre and budget holder level so they can take ownership of all expenditure.

The new Partner Trust would be recharged at the cost centre level for all collaborative procurements.

5.7 Governance Structure

The current governance structure does not suit the needs or unlock the benefits associated with a collaborative strategy. Current governance aligned to individual organisations, impedes collaborative procurement operations and collaborative opportunities realisation, results in multiple inconsistent approval processes and creates a duplication of effort for HNYPC Partner Trusts. It has also been found that there is a lack of clarity on requirements amongst the Partner Trusts and there is no single forum to hold procurement accountable, inhibiting on traceability and auditability.

A new governance structure has been designed which shows how the HNYPC will integrate into its Partner Trusts. HNYPC will be responsible for all non-pay spend of Partner Trusts excluding Pharmacy and NHS to NHS expenditure.

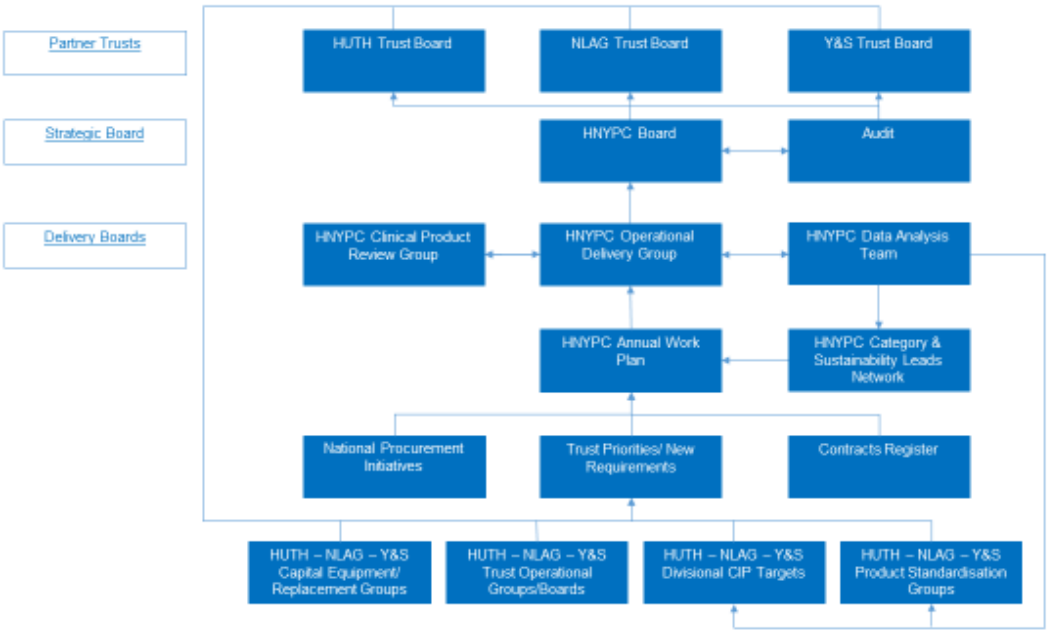


Figure 54 – Governance Structure

Each of the committees and boards set out above have defined responsibility to ensure that HNYPC delivers its procurement strategy.

Membership	Responsibilities
HNYPC Board • Director of Finance Hull/NLAG • Director of Finance York • Director of Procurement HNYPC • Medical Director • Operations Director • Nursing Director • Estates & Facilities Director	• The Partner Trusts who have signed up to the MOU are required to form an oversight body with board level executive representatives. • The Board has equal representation from the Partner Trusts. • The Board provides assurance to the respective partner trusts about the operational effectiveness of procurement activity, highlighting any risks which could impact any Partner Trust. • The Board shall agree and sign off the strategic plan for the service including the setting of key milestones, sign off and approve annual operational plans. • The Board will hold the Operational Delivery Group to account for the safe, effective and efficient delivery of the procurement service.
HNYPC Operational Delivery Group • Director of Procurement HNYPC • Deputy Director – Procurement • Deputy Director – Supply Chain • Deputy Director – Governance & Assurance • NHSSC Customer Relations Manager • NOECPC Customer Relations Manager • Clinical Leads	• The Operational Delivery Group is directly accountable to the HNYPC Board. • Accountable for the delivery of the Partner Trusts work plans and informing these work plans through reviews of data undertaken by the Data Analytics team, through national initiatives, through maintaining the contracts register or through new initiatives as required by the Partner Trusts. • Accountable for ensuing all procurement activity is undertaken in line with relevant procurement regulations and Partner Trust standing financial instructions. • The Operational Delivery Group will establish standing committees to ensure safe and effective operational delivery: Clinical Product Review Group; Data Analytics; Category Lead Network. • The Operational Delivery Group will maintain minutes of all meetings.
HNYPC Clinical Product Review Group • Deputy Director - Procurement • Clinical Procurement Specialists • Theatres Representative • Nursing Representative • EBME Representative	• The Clinical Product Review Group is directly accountable to the HNYPC Operational Delivery Group. • Accountable for reviewing opportunities for standardisation of clinical products across the Humber & North Yorkshire region. • Responsible for the delivery of clinical product trials in a safe and consistent manner. • Will provide clinical challenge where opportunities for standardisation are not being taken and escalate any issues in Partner Trusts to the Operational Delivery Group. • Support the Operational Delivery Group to minimise Partner Trust stockholding where appropriate to ensure efficient procurement operations. • Members of the Clinical Product Review Group will actively promote the work of the Humber & North Yorkshire Procurement Collaborative and the clinical benefits that can be delivered through standardisation and rationalisation.
HNYPC Category & Sustainability Leads Network • Deputy Director - Procurement • Deputy Director – Supply Chain • Procurement Business Partners (CSS, S&CC, OCA, GC, EF&C) • HNYPC Sustainability Lead	• Accountable to the Operational Delivery Group. • Responsible for the development of value based sourcing strategies which cover key categories of spend for Partner Trusts. • Will work with the Data Analytics team to build category strategies that understand suppliers, markets and Partner Trust's needs.

	• Responsible for delivery of the HNYPC annual work plan. • Will capture and report all benefits delivered through the category & sustainability work. • Responsible for the development of the HNYPC Sustainability Plan. • Works with the HNY Sustainability Lead as well as the Trust Sustainability Leads to ensure alignment of the plan and delivery.
HNYPC Data Analytics • Director of Procurement • Procurement Systems Lead • Procurement Analyst(s) • Catalogue Manager(s)	• Accountable to the Operational Delivery Group. • Provides data and analysis to the Category Leads network to inform sourcing decisions and to structure category strategies. • Supports all procurement functions in making the best use of procurement data as part of the sourcing process. • Compiles procurement data from all Partner Trusts on a monthly basis. • Manages the sharing of data with all Partner Trusts. • Reviews information within the Spend Comparison Service and other external data sources to identify opportunities. • Identifies and delivers the systems strategy to achieve system harmonisation.

Figure 55 – HNYPC Committees/ Boards

The recommended structure will enable HNYPC to work effectively with Partner Trusts at an operational level including Clinical Councils and customers, with oversight and approval from HNYPC. This provides a single approval route, compared to potentially requiring each HNYPC Partner Trust to approve each decision in the procurement cycle. The governance structure will support delivery of HNYPC objectives and will support delivery of a collaborative first approach to procurement maximising delivery of the non-financial and financial benefits.

It is noted that the role of Medical Directors is key in ensuring that the inter-lock between clinical procurement and the customers is effective. To achieve this, it is assumed that Medical Director (or deputy) attendance is mandatory at Procurement Board meetings when reviewing clinical procurement decisions.

To enable HNYPC to function effectively, and avoid substantial process inefficiency (e.g. duplicate approvals), HNYPC is dependent upon the following authorities being delegated to: (a) HNYPC Operational Delivery Group, and (b) to HNYPC Board for certain values:

- Entering contracts and agreements to a defined value, subject to meeting SFI criteria;
- Manual procurement as required, including ordering and approving ordering of goods and services for HNYPC Partner Trusts in accordance with SFIs;
- Update of prices in accordance with contract terms and conditions;
- Enforcement of contract terms and conditions on behalf of HNYPC Partner Trusts.

In the event that the HNYPC Operational Delivery Group does not have sufficient authority to approve a decision, it is assumed that this will be escalated to the HNYPC Board. This will ensure that there remains a single approving authority for HNYPC decisions, rather than requiring approvals across multiple Partner Trusts.

5.8 Procurement Strategy

A new three year procurement strategy has been devised for HNYPC which is based around the criteria used to score the options presented in section 4.

	2023/2024				2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1. Supports the aims and vision of the ICS and collaborative members												
Agree and embed the vision and aims within the Procurement Collaborative.	■	■										
Review progress against the vision and aims and update as required.					■	■	■	■	■	■		
2. Creates a single procurement function which will help support the sustainable provision of clinical and non-clinical services												
To have the Sustainability & Social Value Lead in post or the offer made.		■										
The Sustainability & Social Value Lead to have engaged with NHS England & Improvement and the ICS.			■	■								
Local policies and processes to be updated with sustainability and social value considerations including how to innovate suppliers to offer products and services differently.					■	■						
To have agreed a benefits realisation plan.						■						
To be regularly reporting on sustainability and social value benefits.							■	■	■	■		
To be viewed as an innovative thinking organisation around sustainability & social value.									■	■		
3. Establishes the collaborative as a centre of procurement and commercial excellence which provides procurement and commercial services to its member organisations												
To have the new structure approved with posts either recruited into or offers made.		■										
Standard policies and processes for the procurement collaborative to be written and agreed.			■	■	■	■						
A commercial systems strategy to be approved and in implementation.					■	■						
All procurement staff to be trained around being a provider of services.						■						
Members of the collaborative to speak at relevant forums.			■	■	■	■	■	■	■	■		
For Humber & North Yorkshire Procurement Collaborative to be seen as a centre of procurement excellence.									■	■		
4. Supports supplier rationalisation and cost savings												
Procurement Business Partners and Clinical Procurement Specialists in post or offers made.		■										
Procurement Business Partners to have engaged with all care groups with an			■	■								

	agreed way of working across organisational boundaries in place.												
	Product standardisation undertaken in each care group with case study created												
	Product standardisation opportunities discussed as business as usual a care group forums and being tracked through contract management.												
5. Ensures standardised robust product selection and range management practices are in place													
	Procurement Business Partners, Clinical Procurement Specialists and Governance and Assurance Lead in post or offers made.												
	Documented product selection process agreed with each care group.												
	Standardised product selection process written by the Governance and Assurance Lead for implementation by Procurement Business Partners.												
	Product selection process embedded as part of business as usual with each care group.												
	Innovative discussions with industry around technology advancements which can improve clinical care and the patient experience.												
6. Ensures that policies, practices and procedures are standardised and provide for the effective provision of procurement to the collaborative trusts													
	A full register of local policies and procedures captured with gaps identified.												
	A review of supply chain activities undertaken with efficiencies identified.												
	An individual appointed or offered the role of Governance and Assurance Manager.												
	A single set of procurement policies, practices and procedures agreed and signed off by the procurement board.												
	Standard operating procedures for stock management in place.												
	All procurement staff to have been trained in the content of the policies and procedures.												
	A process for annual review of documentation established.												
	Training for new starters and for all staff following a policy update part of business as usual.												
	Stock holding review undertaken across all areas with a materials management service provided to all appropriate clinical areas.												
	Audit completed on compliance to all policies and procedures.												

7. Ensures innovative and robust Supplier Relationship Management (SRM)													
	To have some individuals in post and to have offered on all posts.												
	To have developed a supplier segmentation tool and contract management/ SRM tool kit.												
	Establish a single record of all contracts held by the trusts.												
	To have trialled the tool kit on 5 suppliers and captured the benefits.												
	Roll out of the tool kit to all applicable suppliers.												
	All contracts, variations and modifications to be held on single contract register.												
	Develop and implement transactional relationship management which reduces the cost of doing business.												
8. Develops P2P e-commerce processes and systems to ensure smooth and efficient processing for all purchasing requirements													
	To have an established data systems and technology roadmap and secured investment.												
	Appointed people into or offered all data posts within the team.												
	Embed the data systems and technology roadmap and link to Scan for Safety.												
	Agree data standards and train all individuals to ensure compliant data entry.												
	All procurement transactions to be undertaken through systems to allow for centralised reporting and data driven decisions.												
9. Enables effective partnering with senior stakeholders, internal customers and suppliers													
	To have in place or have made offers to all procurement business partners and clinical procurement specialists.												
	Regular business partner meetings and clinical product review group meetings established across all three organisations.												
	Supplier relationship management in place for 5 suppliers.												
	Supplier relationship management rolled out to all applicable suppliers.												
	Benefits realisation undertaken on business partnering and SRM to ensure it still meets the needs of member trusts.												
10. Ensures all staff are given the opportunity to develop their potential													
	Standardise job descriptions and person specifications aligned to the strategy.												
	Existing staff transitioned into new structure.												
	New resource in post.												

	Offers made on all posts.												
	Embed graduate(s)/ apprentice(s) within the procurement structure.												
	All staff to have had a skills development analysis which informs their PDP.												
	Development to be fully embedded as part of BAU.												

Figure 56 – Procurement Strategy

5.9 Procurement Policies & Procedures

A review of the various policies and procedures in place at each of the HNYPC Partner Trusts identified the following:

- Varied thresholds within procurement policies and SFIs at each HNYPC Partner Trust, which results in a lack of consistency across the ICS;
- Reliance on contract extensions and waivers due to lack of time and resource available to undertake new projects and tenders. This is resulting in spend not being sufficiently market tested and reducing value for money;
- Duplication of workloads across the ICS due to insufficient communication and alignment of work-plans, which means there is no leveraging of the full ICS spend, reducing the efficiency of the collective;
- Little alignment of contracts across ICS; or efforts to align contract end dates to support future consolidation;
- Absence of contract owners and uniform use of Supplier Relationship Management prevents best value delivery from key contracts and suppliers;
- Little formalised contract management processes and recognised quarterly review meetings with key suppliers across ICS provide limited risk protection and financial optimisation of contracts;
- Procurement do report into some boards and have a degree of visibility with the Executive Teams, but there is not always sufficient engagement from key stakeholders to drive projects forward.

These documents tend to be published on each organisations intranet but there is no tracking around customer stakeholder engagement to ensure that the content of the document has been read or is understood.

All three Partner Trusts have separate procurement policy documentation. In total 25 documents were shared which need to be standardised into a single policy for HNYPC. These include:

- Procurement Policy;
- Procurement Strategy;
- Waiver Form;
- Conflict of Interest;
- How-to Guides.

Other policies which do not exist also need to be generated. These include:

- Contract Management Strategy;
- Modern Slavery Statement;
- Sustainable Procurement Policy;
- Savings Policy;
- Data Protection Impact Assessment.

A single set of HNYPC Policies and processes are required to give effect to the HNYPC strategies, this includes:

- The Cultural Principles and Customer Service Principles in how HNYPC delivers procurement services for Partner Trusts;
- Category Management ensuring delivery in a manner that delivers the strategy and policy, enabling aggregation of spend;
- Sourcing to be a value-adding process by planning effectively and reducing the number of sourcing activities undertaken;
- Order Cycle Management – ensuring process efficiency, minimising manual processes;
- Sustainability – the Procurement Policy & Governance lead would be responsible for working with the Sustainability Lead to ensure the sustainability policy aligns with procurement policy;
- Audit – act as the main point of contact between the HNYPC and Audit teams to ensure all audit recommendations are implemented in a timely manner;
- Contract Management and Supplier Relationship Management – ensuring that contracted benefits are delivered, and incremental value added by SRM as appropriate;
- HNYPC internal governance processes (e.g. gateways during the procurement cycle and roles & responsibilities);
- HNYPC supplier governance such as due diligence, and obligations delivery management;
- The approach to development of a consistent data architecture and reporting to inform business decisions.

The procurement policies and processes should be stored on a web portal that is structured to follow the procurement cycle, with the supporting tools for each stage stored within its specific area. Deployment of the HNYPC procurement policies will require HNYPC staff to be trained, as well as wider engagement with stakeholders impacted by the HNYPC policies.

A clear savings policy has been developed that sets out how savings are calculated, recorded and checked throughout the contract. The savings policy sets out cash releasing, cost avoidance and other savings such as sustainability benefits. This sets out the way in which HNYPC will be measured in its performance to support the Partner Trusts financial positions.

5.10 Standing Financial Instructions & Scheme of Delegation

There are differences between HNYPC Partner Trusts, and all documentation is currently aligned to customer organisations. The current SFI's require updating to reflect the revised governance structure and enable delivery of the recommended option. The current procurement thresholds are:

	HUTH (non-FT)	NLAG (FT)	YSTH (FT)
Informal Quotation	£0-£10k (obtain min 3)	£0-£25k	n/a
Formal Quotation	£10k-£50k (obtain min 3)	£25k-£50k (obtain min 3)	£25k-£50k (obtain min 3)
Tender	£50k+	£50k+ (obtain min 4)	£50k+

Figure 57 – SFI Current Thresholds

Observations from reviewing the current SFIs include:

- Not clear that you cannot waive procurement law;
- Not compliant with existing procurement regulation;
- Customers are provided a wide remit e.g. all budget holders are able to authorise contract amendments within financial thresholds. How do these individuals know it is a compliant contract amendment;
- A number of reasons for waiver shouldn't require a waiver e.g. a requirement is covered by an existing contract, this is either a compliant or non-compliant contract amendment;
- Acceptance of tenders is based on the lowest price rather than linked to the evaluation criteria;
- Not all tenders have to come through Procurement;
- List of "approved firms" for construction work. It is not clear how this list has been generated and whether it is legally compliant. The fact that it is down to the CFO to ensure their financial standing before calling off the approved list suggests the list is non-compliant;
- Procurement do not appear in the list of staff with authorisation in awarding contracts. How is compliance and records of contracts maintained;
- Personnel, agency and temporary staff contracts are excluded from procurement rules, it is not clear why;
- Requirement for every tender for the CFO to be satisfied with the financial standing of the company;
- Significant reliance upon the CEO e.g. escalating for admission of late tenders;
- Suppliers are given the opportunity by default to correct errors in their tender response, this should only be undertaken in line with procurement law;
- Far too detailed so are quickly out of date or prevent the Trust from concluding a contract e.g. there are insufficient suppliers because SFIs require a certain number of responses;
- Materials Management orders are a breach of SFIs.

A single version of the standing financial instructions relating to procurement activity have been drafted and implement the following recommendations:

- A single, simple set of SFIs relating to procurement activity should be agreed across HNYPC;
- The single set should be compliant with procurement regulation;
- Less remit should be provided to customers, procurement should sign all contracts and variations/ amendments once appropriate budget holder approval is gained;
- The waiver process should be simplified and applied only where it is legally compliant to do so and appropriate to do so;
- Approved supplier lists should be removed unless compliantly procured;
- Escalation to CEO/CFO should be minimised;
- Move to "no PO, no pay";
- Clarity around what level to publish contract opportunities;
- Ensures Materials Management activity is covered and compliant.

The revised SFIs recommends all procurement activity goes through three gateways:

1. Procurement Initiation Document – the decision as to how quotations/ tenders/ waivers/ bulk deals on existing contracts will be obtained.
2. Approval to Award/ Regulation 84 Report – the decision as to which economic operator the contract will be awarded to. This decision will need to be ratified in line with the scheme of delegation.
3. Contract Signature – the physical signature of the contract document and uploading the document onto the HNYPC central system.

The scheme of delegation relating to procurement activity is set out below:

Level of Expenditure	Process to be undertaken
Less than £10k excluding VAT	Quotations to be obtained from a sufficient number of firms/individuals to provide fair and adequate competition as appropriate to ensure value for money.
£10k to £50k excluding VAT	HNYPC to obtain formal quotations from a sufficient number of firms/individuals to provide fair and adequate competition as appropriate to ensure value for money.
£50k excluding VAT to appropriate procurement threshold including VAT	A local tender exercise to be undertaken with the opportunity published in line with Procurement Regulation.
Over the appropriate procurement threshold including VAT	A formal procurement exercise to be undertaken with the opportunity published in line with Procurement Regulation.

Figure 58 – SFI Future Thresholds

Gateway	Task	£10k	£10-£50k	£50k - PCR	PCR+
1	Approving the procurement strategy.	Senior Buyer	Procurement / Contract Manager	Procurement Business Partner	Deputy Director of Procurement
	Waiving of quotations and tenders subject to SFIs and SOs (including approval of single tenders).	Procurement / Contract Manager	Procurement Business Partner	Deputy Director of Procurement	Director of Procurement
	Permission to consider late quotations/ tenders.	Procurement / Contract Manager	Procurement Business Partner	Deputy Director of Procurement	Director of Procurement
2	Approving the decision to award.	Senior Buyer	Procurement / Contract Manager	Procurement Business Partner	Deputy Director of Procurement
3	Entering contracts and signing relevant documentation (once appropriate budget holder approval obtained).	Senior Buyer	Procurement / Contract Manager	Procurement Business Partner	Deputy Director of Procurement
	Lease Contracts.	Chief Finance Officer for each applicable Partner Trust			

Figure 59 – Approval Thresholds

All grades stated above are the minimum grade of staff who can undertake the specified action. All staff above that grade also hold delegated authority. In calculating the level of expenditure the total contract value should be used rather than the cost of a contract amendment or variation e.g. original contract value plus variation.

5.11 Procurement Planning

The current planning for procurement procedures is carried out on an ad-hoc basis, there is no combined contracts register showing expiring contracts to enable effective planning. Covid-19 has had a detrimental impact to procurement planning with 37% of the contracts held having expired and almost 50% of all contracts held on the work plan for renewal in 2022/23.

It is evident that data is requested as and when project requirements arise, and there is no standard form for requesting or capturing usage data. The absence of category specific project groups and a standard Procurement Initiation Document in use across

the HNYPC Partner Trusts hinders the ability to align and establish spend, service baselines and enable project sign-offs.

HNYPC will implement a 36-month forward view of procurement requirements reflecting both the plans to deliver business partner strategies and routes to market. This is to be based on:

- Existing contracts that are due to expire, identifying where they are to be replaced, and where they can be aggregated into other contracts;
- Engagement with stakeholders to confirm budgets allocated for external expenditure, noting revised ways of working, including the need for early engagement to add value.

It will be necessary to review the HNYPC procurement plan, and particularly changes to the plan, at the Procurement Board with changes being formally signed off. The HNYPC Procurement Plan will be used to plan HNYPC resources required to support delivery of the plan, there is a dependency on the provision of an adequate resource planning tool. This will be needed to enable HNYPC to align resources to contracts required to meet requirements and deliver category strategies and plans.

Where additional resources are required (e.g. specialist technical skills required for capital projects), this will be identified during the resource planning stage, and included within project costs. A further dependency is that a standardised Procurement Initiation Document is deployed as part of Gateway 1: this is the point at which requirements move from the HNYPC Procurement Plan to becoming live projects.

5.12 Alignment to National Objectives

The organisational form and governance structure has been established to meet the requirements of national and local objectives:

- Procurement activity will be deployed across the ICS making the most of capabilities and common policies and processes. Data will be share across all Partner Trusts to ensure data led decisions are being made;
- Although the proposed structure is not aligned to category based procurement, the structure is aligned to care groups to establish business partners with the aims of strengthening engagement and delivering value based procurement through patient pathways. Procurement Business Partners will manage the relationships with customers across the ICS and with our suppliers;
- Regular conversation is had with neighbouring ICSs and the national team to share best practice and identify opportunities for wider collaboration;
- The proposed structure removes duplication, simplifies the procurement process but enhances governance. It sets aligned targets against mutually agreed KPIs to allow performance to be measured in a consistent manner;
- Investment in data and technology to provide better visibility of procurement activity, stock management and opportunities for efficiency improvements, risk management and cost reduction;
- Dedicated resource to deliver sustainability, social value, Modern Slavery and procurement regulation requirements.

6. Preferred Option – Structure & Resource Requirements

6.1 Role Profiles

To help in the development of a collaborative procurement function NHSEI have developed a number of role profiles and associated competencies. These however cause greater confusion than help as they do not align to Agenda for Change job profiles and have only been completed for the more senior posts within an ICS Procurement function:

Band	Agenda for Change National Profile	NHSEI Guidance
Band 9		Head of ICS Procurement
Band 8D		Data & Technology Lead
Band 8C		Procurement Category Lead
Band 8B	Head of Procurement & Supply	Procurement Sustainability Lead
Band 8A		
Band 7	Procurement Team Manager	
Band 6	Procurement Officer Higher Level	
Band 5	Procurement Officer	
Band 4	Procurement Administrative Officer	
Band 3	Procurement Administrative Officer Supply Chain Assistant	
Band 2	Stores Clerk Storekeeper Procurement Assistant Administrator Supply Chain Assistant	

Figure 60 – Existing Job Profiles

Further role profiles are due to be released by NHSEI:

- ICS Supply Chain Lead – Minimum Band 8C;
- Clinical Procurement Specialist – Band to be confirmed.

All other role profiles are due to be determined by each ICS using the published competency framework. Although this sets out the expected competencies it will be down to each ICS to establish their own banding which could lead to inconsistencies between ICSs and therefore staff moving to earn more to do the same work, especially in an environment where remote working is an option.

Existing role profiles across HNYPC Partner Trusts are inconsistent despite roles being similar across the procurement teams. There will need to be an alignment of role profiles across HNYPC to create consistency.

6.2 Capability Assessment

A review of the current roles and skill mix within each Partner Trust procurement function has been carried out and has been used to inform the risk around the future structure. The capability assessment looks at the performance of an individual, their career aspirations and the likelihood of them staying in post. This exercise has shown:

Category		HUTH	NLAG	YSTH
Total Staff		36	29	59
Qualified Staff (e.g. MCIPS)		1	4	9
Performance Rating	Exceed Expectations	3	2	3
	Meets Expectations	25	27	46
	Partially Meets Expectations	8	0	10
Readiness for Promotion	Ready in 2+ Years	4	0	6
	Ready in 1-2 Years	0	0	6
	Ready in 6-12 Months	0	1	5
	Ready Now	0	5	16
	Temporary/ Short-Term Cover	0	2	4
	Content in Current Role or Not Applicable	32	21	22
Flight Risk	Content in Current Role	22	13	35
	Could Leave 2+ Years	7	4	8
	Could Leave 1-2 Years	2	4	6
	Could Leave 6-12 Months	3	6	4
	Looking Now	2	2	6
	Exceeds Expectations and Flight Risk	0	1	0
PDP in Place	Yes	36	29	42

Figure 61 – Succession Planning

The majority of individuals are meeting expectation (79%), are not looking for promotion (60%) and are content in their current role (56%). Only one individual is exceeding expectations and is a flight risk. This demographic can make organisational change difficult.

NHSEI have developed a skills development analysis tool which reviews an individual against the skills required to undertake their role. This assessment will be completed as part of any interview process for new roles and for all roles as part of the annual appraisal and development programme. It has not been completed as part of development of this business case due to the detailed nature of the tool. It is likely training and development will be required to close any gaps identified from the skills analysis.

6.3 Organisational Enablement

There is limited evidence that existing HNYPC procurement teams enable their staff to develop capability e.g. through secondment offerings. This in turn limits the opportunity for in-role staff development, and therefore hinders the growth and maturity of the ICS.

Moving staff into a single management organisation will allow for wider development opportunities and stretch projects to be offered. A procurement resourcing and activity plan can be developed allowing for individuals to shadow more complex projects as part of their development. Bringing the teams together will also ensure that there is resilience in resourcing as single points of failure can be designed out. Individually, procurement teams have struggled to justify the need for specific roles, such as data analysts, which can be justified under a collective resource model.

This includes staff nearing promotion undertaking higher grade roles to gain necessary experience at that level, including placements across HNYPC in non-procurement roles. There is also an opportunity to develop a talent exchange with relevant organisations (e.g. NOECPC, NHSSC). This will provide HNYPC staff with experience across wider industry and help them input to continuous improvement by bringing ideas to improve performance.

During Covid-19 Procurement staff were able to work flexibly and remotely to undertake their roles. It is proposed this approach continues to ensure geography does not act as a barrier to delivery.

6.4 Balance of Roles

The design for the future structure has considered the balance of roles to ensure that those who wish to progress their careers can see a career path locally rather than have to leave the organisation to seek their next challenge. The current organisational structure limits the opportunity to progress internally, this is due to various reasons such as the ratio of staff roles to the next grade and the gaps between roles and bands within the existing procurement teams. There is a pan-NHS issue in recruiting the right skills into the right specialist areas such as clinical procurement specialists which can inhibit delivery of procurement strategies.

The organisation structure of HNYPC has been designed to ensure that:

- There are no functional areas with gaps between grades (e.g. a Grade 4 reporting to a Grade 8C);
- Excessive and unmanageable numbers of staff are not reporting to the role above.

It is hoped that this approach promotes staff retention and progression within HNYPC with individuals who have deep organisational knowledge and motivates staff, with clear opportunity to develop as part of a shift to a high-skilled procurement function.

6.5 Procurement Engagement

Procurement engagement with customers is currently mixed. Whilst there are pockets of good engagement there is also evidence that the timing and amount of engagement is suboptimal, inhibiting the scope for procurement to add value.

To address this the new structure for procurement has been set up to align to the customers by way of procurement business partners. This will see the procurement team align to the care groups at each of the Partner Trusts. Procurement Business Partners will be required to create a stakeholder engagement plan for both internal and external stakeholders. They will be required to develop effective processes and procedures to ensure procurement is engaged sufficiently early to add value and develop effective monitoring to evidence success. Contract Management and Supplier Relationship Management will also be established to support closer engagement with external stakeholders post contract.

During development of the business case, there were a number of instances where it appeared that staff outside of Procurement are undertaking roles that will be undertaken by HNYPC (e.g. Estates teams placing certain contracts, and other teams undertaking Contract Management activity). To ensure that this behaviour ceases, the strategy and governance will need to be cascaded across HNYPC Partner Trusts with formal sign-off and supporting training.

HNYPC will undertake measurement of the effectiveness of procurement engagement as part of the general performance monitoring undertaken. This includes noting instances where timing has been sub-optimal preventing the opportunity for HNYPC to add value.

6.6 Monitoring Effectiveness

There is a general lack of effective monitoring throughout HNYPC Partner Trusts currently, whether this relates to the timing of the engagement being effective for procurement to deliver the best value, or seeking feedback to ensure there is continual development and lessons learnt. This can result in incorrect governance, and policies and procedures not being followed.

Effective measurement of compliant procurement policies and procedures is important to assuring that governance is being effectively followed, and to input into future process improvement.

Waivers and voluntary ex ante transparency notices can be indicative of failure to engage in a timely fashion to enable procurement to add value. As such, these should also be reviewed, with root cause analysis of instances where there is indication of poor engagement. The Procurement Initiation Document is key to identify stakeholders that are to be engaged: this will provide part of the audit trail of engagement.

6.7 Resource Planning

Current procurement planning is ad-hoc and reactive to current pressures. This results in late engagement and inadequate resources to fulfil the requirement, and limits the scope for procurement to act strategically and deliver value above compliance. Government policy requires planning at least 36 months in advance to enable aggregate spending. There are currently considerable challenges with workload exceeding resource levels, gaps in roles, challenges in recruiting the right capability, and single points of failure; these have been designed out to ensure resilience and sustainability.

6.8 Leadership, Culture & Values

The leadership, culture and values are set by each Partner Trust. The creation of the HNYPC will remove the corporate framework and in-turn readjust the current leadership, culture and values to serve the needs of all HNYPC Partner Trusts. This provides for an opportunity to develop a specific focus on the cultural and customer services principles.

The leadership, culture and values will be built into the role profiles developed and management processes, ensuring that these are embedded in HNYPC. This will be supported by a training programme with refresher training and new-starter training to ensure that all aspects of leadership, culture and values are fully adopted by HNYPC staff.

Consideration will need to be given to the branding of HNYPC to enable reinforcing the leadership, culture and values. However, this also needs to consider that some staff may identify strongly to the current organisation that they work for. Further consideration also needs to be given to e-mail addresses and other corporate identifiers.

6.9 Agile Working

From the staff engagement undertaken a key issue for staff is where they would be located. The proposition is that all roles will be assessed to establish whether they are agile or fixed. Agile workers will be based in their existing Trust but will be required to travel when working on collaborative activity. Fixed workers will continue to work from their existing base.

Agile workers will require the equipment to work more efficiently in this environment and this will include resources for hot-desking and virtual meeting facilities. The intention is to maintain positive and valuable relationships which team members have with their existing Partner Trust customers as well as provide them with the tools to develop similar relationships within the other two Partner Trusts. It is hoped that the flexibility of this approach will help to retain staff in the new organisation.

It is important that there is a level of IT compatibility across the three Partner Trusts. At the moment the three Partner Trusts work on separate networks and generally are not equipped to support agile working. For example it is not possible to join the Wi-Fi at all three Partner Trusts and it is not possible to hot desk as all three Partner Trusts use different hardware. Laptops and docking stations using the same hardware would help support agile working.

6.10 Staff Retention, Talent Development & Apprenticeships

YSTH have had success in running graduate and apprenticeship schemes within procurement utilising the HCSA sponsored National Procurement Graduate Scheme. They have also been able to establish 'run-through' posts which allow individuals to be recruited at one grade and to transition to the next grade once they have completed training. It is intended that HNYPC adopt this approach across all grades but that this is managed within the proposed structure and budget presented. HNYPC will not request further funds or posts to undertake this activity.

The training and development budget for procurement needs to be increased to align with the national average which is £217 per annum per person. This is picked up in the costing structure below.

6.11 Proposed Structure

To deliver the procurement strategy a new structure will be required. There are various options available to establishing a future procurement structure:

- Category alignment;
- Care Group Clinical Pathway/ Business Partner alignment;
- Delivery of both.

Following engagement with stakeholders it was decided not to progress with a category management approach as it was felt greater value could be delivered by aligning procurement to the care groups and patient pathways, providing a procurement business partner structure.

Existing spend information by category and care group has been used to influence resourcing structures as well as reference made to NHSEI role profiles. It is noted that spend figures used is spend during Covid-19 but these have been checked against 2019 spend levels in YSTH which show proportions are similar. There is also a need to standardise bandings for the same roles across the three Partner Trusts however this may need to be progressed in slower time due to the cost associated with alignment.

A review of spend information showed:

Care Group	HUTH	NLAG	YSTH	Total	% Split
Clinical Support Services	£103,768,627	£16,849,086	£22,727,798	**£143,345,511**	48.47%
Community & Therapies	£0	£2,613,053	£0	**£2,613,053**	0.88%
Emergency & Elderly Medicine	£131,065	£0	£6,834,883	**£6,965,948**	2.36%
Family Health	£5,071,449	£1,296,752	£1,849,705	**£8,217,906**	2.78%
Specialist Medicine	£11,453,518	£11,240,763	£7,210,155	**£29,904,436**	10.11%
Surgery & Critical Care	£10,968,421	£10,936,828	£4,621,231	**£15,558,059**	5.26%
Corporate					
Estates & Facilities	£29,583,795	£6,626,432	£25,435,676	**£61,645,903**	20.84%
Corporate General	£10,702,433	£9,029,349	£7,786,500	**£27,518,283**	9.30%
Capital/ Charity Spend	£81,459,377	£69,797,198	£91,937,275	**£243,193,850**	

Figure 62 – Care Group Alignment

Based on spend information Procurement Business Partners should be set up as follows:

- Clinical Support Services – 48.47%;
- Medicine & Healthcare – 16.13%;
- Surgery & Critical Care – 5.26%;
- General Corporate – 9.30%;
- Estates, Facilities & Capital – 20.84%.

New roles have also been provided within the structure where it believed that additional value can be added. These are further discussed below:

- Contract Management;
- Governance & Assurance;
- Procurement Systems & Data;
- Sustainability & Social Value.

The following sections address the structure and resource required by team as per option 5 explained above.

6.12 Procurement Directorate Structure & Resource

The current governance structure of the existing procurement teams is organised to align support to individual HNYPC Partner Trusts. This results in individual procurement teams with capabilities spanning the initial procurement activity of letting contracts, raising purchase orders and ensuring product is delivered to the point of consumption. Focusing on delivery at Trust level results in the absence of clear strategy and a failure to achieve aggregation of expenditure across HNYPC Partner Trusts.

Below is a summary of current WTE organisation structure by salary band.

Band	Proc	CPS	Systems	Total	Weight	Midpoint Salary	Total Cost
Band 9	1	0	0	**1**	**1.85%**	£118,928.32	**£118,928.32**
Band 8D	0	0	0	**0**	**0.00%**	£99,005.30	**£0.00**
Band 8C	3	0	0	**3**	**5.56%**	£82,946.91	**£248,840.73**
Band 8B	0	0	0	**0**	**0.00%**	£68,975.29	**£0.00**
Band 8A	0	0	0	**0**	**0.00%**	£59,184.91	**£0.00**
Band 7	4	1	0	**5**	**9.27%**	£52,769.50	**£263,847.50**
Band 6	4.78	0	0.9	**5.68**	**10.54%**	£42,580.47	**£241,857.07**
Band 5	4	0	0	**4**	**7.42%**	£39,199.08	**£156,796.32**
Band 4	16.44	0	0	**16.44**	**30.50%**	£30,672.55	**£504,256.72**
Band 3	17.79	0	1	**18.79**	**34.86%**	£26,692.56	**£501,553.20**
Band 2	0	0	0	**0**	**0.00%**	£24,309.69	**£0.00**
Total	**51.01**	**1**	**1.9**	**53.91**			**£2,036,079.86**

Figure 63 – Existing Procurement Structure

Comparison of the role titles across the three Partner Trusts shows some consistencies in job role and grade but also some inconsistencies e.g. Procurement/ Contracts Officer at both band 3 and 5:

Band	HUTH	NLAG	YSTH
Band 8C	Head of Procurement	Head of Procurement	Head of Procurement
Band 8B			
Band 8A			
Band 7	Senior Contracts Manager	Clinical Nurse Specialist Sourcing & Contracts Lead	Deputy Head of Procurement Operational Lead for Procurement
Band 6	Contracts Manager		Specialist Procurement Officer Procurement Systems Manager

Band 5	Contracts Officer Senior Buyer	Higher Procurement Officer	
Band 4	Contracts Support Officer	Procurement Supervisor	Senior Buyer Procurement Graduate
Band 3	Assistant Buyer	Sourcing & Contracts Officer Procurement Officer	Buyer Procurement Systems Officer

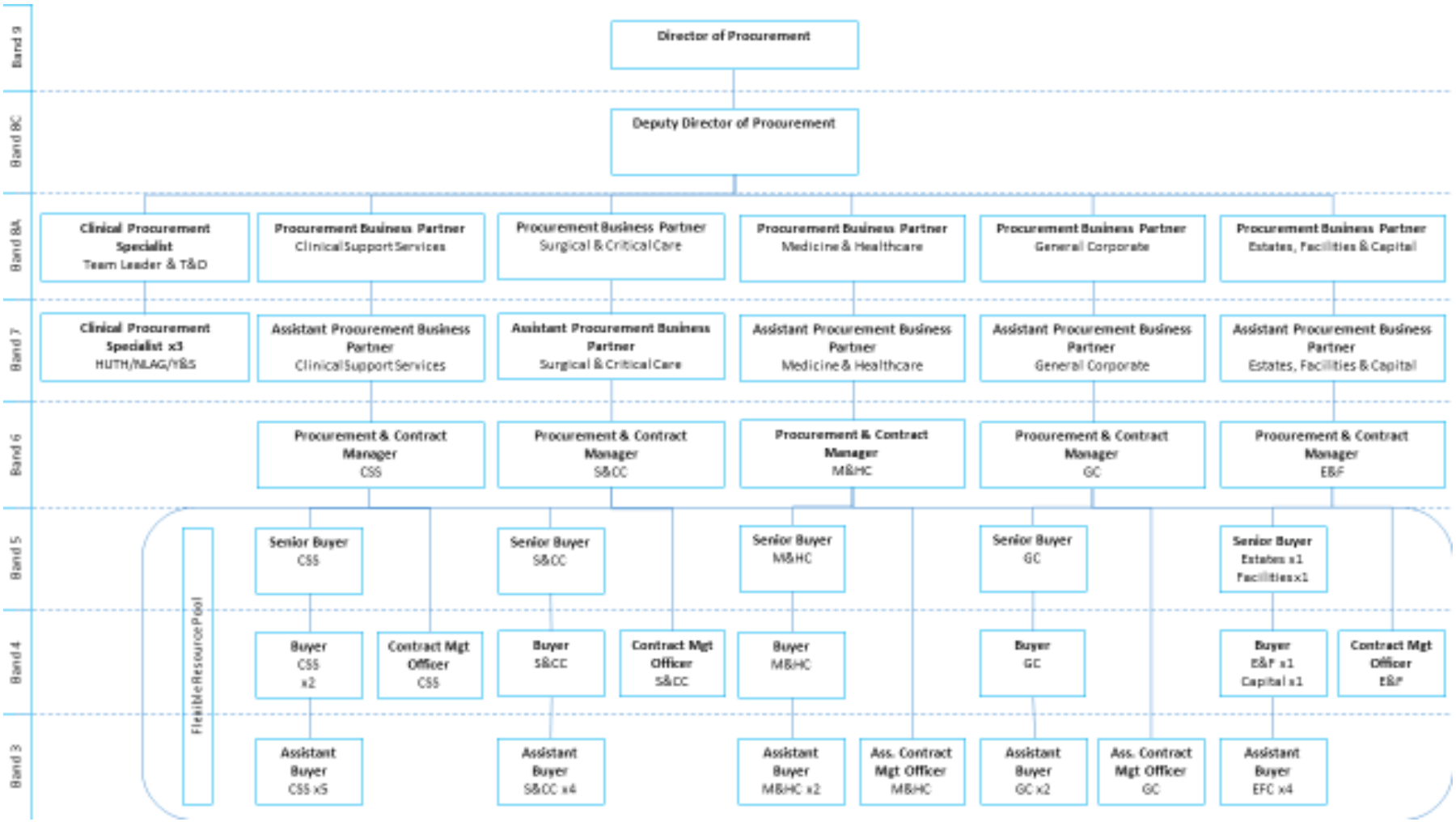
Figure 64 – Existing Job Profiles

One of the biggest challenges with the current structure is that over 65% of the Procurement function across the three Partner Trusts are band 4 or below. By consolidating contracts across the Partner Trusts the value and importance of those contracts will increase. It will require a more senior procurement resource to deliver those procurements, something that does not exist within the current structure.

NHSEI guidance that Category Leads should be a minimum of band 8C sees a significant increase from the existing band 6 staff undertaking this role at the moment. This raises a number of risks including:

- Affordability – to what extent is the future structure affordable in comparison to existing structures;
- Alignment to Agenda for Change principles – to what extent does the NHSEI guidance on roles align to Agenda for Change principles, is it possible to evidence the significant different in published job evaluated roles;
- Availability of staff – a common message from the three Partner Trusts is it is difficult to recruit staff at present. Although more senior roles may be attractive to candidates there is no evidence from NHSEI that there are 'spare' qualified and experienced procurement staff who could fill these roles. It may however be possible to attract people from the private sector who have transferrable skills;
- Consistency across ICSs – there is a risk that if the NHSEI suggested bandings are embedded in some ICSs and not others, procurement staff will move to where bandings are higher. This is a higher risk with the increase in remote working.

On reflection of the above risks the decisions has been made not to align to NHSEI role profiles. The HNYPC organisation structure has been designed following discussion with various stakeholders including Heads of Procurement from HNYPC Partner Trusts:


Band 9
Band 8C
Band 8A
Band 7
Band 6
Band 5
Band 4
Band 3
Director of Procurement
Deputy Director of Procurement
Clinical Procurement Specialist
Team Leader & T&D
Procurement Business Partner
Clinical Support Services
Procurement Business Partner
Surgical & Critical Care
Procurement Business Partner
Medicine & Healthcare
Procurement Business Partner
General Corporate
Procurement Business Partner
Estates, Facilities & Capital
Clinical Procurement Specialist x3
HUTH/NLAG/Y&S
Assistant Procurement Business Partner
Clinical Support Services
Assistant Procurement Business Partner
Surgical & Critical Care
Assistant Procurement Business Partner
Medicine & Healthcare
Assistant Procurement Business Partner
General Corporate
Assistant Procurement Business Partner
Estates, Facilities & Capital
Procurement & Contract Manager
CSS
Procurement & Contract Manager
S&CC
Procurement & Contract Manager
M&HC
Procurement & Contract Manager
GC
Procurement & Contract Manager
E&F
Flexible Resource Pool
Senior Buyer
CSS
Senior Buyer
S&CC
Senior Buyer
M&HC
Senior Buyer
GC
Senior Buyer
Estates x1
Facilities x1
Buyer
CSS
x2
Contract Mgt Officer
CSS
Buyer
S&CC
Contract Mgt Officer
S&CC
Buyer
M&HC
Buyer
GC
Buyer
E&F x1
Capital x1
Contract Mgt Officer
E&F
Assistant Buyer
CSS x5
Assistant Buyer
S&CC x4
Assistant Buyer
M&HC x2
Ass. Contract Mgt Officer
M&HC
Assistant Buyer
GC x2
Ass. Contract Mgt Officer
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Assistant Buyer
EFC x4

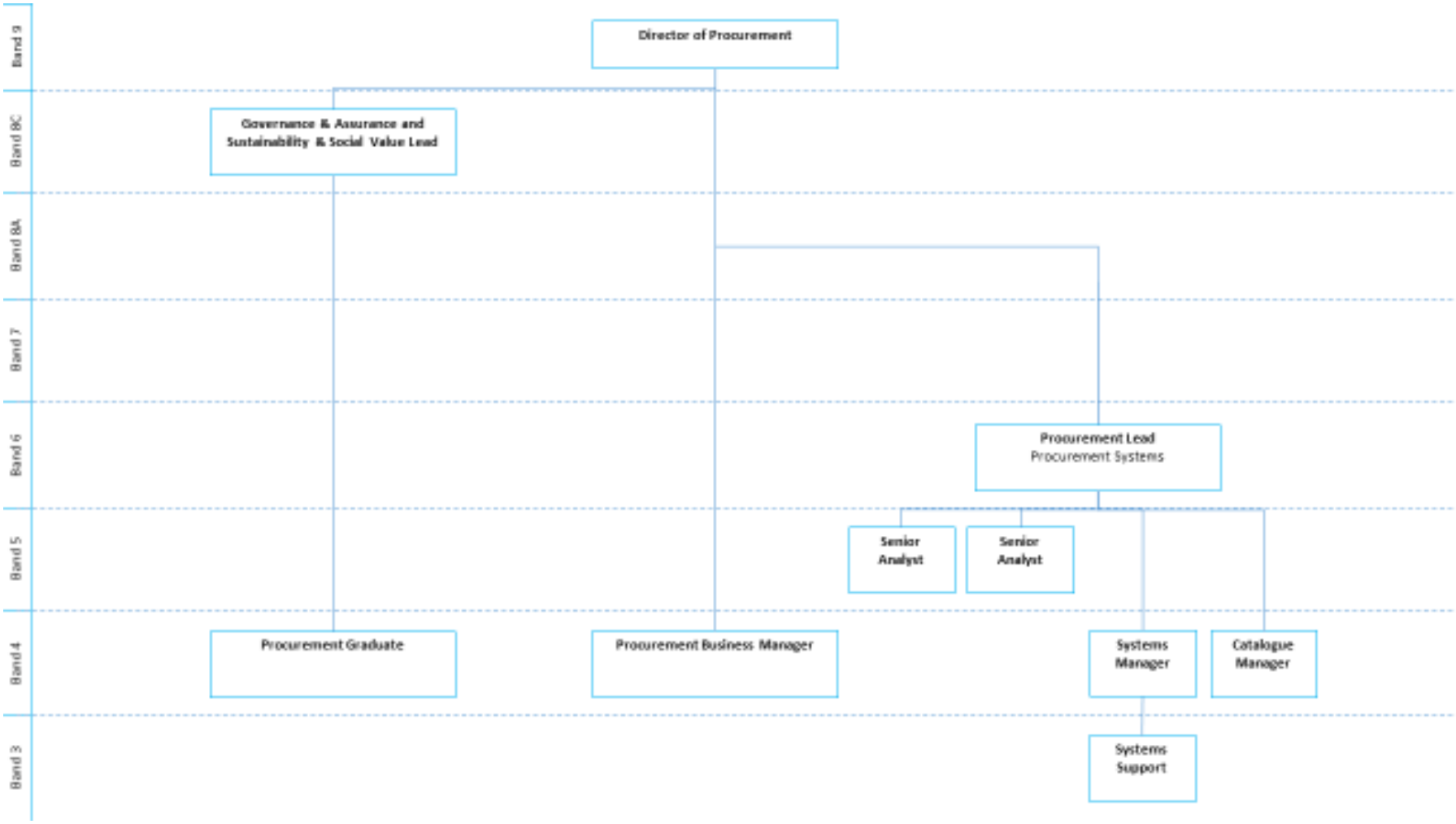

Figure 65 – Procurement Structure

This increases the procurement headcount however expands procurement to cover new and expanded responsibilities:

- Business Manager;
- Governance & Assurance;
- Sustainability and Social Value;
- Contract Management;
- Increases Clinical Procurement Specialist support;
- Increases Systems and Data support.

An overview of roles and responsibilities under the new structure:

Title	Proposed Band	Current Band	Responsibilities
Director of Procurement	9	9	Overall responsibility and accountability for the function and Procurement strategy across all Partner Trusts. Leading the senior management team, setting strategic direction and representing HNYPC at the highest level.
Business Manager	4	n/a	Provides administrative support to Director of Procurement and senior management team. Arranging diaries, organising events, minutes of meetings. Collates reports and data returns.
Deputy Director of Procurement	8C	8C	Responsible for the management and leadership of the procurement business partner function for the organisation. To identify, develop and drive 3-5 year sourcing strategies, acting as lead for all procurement business partner areas within the remit of the procurement department, through pro-active leadership.
Procurement Business Partner	8A	n/a	Responsible for strategic management of procurement activity within their prospective care group for a wide range of complex healthcare related goods and services. To identify, develop and drive sourcing strategies for their business partner area in collaboration with the stakeholders.
Clinical Procurement Specialist Team Lead	8A	n/a	Responsible for overall management of the Trust-based clinical procurement specialists. Escalating areas of non-compliance or disagreement. Taking the lead as Trauma and Orthopaedic clinical procurement specialist across all Partner Trusts.
Clinical Procurement Specialist	7	7	To act as the clinical procurement lead for a specific Partner Trust. Responsible for delivering the standardisation of clinical product, evaluating new clinical products and supporting clinical teams in the change of products.
Procurement & Contract Manager	6	6	Actively seeks to implement opportunities for added value procurement through contracting and improved cost effective supply arrangements, whilst maintaining customer service levels and compliance to procurement regulation across the Partner Trust's clinical and corporate directorates. Responsible for the creation of contracts, monitoring and continual review and management of existing contracts in collaboration with the customer.
Senior Buyer	5	5	Lead the procurement process for low to medium value supplies and services contracts. Support the procurement process for high value contracts, preparing relevant documentation, building online

			questionnaires, designing bidding, evaluation and commercial models and supporting suppliers through the process.
Buyer	4	4	Lead the procurement process for low value supplies and services contracts. Support the procurement process for medium value contracts, preparing relevant documentation, building online questionnaires, designing bidding, evaluation and commercial models and supporting suppliers through the process.
Contract Management Officer	4	n/a	Responsible for the creation of low/medium value contracts, monitoring and continual review and management of existing contracts in collaboration with the customer.
Assistant Buyer	3	3	Administrative support for the business partner team, arranging meetings, writing minutes, reviewing specifications, handling supplier enquiries.
Assistant Contract Management Officer	3	n/a	Support to the Procurement & Contract Manager in the monitoring and continual review of a portfolio of contracts in collaboration with the customer.
Governance & Assurance and sustainability & Social Value Procurement Manager	8C	n/a	Responsible for all procurement related policies and procedures ensuring they are updated in line with national policy. Provide training to all procurement individuals to ensure compliance. Provide assurance to the Operational Delivery Group that procurement is being undertaken in a compliant manner. Lead the implementation of sustainability and social value requirements ensuring best practice in all procurement activity. Developing and reporting on sustainability and social value metrics.
Procurement Systems Lead	6	6	Responsible for the technical management of a number of systems, technologies and processes in use across the Trust and partners. Management of information across the department including the gathering and reporting of performance metrics and analysis of spend information.
Senior Analyst	5	n/a	Responsible for the analysis of expenditure, benchmarking and opportunity assessment for use by the Procurement Business Partners.
Systems Manager	4	n/a	Responsible for the management of all procurement based systems ensuring they are used in the correct manner to enable accurate reporting. To arrange and deliver systems training to all stakeholders.
Catalogue Manager	4	n/a	Responsible for development and maintenance of supplier catalogues. Liaison with suppliers to ensure data is up to date and accurate. Ensures that all catalogue information is fed into the correct systems and information flows are automated.
Procurement Graduate	4	4	This individual will work with all elements of the procurement team to widen their knowledge and experience.
Systems Support	3	3	Responsibility for first line support to end-users of eProcurement system. Provide training to end users of the system to ensure consistent data entry for reporting purposes.

Figure 66 – Procurement Roles & Responsibilities

Based on mid-point salary the new procurement structure will cost £2.6m per annum:

Band	Proc	CPS	CM/SRM	Systems	Gov & Sust	Total	Weight	Midpoint Salary	Total Cost
Band 9	1	0	0	0	0	**1**	**1.54%**	£118,928.32	**£118,928.32**
Band 8D	0	0	0	0	0	**0**	**0.00%**	£99,005.30	**£0.00**
Band 8C	1	0	0	0	1	**2**	**3.08%**	£82,946.91	**£165,893.82**
Band 8B	0	0	0	0	0	**0**	**0.00%**	£68,975.29	**£0.00**
Band 8A	5	1	0	0	0	**6**	**9.23%**	£59,184.91	**£355,109.46**
Band 7	5	3	0	0	0	**8**	**12.31%**	£52,769.50	**£422,156.00**
Band 6	2.5	0	2.5	1	0	**6**	**9.23%**	£42,580.47	**£255,482.82**
Band 5	6	0	0	2	0	**8**	**12.31%**	£39,199.08	**£313,592.64**
Band 4	7	0	3	2	2	**14**	**21.54%**	£30,672.55	**£429,415.70**
Band 3	17	0	2	1	0	**20**	**30.77%**	£26,692.56	**£533,851.20**
Band 2	0	0	0	0	0	**0**	**0.00%**	£24,309.69	**£0.00**
Total	**44.5**	**4**	**7.5**	**6**	**3**	**65**			**£2,594,429.96**

Figure 67 – Total Proposed Procurement Structure

However, this doesn't take into account those working less than full time. Within Procurement there are eleven individuals who work part time. The cost of this is:

Band	Proc	Systems	Total	Midpoint Salary	Total Cost
Band 6	0.22	0.09	**0.31**	£42,580.47	**£13,199.95**
Band 4	0.56	0	**0.56**	£30,672.55	**£17,176.63**
Band 3	2.21	0	**2.21**	£26,692.56	**£58,990.56**
Total	**2.99**	**0.91**	**3.9**		**£89,367.12**

Figure 68 – Procurement Part Time Resource

The proposed Procurement structure has been calculated using full time equivalents at mid-point. The assumption is existing resource will move into the new structure on their current terms. The total proposed cost has therefore been reduced by £89,367.12 to reflect this position. When a new recruitment process is undertaken and an external candidate is successful then this will present an additional cost pressure as that individual may wish to work fulltime. To ensure that the best talent is attracted to HNYPC then a flexible approach should be undertaken to recruitment rather than restricting the hours. This will need to be managed within budget.

6.12.1 Strategic Procurement Team

The three Partner Trusts spend approximately £1bn per annum on goods and services from third party suppliers. Notwithstanding the opportunities which collaborative procurement can bring, there has been very little collaborative procurement between the three Partner Trusts and procurement leaders have not been required to demonstrate collaborative activity as part of their performance targets. It is clear that there would be economies of scale and cost benefits to each of the Trusts if we were able to maximise the impact of this leverage.

The small size of the current individual teams limits the opportunity for specialist business partnering approaches. YSTH are the closest to implementing a business partner approach having Senior Procurement Officers covering Medical/Surgical, Capital & Corporate and Estates (LLP). Most procurement staff are generalists, thereby limiting in-depth market knowledge and the benefits this brings in terms of clinical engagement and sourcing strategy.

At present there is extensive duplication of effort with each Trust procuring separately, meaning that there is significant opportunity to release capacity (i.e. procuring once rather than three times) releasing resources for more competitive market testing to achieve best value. In addition, greater capacity will allow the team to focus on areas not currently under procurement control/influence, again increasing the opportunities for savings; areas which provide opportunity include estates and facilities and agency staffing.

Complementary strengths and weaknesses across the three Trusts means that there is a strong foundation to benchmark existing systems, benefit from shared learning and work together to harmonise systems, maximise efficiency and capitalise on savings opportunities. Particular strengths recognise the focus of each organisation and how resources are deployed. Having said this, there is a potential skills and seniority gap with 75% of procurement staff band 5 or below. Bringing contracts together for collaboration will increase the number of full procurement exercises that need to be undertaken which are usually managed by fully qualified procurement staff at band 7 and above of which there are only 9.

The talent pool for good quality procurement and supplies staff is small and trusts are competing for the same staff. There are limited entry level positions for graduates or apprentices in place across the three organisations. Despite both Hull and York Universities offering summer internships or year-long work based placements for students with both Universities finding it challenging to identify local employers.

Limited resources and skills have resulted in risk averse attitudes to compliance and in some instances expediency has driven decision making. The HNYPC approach to procurement will focus on a thorough options appraisal, review of market strategy and long term value options. A collaborative approach to procurement using a consolidated establishment would provide the opportunity to create staff development programmes, develop professional expertise and create “grow your own” opportunities to develop talent and provide succession planning. The re-assertion of best practice line management principles will be core to the HNYPC, to foster a high performance culture and develop a motivated and dynamic team.

To support the strategic procurement teams, both YSTH and NLAG are members of NOECPC and utilise a number of their procurement frameworks. HUTH have not signed up as members of NOECPC. Each Trust has a good working relationship with NHSSC, however, variation of practice is seen across the trusts in terms of engagement methodology and savings opportunities can be missed or subject to significant delay in some cases. This business case sets out how these issues can be addressed via a consistent approach to NHSSC engagement with the support of Clinical Procurement Specialists in each Partner Trust.

The narrow focus on immediate savings delivery has resulted in relatively light focus given to category management, contract management, senior stakeholder/clinical engagement and market engagement and management. Further, contract compliance issues have had to be addressed within the context of limited resources, resulting in the need for expediency (reverting to existing frameworks agreements) rather than initiating competitive market tests via full tenders. In feedback from stakeholders the default position of procurement is to purchase though framework rather than test the market and select the most appropriate sourcing route. This is not a surprise given the junior nature of the staff employed. It is recognised that best practice procurement

which incorporates the elements listed above are able to deliver greater long term, recurring and sustainable savings as well as improved quality and outcomes.

There are approximately 3,000 contracts across HNYPC half of which need to be replaced within 2022/23. This quantity of contracts to be let across such a small number of procurement staff provides a limited opportunity to leverage the sourcing process to add value. There is limited evidence of experience and skills in value analysis and value engineering, which will be imperative to drive sourcing outcomes and deliver the benefits associated.

The category teams will align themselves to their stakeholders across the Partner Trusts, will meet with them regularly to discuss their requirements and will develop category strategies which can be used for any procurement within their category. These strategies will be developed with the business and suppliers and be updated on an annual basis.

The category strategies will inform the sourcing process. The sourcing process will not automatically defer to use of a framework or an open tender but will use the market information contained within the category strategy to inform the most appropriate route to market to deliver the aims of the procurement being undertaken.

Sourcing will also not assume that consolidation is the right answer to any procurement exercise. The category strategy will inform whether consolidation across Partner Trusts is the right thing to do. For example, it would not be appropriate for taxi services to be consolidated as the geography over the ICS is too large for this to provide value for money.

Sourcing expertise will reflect the shift in sourcing from being a compliance function to a value-adding stage of the procurement cycle. There will be a reduction in low-value tactical sourcing and a requirement for procurement leads to complete a Procurement Initiation Document for all procurement activity. The Procurement Initiation Document will pose a number of questions for the procurement lead which will prompt best practice requirements.

The more junior posts within the procurement team (band 5 and below) will operate in a flexible resource pool. Whilst they will be aligned to a Procurement Business Partner for management responsibility they will be able to work across business partners. This will allow HNYPC to react to changes in demand on procurement and will also allow staff to gain a greater experience across different categories as part of their development.

6.12.2 Clinical Procurement Specialists

Four posts are included for clinical procurement specialists which is an increase of three from the existing single person dedicated to this at NLAG. Rather than having the Clinical Procurement Specialists working across trusts they will be Trust based. The reason for this is twofold:

1. To be able to deliver change it will be important for the Clinical Procurement Specialists to have relationships at a Trust level, to understand the clinical practices of each Trust and any politics that may exist;
2. Clinical Procurement Specialists will be expected to maintain their clinical registration so will be required to undertake clinical practice. This is best undertaken locally.

The only post which isn't Trust specific is the Clinical Procurement Specialist team leader who will also act as Trauma and Orthopaedic lead across the Partner Trusts. The benefits for implementing this are the greater relationship and engagement with the clinical community to deliver change programmes. Although there are four posts it is not intended that these will be advertised as full time posts but will offer clinicians the opportunity to second for a period of time whilst maintaining their clinical practice. Other recruitment options will also be considered such as part-time work in procurement and part time work in a clinical setting. This may mean that it's possible to recruit more people than posts within budget.

6.12.3 Contract Management & Supplier Relationship Management

There are no resources allocated to Contract Management and Supplier Relationship Management. Contract Management is devolved to individuals within the business, those who originally identified the need for the product or service. There is no competency assessment of individuals within the business that they can manage contracts, nor is there any guidance provided as to how to manage contracts. This means that there is a risk suppliers alter the level of service they promised to provide as part of the bid process, and then tone the service down to increase their profits. Due to the lack of Contract or Supplier Management it is not possible to quantify this risk. Good contract management can ensure value obtained through the procurement process is delivered throughout the contract period.

The proposed approach is that Procurement will directly employ contract managers who also operate as Business Partners which face into the Trust Care Groups. These individuals will support the Care Groups in managing their contracts and holding suppliers to account. Contractual performance information will be collected and reported within the HNYPC procurement system.

This will require the development of clear definition of the scope of Contract Management, with supporting policies, procedures and roles and responsibilities. This includes the SFIs formalising the approach and approval to undertake Contract Management. Role profiles will need to be defined to reflect the requirements of the roles, with training developed to ensure that resources are capable of delivering their roles to the required standard. It is noted that effective systems are required to deliver Contract Management. This includes supplier reporting and obligation management, with exceptions of non-compliance highlighted to the Contracts Management team.

The Contract Management function will also be required to capture and report the benefits that they deliver to evidence the return on investment they bring.

The Contract Management function will review all contracts contained within the contracts register to ensure that the information held about the contract is complete and to score them based on value and risk. This approach will grade the contracts:

- Gold (high value/high risk);
- Silver (of moderate value/risk);
- Bronze (of low value/risk);
- Transactional (a one off purchase not requiring any management).

The current value of contracts let by procurement has a total of £445.6m over 3,000 contracts. Ensuring that the supplier delivers what they promise is therefore significant in terms of achieving value for money. Research has shown (Lifecycle Management Group 2020) that contract management can reduce costs by 5%-10%. In light of recent

events (EU Exit & Covid-19) supply resilience is another important factor that Contract Management can support.

It is recommended that HNYPC develop Supplier Relationship Management (SRM) expertise to support the delivery enhanced benefits beyond those contracted. This work will be completed between the Contract Management and Strategic Procurement teams. The objective is to provide SRM to the Top 20 suppliers to HNYPC Partner Trusts., covering approximately 48% of spend that is currently reported within the contract registers.

6.12.4 Procurement Data Analysts

Four additional posts have been requested within the data analysis team to reflect the greater importance of data driven decisions within procurement. There are a number of self-service/ automated processes that could also be considered e.g. supplier managed catalogues which go directly to the contract managers to approve for any changes. This would reduce the need for catalogue managers. This will take time and effort to manage the implementation. If successful, posts could be released, because of this the data team will move to manage other data streams such as integration with Scan4Safety or supporting the contract management team to evidence supplier performance against KPIs.

New procurement systems will need to be deployed to allow for agile working. At the moment a lot of the procurement data is captured locally on spreadsheets. This approach carries risk around data integrity and tracking changes made to data. Cloud based systems will allow all teams to log in wherever they are working and will also provide an audit trail for all changes made. The implementation of new systems will require training and new ways of working. Resource has been included in the structure for systems management and training.

6.12.5 Governance & Assurance and Sustainability

There is no resource in any of the Partner Trust procurement teams who is responsible for maintaining and updating policies and procedures despite regular updates being issued by Government and NHSEI. In 2020 Government issued 11 Procurement Policy Notes (PPNs), and in 2021 there were an additional 10. These PPNs require procurement teams to update their locally policies and processes and ensure all staff are aware of the changes. The content of PPNs can change the interpretation or meaning of the Public Contract Regulations 2015 and as such there is a legal requirement to comply with changes.

As the Partner Trusts do not have resource dedicated to monitoring procurement policy and process, these changes can often be overlooked meaning that procurement activity is not legally compliant. A recent change which required organisations with a non-pay spend over £200m per annum to publish their procurement pipelines for a minimum of 18 months in advance by 1st April 2022 was not implemented on time.

The principal aim of procurement undertaken by NHS organisations is to deliver essential goods and services and improve patient outcomes, while increasing value from every pound spent in the NHS. NHS procurement also has an essential role to play in the delivery of the NHS commitment to reach net zero by 2045, as more than 60% of NHS carbon emissions occur in the supply chain. Social value, when incorporated effectively, will help reduce health inequalities, drive better environmental performance, and deliver even more value from procured products and services.

There is a current lack of connection between sustainability policy and implementation at customer level procurement. This includes inadequate resources dedicated to developing the NHSEI framework. NHSEI have established three work streams to deliver their purpose "to ensure that every pound the NHS spends on products and services is socially and environmentally responsible. This is underpinned by an ambition to deliver net zero carbon and embed social value and eradicate modern slavery across our supply chain". This shows how procurement is being used to deliver more than just the purchase of goods and services.

Key milestones within the NHSEI plan that HNYPC will need to embed locally include:

- April 2022 – All procurements to include a minimum 10% net zero and social value weighting;
- April 2023 – All contracts above £5m require suppliers to publish a carbon reduction plan for their UK direct emissions as a qualifying criterion;
- April 2024 – All procurement require suppliers to publish a carbon reduction plan;
- April 2027 – All suppliers will be required to publicly report targets, emissions and publish a carbon reduction plan for global emissions aligned to the NHS net zero target, for both their direct and indirect emissions;
- April 2028 – New requirements will be introduced overseeing the provision of carbon foot printing for individual products supplied to the NHS;
- April 2030 – All suppliers will be required to demonstrate progress in line with the NHS' net zero targets, through published progress reports and continued carbon emissions reporting;
- 2045 – Net zero supply chain.

The Humber & North Yorkshire Sustainability and Net Zero programme was introduced towards the end of the 2020 and has gained momentum with the establishment of a network of organisation level sustainability leads. Initial work has been carried out to establish the HNY Partnership's baseline carbon footprint to understand the scale of the task. Work is underway to develop a Humber & North Yorkshire climate change vision statement and green plan, which will be underpinned by green plans that are being developed by Partner Trusts.

A Green Plan and draft targets have been developed by HNYICS. There is a specific section within the plan which addresses Supply Chain and Procurement however Procurement will be an enabler to the other areas being investigated e.g. travel & transport, food & nutrition and digital transformation.

The dedicated Procurement Sustainability and Social Value Lead within HNYPC will be a strategic function, advising and directing without direct delivery beyond the formation of strategy and policy. The inward facing aspect of the role is to ensure that each stage of the procurement cycle gives effect to HNYPC requirements to deliver sustainability and social value in line with national policy. This includes:

- Providing a view across HNYPC to ensure that those categories best placed to deliver sustainability and social value are correctly identified and calibrated to deliver the required benefit;
- Advising on requirements definition to ensure that sustainability and social value requirements are properly defined;
- Establishing a HNYPC Procurement Sustainability Plan that aligns to the wider ICS strategy and national policy;
- Advising on commercial and procurement strategies to maximise sustainability and social value delivery through the supply chain;

- Setting baselines and managing reporting against delivered benefit;
- Advising on Contract Management and Supplier Relationship Management sustainability and social value aspects.

6.13 Supply Chain Directorate Structure

The current governance structure of the existing supply chain teams is organised to align support to individual HNYPC Partner Trusts. This is a sensible structure considering the work required in receipting and distributing deliveries and managing inventory locally. Each of the sites does work differently to manage this, so there is work required to standardise ways of working and ensure best practice.

A recent diagnostic completed by NHSSC showed the different ways each of the sites operate and the opportunity for standardisation:

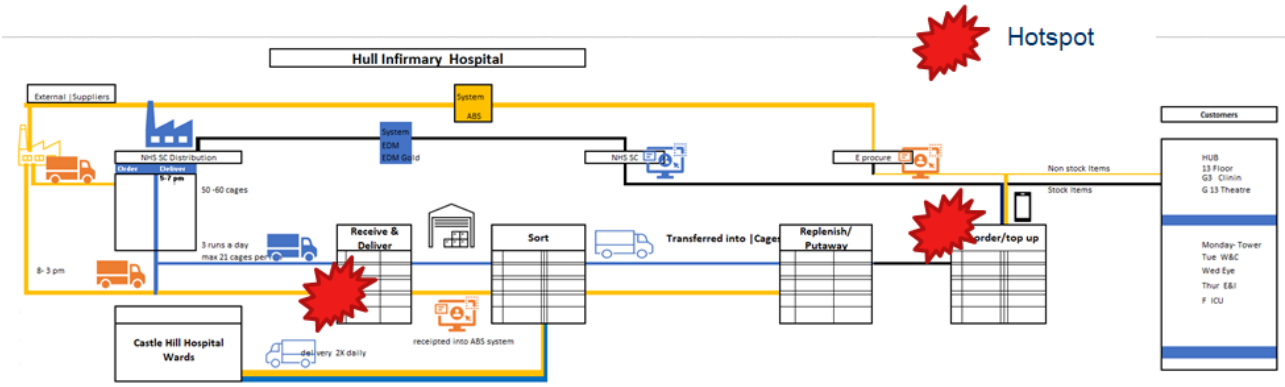

Figure 69 – HRI Materials Flow

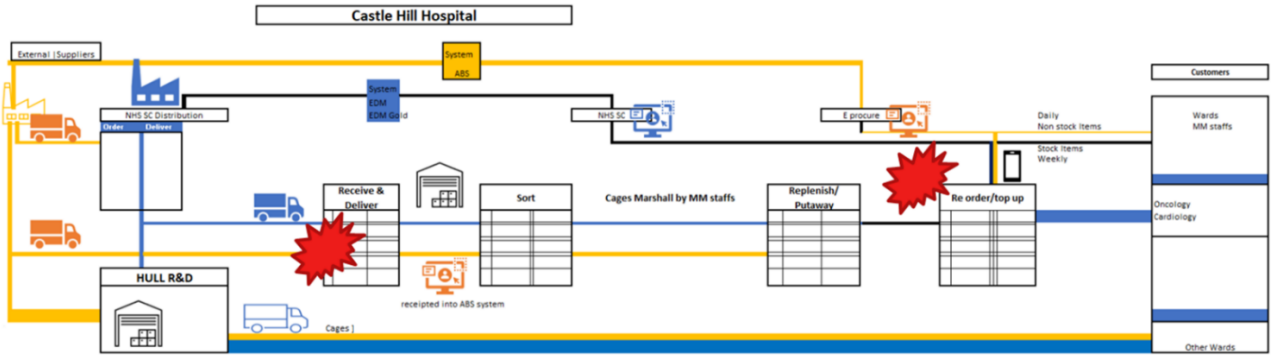

Figure 70 – Castle Hill Materials Flow

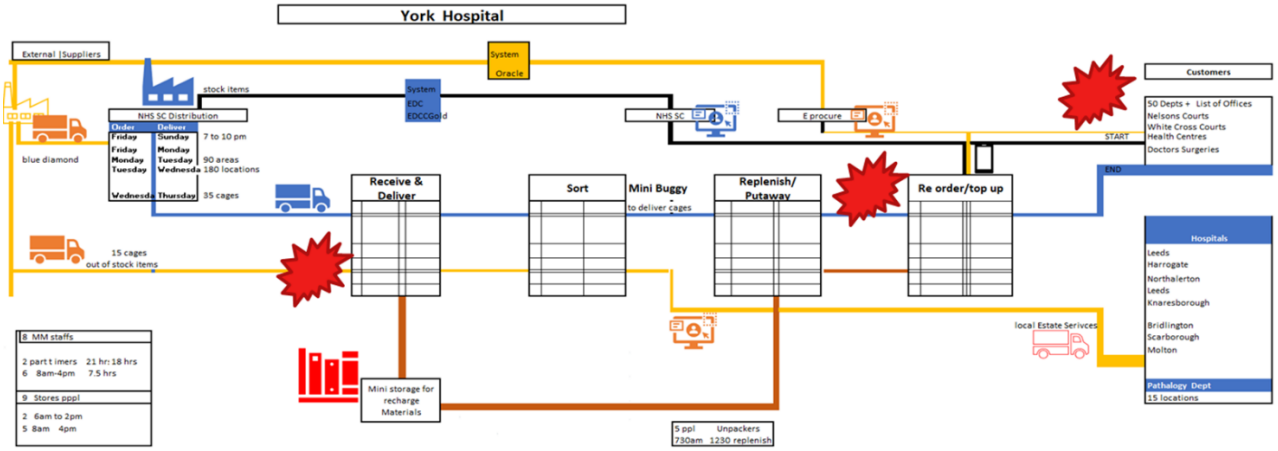

Figure 71 – York Materials Flow

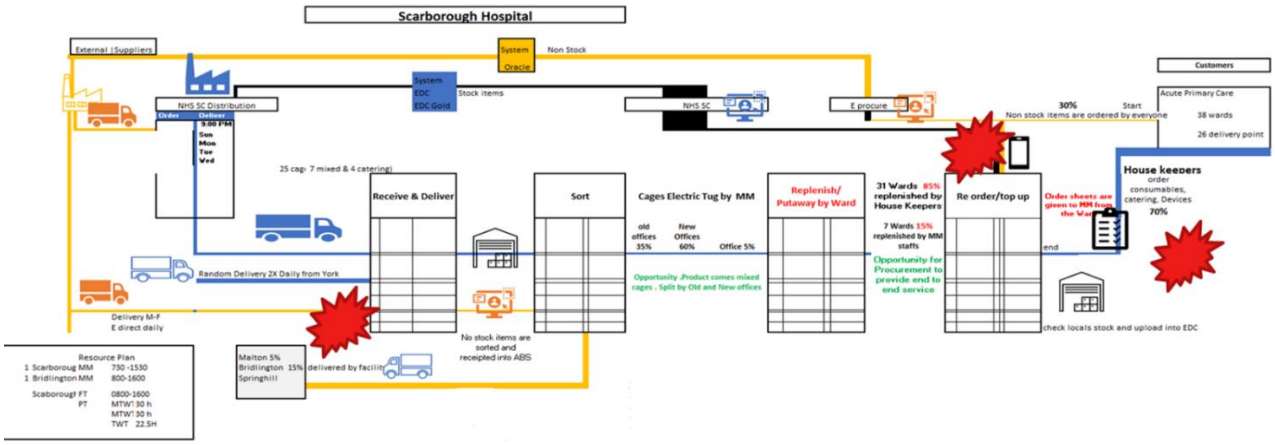

Figure 72 – Scarborough Materials Flow

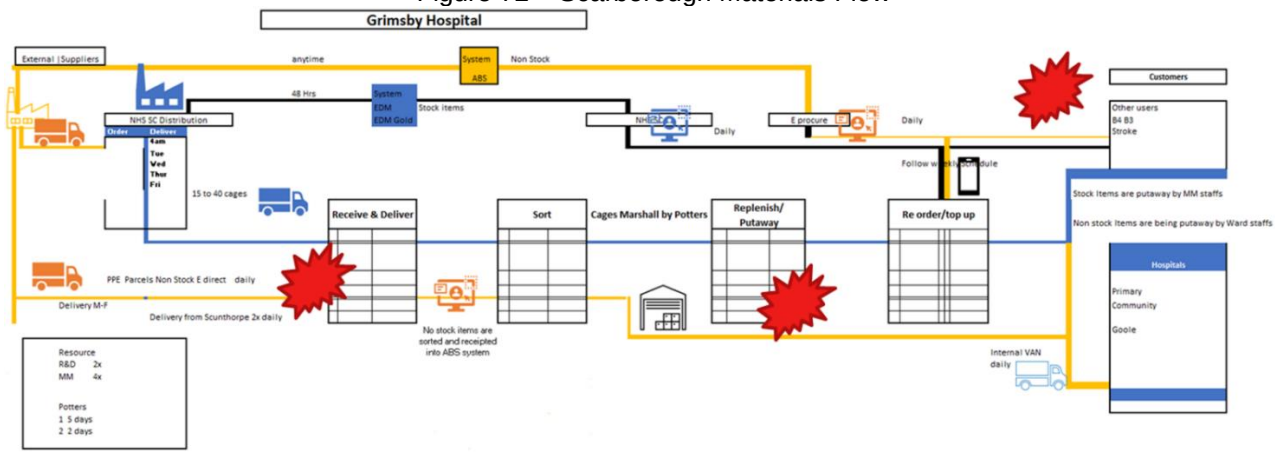

Figure 73 – Grimsby Materials Flow

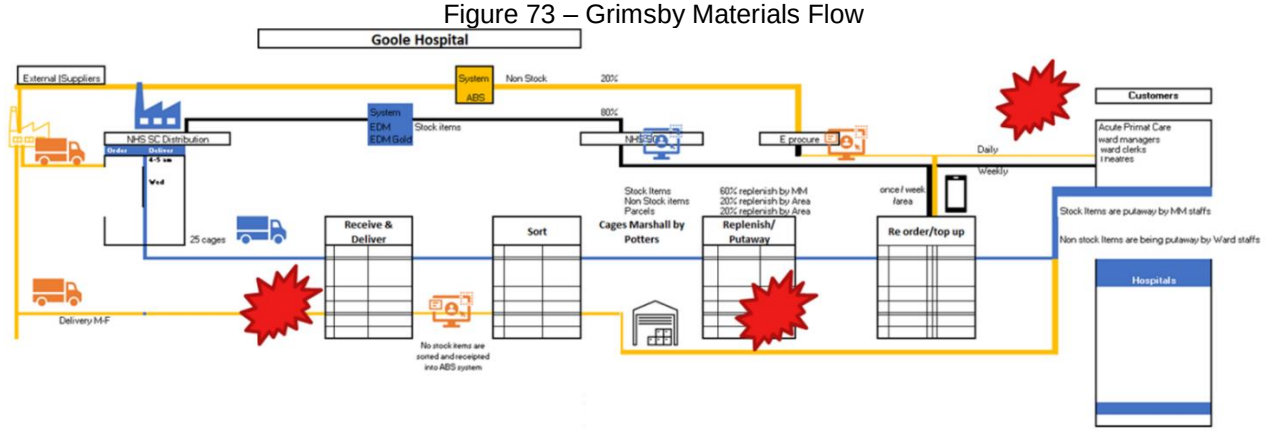

Figure 74 – Goole Materials Flow

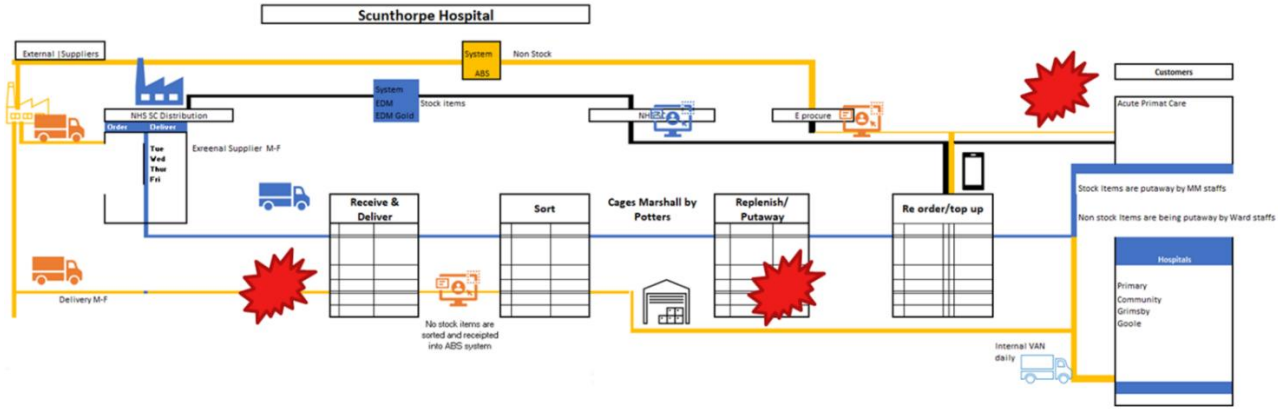

Figure 75 – Scunthorpe Materials Flow

Below is a summary of current organisation structure by salary band:

Band	Stores	Mat Man	Total	Weight	Midpoint Salary	Total Cost
Band 9	0	0	**0**	**0.00%**	£118,928.32	**£0.00**
Band 8D	0	0	**0**	**0.00%**	£99,005.30	**£0.00**
Band 8C	0	0	**0**	**0.00%**	£82,946.91	**£0.00**
Band 8B	0	0	**0**	**0.00%**	£68,975.29	**£0.00**
Band 8A	0	0	**0**	**0.00%**	£59,184.91	**£0.00**
Band 7	0	0	**0**	**0.00%**	£52,769.50	**£0.00**
Band 6	0	0	**0**	**0.00%**	£42,580.47	**£0.00**
Band 5	0	4	**4**	**6.19%**	£39,199.08	**£156,796.32**
Band 4	1	2	**3**	**4.64%**	£30,672.55	**£92,017.65**
Band 3	5	17.96	**22.96**	**35.53%**	£26,692.56	**£612,861.18**
Band 2	19.49	15.18	**34.67**	**53.64%**	£24,309.69	**£842,816.95**
Total	**25.49**	**39.14**	**64.63**			**£1,704,492.10**

Figure 76 – Existing Supply Chain Structure

Comparison of the role titles across the Partner Trusts shows some consistencies in job role and grade but also some inconsistencies e.g. Stores Supervisor at both band 3 and 4:

Band	HUTH	NLAG	YSTH
Band 8C	Head of Procurement	Head of Procurement	Head of Procurement
Band 8B			
Band 8A			
Band 7			
Band 6			
Band 5	Materials Manager	Materials Management Supervisor	Procurement & Disposals Officer
Band 4	Theatres Stores Supervisor	Deputy Materials Management Supervisor	Stores Supervisor
Band 3	Stores Supervisor	Materials Management Officer	Stores Supervisor Materials Management Officer PPE Supervisor
Band 2	Stores Staff Stock Replenisher Materials Management	Receipt & Distribution Officer	Storekeeper Supply Chain Porter PPE Porter

Figure 77 – Existing Job Profiles

The HNYPC Organisation Structure has been designed following discussion with various stakeholders including Heads of Procurement from HNYPC Partner Trusts. It has also been informed by a diagnostic undertaken by NHSSC over a 6 week period which sought feedback from all receipt & distribution and materials management staff.

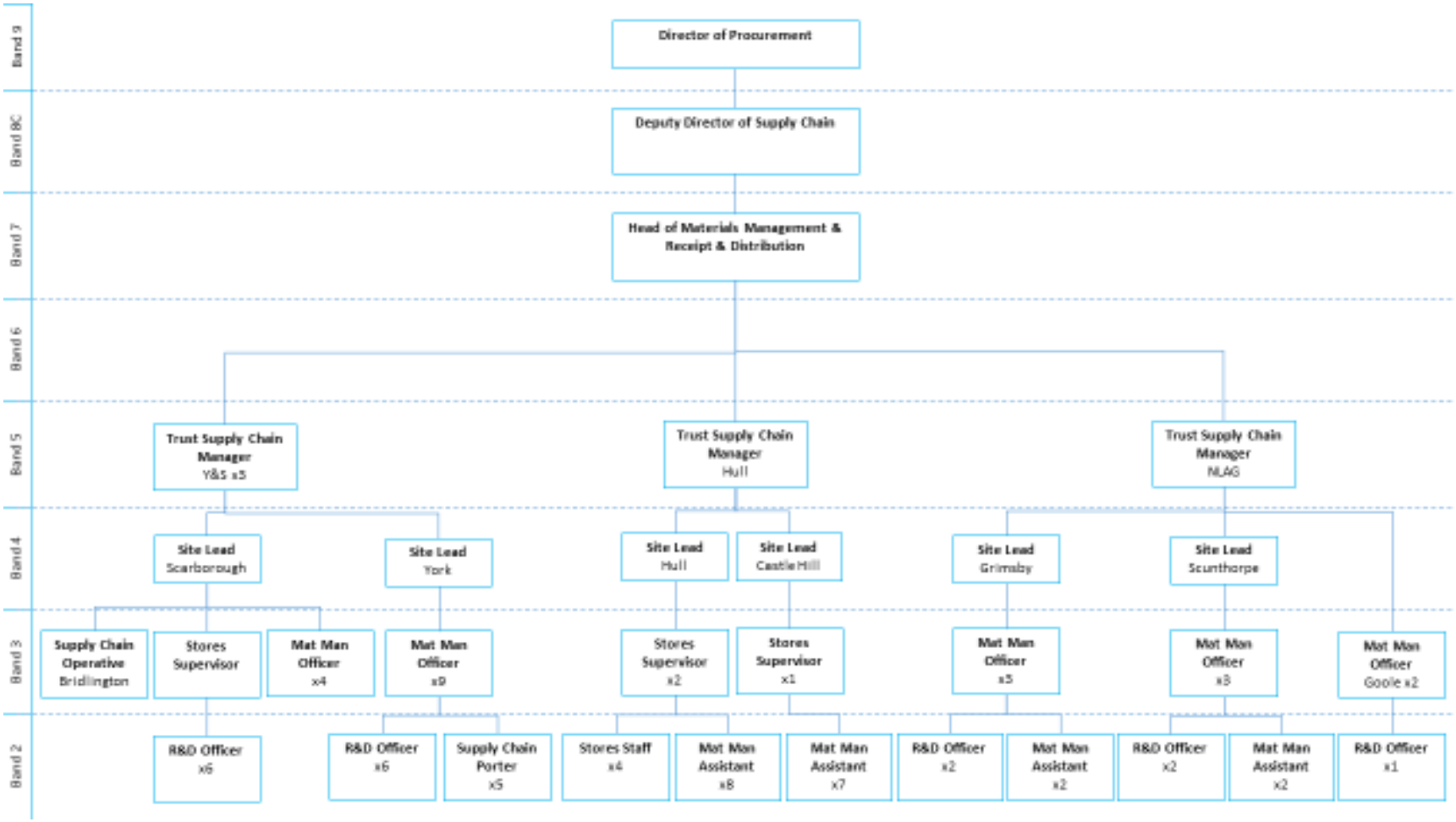

Figure 78 – Proposed Supply Chain Structure

This increases the supply chain headcount however expands materials management coverage across Partner Trusts which will enable better stock management. This requires an additional investment of £267,244.

Title	Proposed Band	Current Band	Responsibilities
Director of Procurement	9	9	Overall responsibility and accountability for the function and Procurement strategy across all Partner Trusts. Leading the senior management team, setting strategic direction and representing the alliance at the highest level.
Deputy Director Supply Chain	8C	n/a	Responsible for service and line management of the group's Inventory Management and logistics services. Provision, development & further deployment of comprehensive inventory management service, ensuring efficient and effective management of the Trust's Internal and external supply chains by utilising new and innovative methods and inventory management systems.
Head of Materials Management & Receipt and Distribution	7	n/a	Responsible for strategic management of the supply chain in a wide range of highly complex healthcare related goods and services and ensuring the Partner Trusts hold a suitable level of stock at all times to deliver clinical services.
Trust Supply Chain Manager	5	5	Responsible for the inventory management of regularly used consumables within clinical areas ensuring stock levels are managed and maintained in an efficient and cost effective manner in line with agreed procedures and processes via the Inventory Management service. Responsible for the receipt and distribution of goods throughout the hospital site. Responsible for the leadership of a team of inventory specialists and logistics officers on a single hospital site including the execution of quality audits
Site Lead	4	4	Responsible for the management of the consolidation centre. Receipting goods, storing, sorting, picking and distribution to hospital sites.
Supply Chain Operative	3	3	Responsible for providing materials management and receipt and distribution services at satellite sites.
Mat Man Officer	3	3	Responsible for the inventory management of regularly used consumables within clinical areas ensuring stock levels are managed and maintained in an efficient and cost effective manner in line with agreed procedures and processes via the Inventory Management service.
Stores Supervisor	3	3	Responsible for managing the receipt, storing, picking and distribution of stock from the consolidation centre to hospital sites. Includes delivery driving responsibilities.
Mat Man Assistant	2	2	Responsible for supporting the inventory management of regularly used consumables within clinical areas ensuring stock levels are managed and maintained in an efficient and cost

			effective manner in line with agreed procedures and processes via the Inventory Management service.
R&D Officer	2	2	Responsible for the receipt, storing, picking and distribution of stock from the consolidation centre to hospital sites. Includes delivery driving responsibilities.

Figure 79 – Supply Chain Roles & Responsibilities

Band	Stores	Mat Man	Total	Weight	Midpoint Salary	Total Cost
Band 9	0	0	**0**	**0.00%**	£118,928.32	**£0.00**
Band 8D	0	0	**0**	**0.00%**	£99,005.30	**£0.00**
Band 8C	0	1	**1**	**1.19%**	£82,946.91	**£82,946.91**
Band 8B	0	0	**0**	**0.00%**	£68,975.29	**£0.00**
Band 8A	0	0	**0**	**0.00%**	£59,184.91	**£0.00**
Band 7	0	1	**1**	**1.19%**	£52,769.50	**£52,769.50**
Band 6	0	0	**0**	**0.00%**	£42,580.47	**£0.00**
Band 5	0	5	**5**	**5.95%**	£39,199.08	**£195,995.40**
Band 4	4	6	**10**	**11.90%**	£30,672.55	**£306,725.50**
Band 3	0	22	**22**	**26.19%**	£26,692.56	**£587,236.32**
Band 2	21	24	**45**	**53.58%**	£24,309.69	**£1,093,936.05**
Total	**25**	**59**	**84**			**£2,319,609.68**

Figure 80 – Proposed Supply Chain Structure

However, this doesn't take into account those working less than full time. Within Supply Chain there are thirty three individuals who work part time. The cost of this is:

Band	Stores	Mat Man	Total	Midpoint Salary	Total Cost
Band 5	1	0	**1**	£39,199.08	**£39,919.08**
Band 3	0	3.04	**3.04**	£26,692.56	**£81,145.38**
Band 2	2.51	6.82	**9.33**	£24,309.69	**£226,809.41**
Total	**3.51**	**9.86**	**13.37**		**£347,873.87**

Figure 81 – Supply Chain Part Time Resource

The proposed Supply Chain structure has been calculated using full time equivalents at mid-point. The assumption is existing resource will move into the new structure on their current terms. The total proposed cost has therefore been reduced by £347,873.87 to reflect this position. When a new recruitment process is undertaken and an external candidate is successful then this will present an additional cost pressure as that individual may wish to work fulltime. To ensure that the best talent is attracted to HNYPC then a flexible approach should be undertaken to recruitment rather than restricting the hours. This will need to be managed within budget.

6.13.1 Receipt & Distribution

Each of the trusts has a receipt and distribution point at their main sites. This team are responsible for taking receipt of all deliveries, receipting the delivery on the e-Procurement system and taking the delivery to the order point.

There is significant resource dedicated to managing the receipt and distribution function across the 8 sites with 25.49 resources dedicated to this. Receipt and distribution for CHH is managed through HRI. This business case proposes putting that function back into CHH and removing the requirement to trans-ship product between sites, removing the duplication of double-handling product as well as the risk to HUTH from undertaking that activity.

One of the complaints around the stores operation comes from NHSSC who deliver into all three trusts using roll cages. The roll cages are taken into the hospital for ward put away but are then often not returned to stores or used for other purposes, e.g. collecting rubbish. There is also evidence that the roll cages are taken by other suppliers. NHSSC track the number of cages delivered into a Trust and the number collected. Across the three trusts there are a significant number of missing roll cages which NHSSC reserve the right to charge for.

A simple change to the way in which receipt and distribution operates will improve the roll cage position. A policy change should be made to ensure roll cages are not allowed to leave stores with all product decanted from a roll cage onto a trolley which is then taken to the put away area, emptied and returned to stores by materials management or stores employees. Not allowing roll cages to leave the stores area will ensure no cost is incurred from NHSSC for missing cages. This approach will also improve the health and safety risk of moving large and heavy cages around the hospital sites.

Overall the NHSSC diagnostic has found a lack of management control and performance management in receipt and distribution, this is not just a finding for the three Partner Trusts but across the country. Improvements in ways of working can be delivered through better management control and performance management which will help resolve the following issues which were raised by Partner Trust staff during the diagnostic:

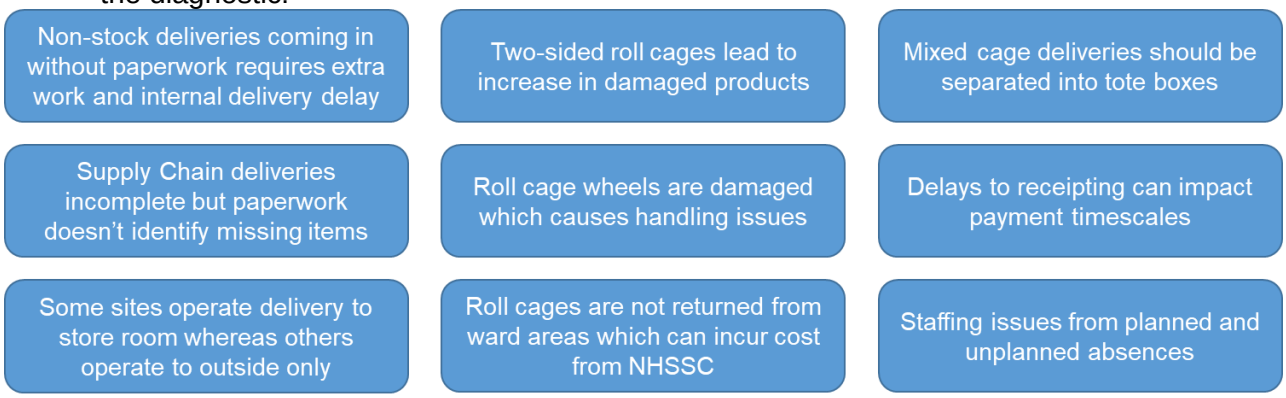

Figure 82 – Receipt & Distribution Findings

6.13.2 Materials Management

Materials Management is a core supply chain function that determines the material requirements for each stocked location by establishing inventory levels and then oversees the supply and distribution of these items. The primary business objectives of Materials Management are assured supply of materials to the optimum inventory levels and achieving a high level of ordering precision through standardisation, digitisation and commercialisation of ordering processes.

Each of the sites within HNYPC operate materials management differently. Only NLAG are close to a consistent approach across all of their sites. These different ways of working confuse customers and cause frustration. In feedback from customers one of

the main concerns was around cages being left in corridors for ward staff to empty. Despite technology solutions being in place, some sites still operate a paper based process. Stakeholders have raised concern that this has led to mistakes and over ordering which negatively impacts their budgets.

Both NLAG and Scarborough need to invest in Materials Management as the level of service provided across the sites needs to be expanded to provide a better service to procurements customers. This proposed structure addresses these service additions.

For clinical areas that have adopted Materials Management within the last 6 years at NLAG, an 11% average recurrent expenditure reduction has been achieved, as well as a 31% improvement in ordering precision. This is achieved through standardising stock levels, consolidating products and suppliers, swapping to approved products and suppliers, standardising order volumes, bulk ordering where possible and organising the stores in order to minimise wastage.

Location	Cost Centre	Period Start	Period End	Av Spend Before	Av Spend After	Precision Before	Precision After	Av Spend Change	Precision Change
SGH Ward 25	202542	01/04/2015	31/03/2016	2,469.77	1,989.86	959.95	1,130.28	-19.43%	15.07%
DPOW Theatre ENT	202325	01/05/2015	30/04/2016	42,422.46	37,072.01	15,990.66	11,561.19	-12.61%	-38.31%
DPOW NICU	202450	01/03/2017	28/02/2018	2,961.58	3,492.57	2,040.72	1,311.00	17.93%	-55.66%
SGH Stroke Unit	202611	01/04/2015	31/03/2016	1,164.19	961.28	637.02	770.08	-17.43%	17.28%
SGH Urology	202563	01/09/2016	31/08/2017	775.33	621.25	643.25	758.14	-19.87%	15.15%
Total				**49,793.32**	**44,136.98**	**20,271.60**	**15,530.70**	**-11.36%**	**-30.53%**

Figure 83 – Materials Management Benefits

There are also savings from clinical staff no longer unpacking and putting away goods, they can focus on delivering patient care. Clinical staff have also mentioned seeing significant levels of the same stock sitting in store rooms and they cannot understand why the product continues to be ordered. It is clear that there are gaps in service quality and value-addition. There is no current capability to share inventory across customer organisations, or to rationalise within individual teams in a customer organisation.

There is no single inventory management system in place at any of the three Partner Trusts which makes data driven decisions impossible especially decisions around appropriate stockholding and future forecasting e.g. the impact on demand created by an incident. This business case proposes implementation of a single inventory management system which aligns to the Scan for Safety programme.

Natural progression opportunities within the current structure are limited and there is not a consistent structure between Partner Trusts. The put away aspects of the current Materials Management Officer roles are physically demanding and the age profile of the current team is not best suited to this, a situation which will not improve with time. Some older staff members have suffered from minor physical issues linked to the general passage of time but this has impacted their ability to perform the full range of tasks at all times.

Materials Management technology and staff will be optimised to reduce the requirement for nursing staff to manage replenishment. All regularly used clinical consumables will be managed by the inventory management team, significantly reducing the time spent by clinical staff on ordering related activities.

Improvements to inventory management is expected to deliver substantial benefit to HNYPC Partner Trusts. The scope of this should include:

- Implementation and maintenance of inventory management, including GS1 bar-coding and Scan4Safety with booking of inventory to individual patient where required;
- Develop overarching stock policy (e.g. how to define stock level, shared inventories, local replenishment, economic order quantities);
- Planning suitable stock levels with customers to optimise pan-HNYPC effectiveness and efficiency and setting appropriate re-order points to manage inventory while protecting performance;
- Receipt of deliveries, including rejections and prompting supplier performance issues;
- Managing notifications for shelf-life expiry and wastage processes.

Any changes to inventory will require a stock policy to ensure consistent management. This should apply data-driven opportunities for improvement. It is noted that there are expected to be some locations (e.g. community settings) where the inventory level is unlikely to justify the full responsibility for inventory management being transferred to HNYPC. An alternative hybrid model is required to support these scenarios where HNYPC enable local staff to discharge those responsibilities. The objective is to reduce waste, including potential to reduce inventory and make balance sheet improvements.

Overall the NHSSC diagnostics has found a lack of management control and performance management in materials management, this is not just a finding for the three Partner Trusts but across the country. Improvements in ways of working can be delivered through better management control and performance management which will help resolve the following issues which were raised by Partner Trust staff during the diagnostic:

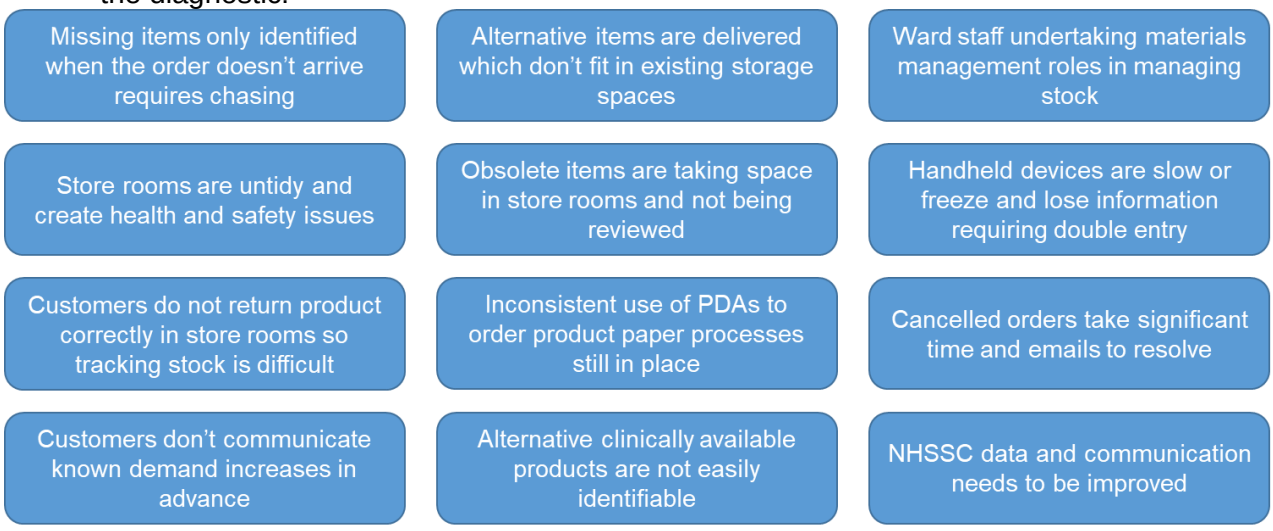

Figure 84 – Materials Management Findings

6.14 Physical Inventory

Model Hospital Data shows that the national peer average for stock holding is 36.1 days of static stock. HUTH performs well, reporting 30.8 whereas YSTH (67.2) and NLAG (69.1) sit significantly higher. A reduction in stockholding would reduce the risk of stock obsolescence and deliver cost reduction.

Although there is some evidence of stockholding reports being shared with customers on a 6 monthly basis there is limited evidence of procurement providing physical

inventory management reports and limited management of most economic order quantity. Asset tagging, and digital control of high value assets is not undertaken pan-HNYPC although HUTH are working on this as part of their Scan4Safety deployment.

It is noted that other ICSs have successfully implemented their own local physical inventory handling processes to drive sustainability improvements by reducing the number of truck rolls into a location. This is by the use of a logistics hub, with small electric vehicles completing the last leg of the journey to customers. This should also be considered as part of the NHSSC review.

6.15 Resource Changes – Impact on Model Hospital

Option 5 better aligns some of the resource to the Model Hospital average such as the band 8A's but keeps the high tail of the band 2 posts although this would be reviewed over time as vacancies arise:

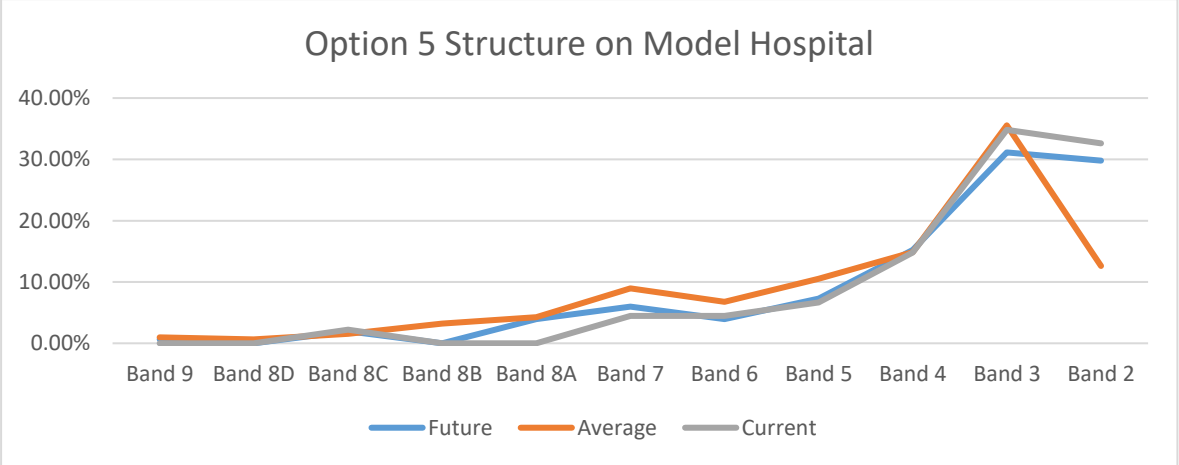

Figure 85 – Option 5 Structure on Model Hospital

7. Preferred Option - Data, Technology & Performance

7.1 Current Position

The current systems in use across the ICS for managing procurement activity are set out below:

System Category		HUTH	NLAG	YSTH
Spend analytics & price benchmarking	System	Spend Comparison Service	Spend Comparison Service	Spend Comparison Service
	Annual Spend	£3.300	£3.300	£3.300
	End Date	31/07/2023	31/07/2023	31/07/2023
Pipeline/ work plan management	System	Excel	n/a	Excel
	Annual Spend	£0	£0	£0
	End Date	n/a (Microsoft Licence)	n/a (No System)	n/a (Microsoft Licence)
eSourcing/ eTendering	System	Pro-Contract	In-Tend	In-Tend
	Annual Spend	£8,397	£1,665	£1,665
	End Date	30/09/2023	30/11/2024	30/11/2024
Contracts & Supplier Management	System	n/a	n/a	In-Tend
	Annual Spend	£0	£0	£0 (included in above cost)
	End Date	n/a (No System)	n/a (No System)	30/11/2024
eCatalogue	System	Advance Business Solutions	Advance Business Solutions	Advance Business Solutions
	Annual Spend	Included in cost below	Included in cost below	Included in Oracle Cloud
	End Date	30/04/2023	30/04/2027	05/04/2024
PEPPOL Access Points	System	n/a	n/a	Pagero
	Annual Spend	£0	£0	Included in Oracle Cloud
	End Date	n/a (No System)	n/a (No System)	05/04/2024
Requisition & Purchase Order	System	Advance Business Solutions	Advance Business Solutions	Oracle Cloud
	Annual Spend	£214,865	£69,932	£108,547.06

	End Date	30/04/2023	30/04/2027	05/04/2024
Inventory Management	System	Advance Business Solutions & Genesis	n/a	Omnicell & Ingenica for Community
	Annual Spend	Included in cost above	£0	£69,912.34
	End Date	30/04/2023	n/a (No System)	21/01/2023

Figure 86 – Procurement Systems

There are multiple systems in use across the three Partner Trusts both for individual tasks but also for the same tasks. These systems don't communicate with one another and therefore cause data discrepancy issues which make reporting difficult. As an example procurement report the use of 1,429 suppliers whereas finance data shows 7,271 suppliers. Data is also not used to inform strategy for future procurements nor to measure the success of meeting other government policy e.g. absence of data on SME (Small to Medium Enterprise) suppliers and how the Partner Trusts support their local communities.

Dedicated procurement resource currently in place to support the effective use of procurement systems, both within Procurement as well as customers across the trusts who input information is limited to 1x band 6 and 1x band 3, both of these posts are at YSHT. Neither HUTH nor NLAG have any dedicated resource in place to ensure the effective and efficient use of procurement systems and data.

7.2 Spend Analytics & Price Benchmarking

The only single instance system used across a stage of the procurement process is spend analytics & price benchmarking where all three Partner Trusts utilise the NHS Spend Comparison Service provided by NHS Digital.

Although all three Partner Trusts are inputting data into the system it is evident that the data submitted isn't consistent nor is the data within the system being used to inform procurement decisions. As an example HUTH are not including all of the Pharmacy expenditure as only £4m of annual spend is included nor is spend (VAT) with HMRC being submitted. The inconsistency of data input by the Partner Trusts questions the value of the reporting functionality available within the system which may explain why it's not being used to inform procurement decisions. This could be an invaluable repository of procurement spend information for collaborative procurement and defining strategy if spend was consistently reported. It would also allow procurement strategies to benchmark against a 'should-cost' position and identify savings opportunities in advance of any procurement.

NHSEI have built HCVPC our own version of the SCS which allows for local customisation.

In the future state there is no change in the system choice here however standardisation of the information input to the system is required to allow for standard reporting. Work will be undertaken to understand the current differences of data being put into the system with a standard operating process put in place to ensure consistent input.

7.3 Pipeline/ Work Plan Management

Pipeline and work plan management is being undertaken in Excel at HUTH and YSTH whereas NLAG doesn't have any process in place to plan procurement activity. Whilst Excel is a valid option it does contain risks around data integrity and security and does not integrate with any other part of the procurement process e.g. you cannot promote a project from the plan into live procurement.

There is also a requirement for organisations with a non-pay expenditure over £200m to publish their procurement pipeline in advance so that suppliers can see when they would expect opportunities to be published. None of the Partner Trusts are currently publishing their pipelines and are therefore not compliant with this requirement.

On review of the work plans submitted:

- 35 contracts don't have end dates;
- 145 contracts are with unknown suppliers;
- 332 contracts have an unknown contract value.

In summer 2022 DHSC through NHSEI announced that Atamis is being rolled out across the NHS and that this will be centrally funded. Implementation of a single system which allows concurrent customer access and mandates the entry of key contract information would ensure data integrity. By using Atamis publication of procurement pipelines will be automatically completed and therefore ensure that the Partner Trusts are compliant with Procurement Regulation.

A project team has been established with representatives at each Trust. The aim is to have implemented the Atamis system by 1st April 2023.

7.4 e-Sourcing/e-Tendering and Contract & Supplier Management

Both NLAG and YSTH use the same system for eSourcing/eTendering and Contract and Supplier Management (although NLAG are not using this module) – In-Tend. This system was provided as part of the membership cost to the NOECPC but this has come to an end following the introduction of a national system by DHSC. Both organisations have signed a 3 year contract with In-Tend taking commitment through to the end of 2024. HUTH are using Pro-Contract for their tendering activity but are not undertaking any contract or supplier management activity through any system. In summer 2022 DHSC through NHSEI communicated the national rollout of their system fully funded to the NHS.

Moving to a single system which is consistent with the pipeline/ work plan module will allow projects to be advanced from the plan to the live environment and will update the published work plan without additional manual intervention. As both NLAG and YSTH have signed 3 year contracts which do not expire until 2024 the proposal is this is seen as a lost cost with the benefit of changing systems before the end date exceeding the lost cost.

7.5 eCatalogue

All Partner Trusts are getting their e-catalogue solution through Advance Business Solutions. This appears to have been deployed as a financial management system rather than a procurement system as none of the organisations are utilising the Tender Management, Contract Management or Spend Analytics modules offered by Advance Business Solutions.

As the ordering processes are automated, catalogues are developed with standardised product descriptions. This ensures the ordering data that feeds the general ledger is consistent, articulate and ultimately improves financial data quality and the non-pay decisions made by budget managers and management accountants.

The proposal is to maintain the existing eCatalogue system but move to a single instance. This way the eCatalogue seen in one Partner Trust is seen across all three ensuring consistency of price paid but also combined demand which should result in a reduced price. This approach will also reduce the overhead of maintaining catalogues as only one change will be required by a supplier rather than three changes. To reduce the administrative burden of managing catalogues the use of supplier managed catalogues will be investigated. Buyers will still control whether price changes to a catalogue are accepted but will not be responsible for the loading of data.

ABS have confirmed that a managed service for catalogue management can be implemented. The proposal is that a one off cost around £10k will deliver a consistent catalogue from the existing three Partner Trust catalogues. They will then manage the catalogue for an annual cost of £20k-£25k per annum. The catalogue will then populate a front-end marketplace where users can order from.

7.6 PEPPOL Access Points

PEPPOL (Pan-European Public Procurement On Line) is a set of technical specifications that enables machine-to-machine electronic business transactions. In short, it is the ability to send electronic Purchase Orders, Invoices and other supply chain documents in a standard format and at low cost between different systems providers. At the moment this is only used by YSTH.

The recommendation is that the benefits of this system are reviewed and potentially expanded across the Partner Trusts for consistency.

7.7 Requisition & Purchase Order

Both HUTH and NLAG are using Advance Business Solutions for requisition and purchase order raising whereas YSTH are using Oracle. Both of these systems are predominantly finance systems adapted for procurement. Although HUTH and NLAG are using the same provider these are different instances and therefore the two systems do not talk to one another. The cost for the e-procurement element of the e-financial system is incorporated within the outsourced payments function and is therefore not possible to separate.

Having three separate e-procurement solutions provides additional administrative requirements for HNYPC. Although one collaborative contract may be awarded following a tender exercise, three purchase orders would need to be raised to ensure the costs are fed back into the local Trust ledger. This would then require the supplier to submit three invoices and chase three separate payments. Feedback from suppliers is that this doesn't reduce the cost of doing business with the collaborative and will therefore impact the level of benefit that could be achieved through collaborative procurement.

As such, it is recommended that a common cloud based purchase to pay (P2P) solution is purchased and installed at the front end as a layer over the Partner Trusts finance and accounting system. The P2P solution would hold catalogue content, handle web based requisitions, approval workflows, order transmission, receipting and

invoice management in a single instance, allowing for an intuitive, feature rich, customer experience.

Each Partner Trust will retain its own financial system in the short to medium term, with interfaces synchronising static and transactional data between the cloud system and the Partner Trusts choice of finance/ ERP solution with a selection of standard interface touch points. Decoupling the purchase to pay solution from the Finance system will also reduce dependencies for Partner Trusts to join other shared back office services. For example, a different group of trusts could be part of the Procurement collaboration to those engaged in a shared financial services organisation.

The long term solution should consider a single e-Financial system across the Partner Trusts.

7.8 Inventory Management

Inventory Management sees the biggest divergence in systems. Both HUTH and YSTH have two systems, Advance Business Solutions and Genesis in HUTH and Omnicell and Ingenica in YSTH.

NHSSC have undertaken a review of the Partner Trusts supply activities, this also included systems. As part of the NHSSC review it has been recommended that opportunities for automated/ semi-automated inventory management systems needs to be considered. Other NHS organisations are using cabinets which issue stock and automatically reorder based on pre-set order levels. The requirement will also need to consider automatic stock checking and automatic replenishment, as well as the returns process to provide an appropriate balance between risk and cost control.

The NHSSC review is also considering the ownership of inventory management systems and whether the centre should take the same approach to these as they have done with the Atamis programme e.g. provide a funded system for the NHS. The decision on whether to do this will take time as will any procurement process.

The recommendation is that the Partner Trusts move to the same inventory management solution to provide visibility of stockholding across the Partner Trusts and that this project is agreed and delivered in collaboration with the Scan4Safety team.

7.9 Scan4Safety

Scan4Safety is in the process of being rolled out at HUTH with conversations ongoing around implementation at NLAG and YSTH. Any decision to rollout at NLAG and YSTH will be subject to a separate business case. Although procurement is not responsible for the rollout of Scan4Safety it plays an important role when a new department is set up and is a key user of the data which the programme generates.

Procurement are required to provide a purchase order report at the start of the implementation of Scan4Safety into any area. This sets out which products have been purchased from which suppliers, at what cost and quantity. This information allows the Scan4Safety team to load product into the system and assign it to clinical teams preference cards. At HUTH around 40% of stock found as part of the Scan4Safety implementation has not been included within the purchase order data which raises questions around how the stock appears in clinical areas.

There are other issues with the process such as changes being made to product selection not feeding into the Scan4Safety team. This means that when clinical

customers scan a product against a patient it is not found. Product is then used and not associated with the procedure. Where PBR applies these costs will not be recharged in full.

To support the Scan4Safety implementation at HUTH and potentially NLAG and YSTH it will be essential to have robust policies, procedures and systems in place within procurement to ensure all products can be scanned and the cost of the procedures undertaken charged appropriately. As such this business case includes the requirement for a single inventory management system to be deployed across all three Partner Trusts.

HUTH's implementation has also highlighted that stock controllers sit outside of Procurement and that there is a communication disconnect between the stock controllers and Procurement. This means that proper stock controls are not in place leading to stock being ordered that isn't required and stock going out of date which needs to be disposed of. All stock management should be centralised into HNYPC with appropriate re-order quantities and levels being agreed with budget holders.

The information and outputs from Scan4Safety should be used by procurement to influence supplier relationship management, contract management and buying behaviours within the business. Scan4Safety should be used as a key system for driving efficiencies and improvements within the patient pathway and identifying cost saving opportunities through standardisation of preference cards. Examples of the data points we could acquire, and the associated benefits include:

- Full traceability of implantable products to patients – reducing risk from product recall;
- Freeing up clinical time to focus on patient care;
- Reducing stock holding through better stock management;
- Ongoing operational efficiencies through better stock management and identifying where stock is held;
- Improved patient level costing with a complete range of items used in each procedure;
- Engagement of clinical community from increased visibility of operational data. Understanding why different clinicians use different products for the same procedure and comparing the outcomes achieved can enable a wider range of clinical discussions about a common ways of working;
- Opportunity to drive standardisation. Savings from elimination of unwarranted variation.

HUTH are moving to a new inventory management system with the key delivery dates being:

Date	Action
November 21 – August 22	Data gathering.
January 22 – September 22	Planning stages.
May 22 – July 22	Design stages.
June 22 – July 22	Systems build.
July 22 – September 22	Systems testing.
October 22 – November 22	Cutover for testing within live environment.
November 22 – March 23	Migration of existing users to new system.

Figure 87 – Scan4Safety Timeline

7.10 Opportunity/ Future State

The current systems and applications have been assessed as having substantial performance gaps to best-in-class. In addition, the approach for systems and applications to support each stage of the procurement cycle, with integration between systems and applications, brings increased cost and reduced quality of data insights.

The recommendation is that a two stage approach is taken to the future systems strategy. The first stage is to standardise, where possible, onto an existing system for all Partner Trusts. The aims of this are that:

- All Partner Trusts use the same instance of the same system in a consistent manner allowing for accurate reporting;
- Standardised technology architecture is required to enable HNYPC to operate effectively and avoid substantial manual processes and duplication;
- Improved use of technology is required to enable delivery of the benefits anticipated by the creation of HNYPC;
- Opportunity to transform procurement work by ensuring broad availability and adoption of digital source to pay tools to make procurement automated, proactive and predictive.

The desired future systems strategy is set out below which focuses on moving all three Partner Trusts to the same instance of the same system. To select from within the existing systems and applications currently used by HNYPC Partner Trusts at each stage of the procurement cycle, and deploy that across HNYPC. By selecting from within existing systems, the need for appraisal of different systems and applications is constrained, and the speed of deployment is increased, ensuring that harmonised systems are deployed as quickly as possible. The expected timescale to achieve alignment is 12 months.

System Category		HUTH	NLAG	YSTH
Spend analytics & price benchmarking	System	Spend Comparison Service	Spend Comparison Service	Spend Comparison Service
	Annual Spend	£3.300	£3.300	£3.300
	End Date	n/a (internal NHS System)	n/a (internal NHS System)	n/a (internal NHS System)
Pipeline/work plan management	System	Atamis	Atamis	Atamis
	Annual Spend	£0	£0	£0
	End Date	n/a (centrally funded)	n/a (centrally funded)	n/a (centrally funded)
eSourcing/ eTendering	System	Atamis	Atamis	Atamis
	Annual Spend	£0	£0	£0
	End Date	n/a (centrally funded)	n/a (centrally funded)	n/a (centrally funded)
Contracts & Supplier Management	System	Atamis	Atamis	Atamis
	Annual Spend	£0	£0	£0
	End Date	n/a (centrally funded)	n/a (centrally funded)	n/a (centrally funded)

eCatalogue	System	Advance Business Solutions	Advance Business Solutions	Advance Business Solutions
	Annual Spend	£8,333	£8,333	£8,333
	End Date	30/04/2027	30/04/2027	30/04/2027
PEPPOL Access Points	System	Pagero	Pagero	Pagero
	Annual Spend	£1,667	£1,667	£1,667
	End Date	TBC	TBC	TBC
Requisition & Purchase Order	System	ABS/Oracle	ABS/Oracle	ABS/Oracle
	Annual Spend	£75,000	£75,000	£75,000
	End Date	TBC	TBC	TBC
Inventory Management	System	Tagnos	Tagnos	Tagnos
	Annual Spend	£47,500	£47,500	£47,500
	End Date	October 2025	October 2025	October 2025

Figure 88 – Future Procurement Systems

8. Preferred Option – Benefits Realisation

8.1 Current HNYPC Costs and Benefits

The current budgeted costs of procurement, materials management and outsourced procurement across the organisations in scope are as follows:

Detailed Revenue Financials

Pay	**2022/23**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**
Band 9	£80,809.00	£80,809.00	£80,809.00	£80,809.00	£80,809.00	£80,809.00
Band 8C	£254,374.00	£254,374.00	£254,374.00	£254,374.00	£254,374.00	£254,374.00
Band 8A	£59,600.00	£59,600.00	£59,600.00	£59,600.00	£59,600.00	£59,600.00
Band 7	£341,898.00	£341,898.00	£341,898.00	£341,898.00	£341,898.00	£341,898.00
Band 6	£268,793.00	£268,793.00	£268,793.00	£268,793.00	£268,793.00	£268,793.00
Band 5	£437,660.00	£437,660.00	£437,660.00	£437,660.00	£437,660.00	£437,660.00
Band 4	£431,223.00	£431,223.00	£431,223.00	£431,223.00	£431,223.00	£431,223.00
Band 3	£1,000,790.00	£1,000,790.00	£1,000,790.00	£1,000,790.00	£1,000,790.00	£1,000,790.00
Band 2	£845,924.00	£845,924.00	£845,924.00	£845,924.00	£845,924.00	£845,924.00
Other Pay Adjustments*	-£28,620.00	-£28,620.00	-£28,620.00	-£28,620.00	-£28,620.00	-£28,620.00
Sub Total Pay	**£3,692,451.00**	**£3,692,451.00**	**£3,692,451.00**	**£3,692,451.00**	**£3,692,451.00**	**£3,692,451.00**
Non-Pay Expenditure						
Med-Surg Equipment Disposal	£10,012.00	£10,012.00	£10,012.00	£10,012.00	£10,012.00	£10,012.00
Staff Uniforms and Clothing	£5,475.00	£5,475.00	£5,475.00	£5,475.00	£5,475.00	£5,475.00
Protective Clothing	£2,625.00	£2,625.00	£2,625.00	£2,625.00	£2,625.00	£2,625.00
Cleaning Materials	£200.00	£200.00	£200.00	£200.00	£200.00	£200.00
Bedding & Linen : Disposable	£600.00	£600.00	£600.00	£600.00	£600.00	£600.00
Other General Supplies	£400.00	£400.00	£400.00	£400.00	£400.00	£400.00
Stationery	£8,108.00	£8,108.00	£8,108.00	£8,108.00	£8,108.00	£8,108.00
Postage & Carriage	£400.00	£400.00	£400.00	£400.00	£400.00	£400.00
Packing & Storage	£500.00	£500.00	£500.00	£500.00	£500.00	£500.00
Travel & Subsistence	£10,200.00	£10,200.00	£10,200.00	£10,200.00	£10,200.00	£10,200.00
Vehicle Running Costs Fuel	£2,500.00	£2,500.00	£2,500.00	£2,500.00	£2,500.00	£2,500.00
Training Expenses	£14,400.00	£14,400.00	£14,400.00	£14,400.00	£14,400.00	£14,400.00
Legal Fees	£2,000.00	£2,000.00	£2,000.00	£2,000.00	£2,000.00	£2,000.00
Professional Fees	£5,100.00	£5,100.00	£5,100.00	£5,100.00	£5,100.00	£5,100.00
Furniture and Fittings	£2,100.00	£2,100.00	£2,100.00	£2,100.00	£2,100.00	£2,100.00
Office Equipment and Purchases	£800.00	£800.00	£800.00	£800.00	£800.00	£800.00
Computer Hardware Purchases	£6,900.00	£6,900.00	£6,900.00	£6,900.00	£6,900.00	£6,900.00
Computer Software/ License Fees	£7,350.00	£7,350.00	£7,350.00	£7,350.00	£7,350.00	£7,350.00
External Consultancy Fees	£8,000.00	£8,000.00	£8,000.00	£8,000.00	£8,000.00	£8,000.00
Miscellaneous Expenditure	£11,800.00	£11,800.00	£11,800.00	£11,800.00	£11,800.00	£11,800.00
General Losses and Special Payments	£1,900.00	£1,900.00	£1,900.00	£1,900.00	£1,900.00	£1,900.00
Staff Benefits	£100.00	£100.00	£100.00	£100.00	£100.00	£100.00
Books, Journals and Subscriptions	£58,500.00	£58,500.00	£58,500.00	£58,500.00	£58,500.00	£58,500.00
Sub Total Non-Pay	**£159,970.00**	**£159,970.00**	**£159,970.00**	**£159,970.00**	**£159,970.00**	**£159,970.00**
Other Non-Pay Adjustments**	**-£154,773.00**	**-£154,773.00**	**-£154,773.00**	**-£154,773.00**	**-£154,773.00**	**-£154,773.00**
Total Pay & Non-Pay	**£3,697,648.00**	**£3,697,648.00**	**£3,697,648.00**	**£3,697,648.00**	**£3,697,648.00**	**£3,697,648.00**

Figure 89 – Current Budget Costs

* Other pay adjustments include budgeted pay efficiency savings and costs for agency staff.

** Other non-pay adjustments relate to an income target at YSTH for the sale of equipment which has reached the end of its useful life. Equipment is typically auctioned and either sent abroad or used within the veterinary sector.

The current return on investment for the procurement teams is:

	HUTH	NLAG	YSTH	Total
Annual Pay Budget	£1,152,509	£941,600	£1,598,342	£3,692,451
Annual Non-Pay Budget	£58,800	£31,700	£69,470	£159,970
Total Expenditure	£1,211,309	£973,300	£1,667,812	£3,852,421

Income Target	£0	£0	£154,773	£154,773
Total Budget Position	£1,211,309	£973,300	£1,513,039	£3,697,648
Saving Target	£1,072,484	£200,000	£913,322	£2,185,806
Return on Investment	0.89	0.21	0.60	0.59

Figure 90 – Current Return on Investment

It should be noted that e-Procurement costs do not sit within procurement budgets as the cost is within the finance budget for the e-finance system, if this was included the ROI for the Procurement team would be lower.

Current savings targets for the three Partner Trusts provides an annual benefit of £2.1m, 0.05% of non-pay spend. Other cluster trusts typically save 2-3% of non-pay spend with the Lord Carter report 'Operational Productivity and performance in English NHS acute hospitals: Unwarranted variations', setting a procurement savings target of 9.5%. There is opportunity for significant improvement on current performance.

8.2 Preferred Option HNYPC Costs

The proposed budgeted costs for procurement, materials management and outsourced procurement across the organisations in scope are as follows:

Detailed Capital Financials

Capital Purchase	Value	Life	Residual Values
Inventory Management System	£57,900.00	5	£0.00
IT & Telecoms Equipment	£75,000.00	5	£0.00
	£132,900.00		

	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28
Inventory Management System	£57,900.00	£0.00	£0.00	£0.00	£0.00	£0.00
Depreciation	£0.00	£11,580.00	£11,580.00	£11,580.00	£11,580.00	£11,580.00
Closing Value	£57,900.00	£46,320.00	£34,740.00	£23,160.00	£11,580.00	£0.00
Capital Charge	£2,026.50	£1,621.20	£1,215.90	£810.60	£405.30	£0.00
IT & Telecoms Equipment	£75,000.00	£0.00	£0.00	£0.00	£0.00	£0.00
Depreciation	£0.00	£405.30	£405.30	£405.30	£405.30	£405.30
Closing Value	£75,000.00	£74,594.70	£74,189.40	£73,784.10	£73,378.80	£72,973.50
Capital Charge	£2,625.00	£2,610.81	£2,596.63	£2,582.44	£2,568.26	£2,554.07
Totals	**£270,451.50**	**£137,132.01**	**£124,727.23**	**£112,322.44**	**£99,917.66**	**£87,512.87**

Detailed Revenue Financials

Pay	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28
Band 9	£118,928.32	£118,928.32	£118,928.32	£118,928.32	£118,928.32	£118,928.32
Band 8C	£254,374.00	£248,840.73	£248,840.73	£248,840.73	£248,840.73	£248,840.73
Band 8A	£59,600.00	£355,109.46	£355,109.46	£355,109.46	£355,109.46	£355,109.46
Band 7	£341,898.00	£474,925.41	£474,925.41	£474,925.41	£474,925.41	£474,925.41
Band 6	£268,793.00	£255,482.76	£255,482.76	£255,482.76	£255,482.76	£255,482.76
Band 5	£437,660.00	£509,587.91	£509,587.91	£509,587.91	£509,587.91	£509,587.91
Band 4	£431,223.00	£613,450.80	£613,450.80	£613,450.80	£613,450.80	£613,450.80
Band 3	£805,449.00	£1,227,857.30	£1,227,857.30	£1,227,857.30	£1,227,857.30	£1,227,857.30
Band 2	£845,924.00	£1,093,936.05	£1,093,936.05	£1,093,936.05	£1,093,936.05	£1,093,936.05
Other Pay Adjustments	£28,980.00	-£407,240.99	-£407,240.99	-£407,240.99	-£407,240.99	-£407,240.99
Sub Total Pay	**£3,592,829.32**	**£4,490,877.75**	**£4,490,877.75**	**£4,490,877.75**	**£4,490,877.75**	**£4,490,877.75**
Non-Pay Expenditure						
Med-Surg Equipment Disposal	£10,012.00	£10,012.00	£10,012.00	£10,012.00	£10,012.00	£10,012.00
Staff Uniforms and Clothing	£5,475.00	£5,475.00	£5,475.00	£5,475.00	£5,475.00	£5,475.00
Protective Clothing	£2,625.00	£2,625.00	£2,625.00	£2,625.00	£2,625.00	£2,625.00
Cleaning Materials	£200.00	£200.00	£200.00	£200.00	£200.00	£200.00
Bedding & Linen : Disposable	£600.00	£600.00	£600.00	£600.00	£600.00	£600.00
Other General Supplies	£400.00	£400.00	£400.00	£400.00	£400.00	£400.00
Stationery	£8,108.00	£8,108.00	£8,108.00	£8,108.00	£8,108.00	£8,108.00
Postage & Carriage	£400.00	£400.00	£400.00	£400.00	£400.00	£400.00
Packing & Storage	£500.00	£500.00	£500.00	£500.00	£500.00	£500.00
Travel & Subsistence	£10,200.00	£10,200.00	£10,200.00	£10,200.00	£10,200.00	£10,200.00
Vehicle Running Costs Fuel	£2,500.00	£2,500.00	£2,500.00	£2,500.00	£2,500.00	£2,500.00
Training Expenses	£14,400.00	£14,400.00	£14,400.00	£14,400.00	£14,400.00	£14,400.00
Legal Fees	£2,000.00	£2,000.00	£2,000.00	£2,000.00	£2,000.00	£2,000.00
Professional Fees	£5,100.00	£5,100.00	£5,100.00	£5,100.00	£5,100.00	£5,100.00
Furniture and Fittings	£2,100.00	£2,100.00	£2,100.00	£2,100.00	£2,100.00	£2,100.00
Office Equipment and Purchases	£800.00	£800.00	£800.00	£800.00	£800.00	£800.00
Computer Hardware Purchases	£6,900.00	£6,900.00	£6,900.00	£6,900.00	£6,900.00	£6,900.00
Computer Software/ License Fees	£7,350.00	£7,350.00	£7,350.00	£7,350.00	£7,350.00	£7,350.00
External Consultancy Fees	£8,000.00	£8,000.00	£8,000.00	£8,000.00	£8,000.00	£8,000.00
Miscellaneous Expenditure	£11,800.00	£11,800.00	£11,800.00	£11,800.00	£11,800.00	£11,800.00
General Losses and Special Payments	£1,900.00	£1,900.00	£1,900.00	£1,900.00	£1,900.00	£1,900.00
Staff Benefits	£100.00	£100.00	£100.00	£100.00	£100.00	£100.00
Books, Journals and Subscriptions	£58,500.00	£58,500.00	£58,500.00	£58,500.00	£58,500.00	£58,500.00
Additional Non-Pay Costs						
HUTH NOECPC Membership	£0.00	£30,000.00	£30,000.00	£30,000.00	£30,000.00	£30,000.00
PEPPOL Access Point	£0.00	£5,000.00	£5,000.00	£5,000.00	£5,000.00	£5,000.00
Purchase to Pay	£0.00	£75,000.00	£75,000.00	£75,000.00	£75,000.00	£75,000.00
Catalogue Management System	£0.00	£25,000.00	£25,000.00	£25,000.00	£25,000.00	£25,000.00
Inventory Management Cloud System	£0.00	£142,500.00	£142,500.00	£142,500.00	£142,500.00	£142,500.00
Helpdesk System	£0.00	£18,000.00	£18,000.00	£18,000.00	£18,000.00	£18,000.00
Training & Development Uplift	£0.00	£16,272.00	£16,272.00	£16,272.00	£16,272.00	£16,272.00
Legal Fees	£0.00	£10,000.00	£0.00	£0.00	£0.00	£0.00
Travel & Subsistence Uplift	£0.00	£7,800.00	£7,800.00	£7,800.00	£7,800.00	£7,800.00
Equipment Lease & Maintenance	£0.00	£750.00	£750.00	£750.00	£750.00	£750.00
Sub Total Non-Pay	**£159,970.00**	**£490,292.00**	**£480,292.00**	**£480,292.00**	**£480,292.00**	**£480,292.00**
Other Non-Pay Adjustments	**-£154,773.00**	**-£154,773.00**	**-£154,773.00**	**-£154,773.00**	**-£154,773.00**	**-£154,773.00**
Total Pay & Non-Pay	**£3,907,572.32**	**£4,959,296.75**	**£4,816,396.75**	**£4,816,396.75**	**£4,816,396.75**	**£4,816,396.75**

Figure 91 – Future Budget Costs

8.2.1 Capital Expenditure

New IT and telephony equipment will be required both to support the increase in FTE allocation, but additionally to provide mobile and remote working capability for those staff that require it. Additionally, depending upon the chosen organisational entity model, the host organisation is likely to want the new organisation to use standard functionality and equipment already supported by the organisation. This expenditure is likely to be capitalised.

A single inventory management system should be deployed across the three Partner Trusts which will provide better visibility of stockholding and better stock management. The proposal is that the inventory management system being deployed at HUTH as part of the S4S programme is rolled out at NLAG and YSTH.

8.2.2 Pay Expenditure

Pay has been calculated using the mid-point of the band plus pension and NI. Efficiency targets on procurement pay expenditure have also been added back into the financial model.

8.2.3 Non-Pay Expenditure

Additional non-pay expenditure is proposed to support the implementation of the HNYPC.

An increase in technology spend is required to remove current paper based actions which will make the team more efficient but also improve access to data. The majority of the existing system cost for procurement sits within the outsourced e-Financial systems and therefore finance budgets, it is not possible to separate this. For HNYPC to work as efficiently as possible a single new system will be required that can integrate with the existing e-Financial systems. A new cloud based helpdesk and support web portal would provide a single point of contact for all ad-hoc support requests and contact from customers and suppliers. Enquiries could be routed to the relevant team electronically, whether they are based locally, centrally or are mobile, enabling customer service levels and response rates to be tracked.

Both YSTH and NLAG are members of NOECPC whereas HUTH have chosen not to join as members. Support from NOECPC will be required to deliver a number of future contracts, and to make engagement as HNYPC easier to manage the proposal is to sign HUTH up as members at a cost of £30,000 per annum. NOECPC operate a rebate model with suppliers which is shared with trusts based on usage. It is therefore expected this investment becomes cost neutral from the rebate model.

Other non-pay spend has either been maintained at existing budget levels or removed as no longer required. Additional spend is however requested to increase learning and development to the national average and an increase in legal costs to support the formation of HNYPC.

Procurement requires other non-pay spend to operate, this includes:

- Capital items such as tugs for moving goods. There are currently a number of tugs across the Partner Trusts which should be replaced every 5-7 years at a cost of £10,000;
- Maintenance of equipment such as pallet trucks. There are currently a number of items which require maintenance on an annual basis at a cost of £250.

The proposal is that redundancy will not be required. In the event that redundancy costs are needed, these will be treated as HNYPC costs and shared between HNYPC Partner Trusts on the same basis as other procurement costs.

Over five years the total additional cost of delivering the transformation and savings programme with associated non-cash and cash benefits is £5,776,643.75.

8.3 Effect on Model Hospital Data

The changes proposed to the cost of Procurement makes a minimal change to the level of investment in back office functions as set out within Model Hospital data:

Pay	Investment as a % of Income	Investment as a % of non-pay
IM&T	1.13%	3.82%
HR	0.72%	2.43%
Gov & Risk	0.54%	1.83%
Finance	0.43%	1.46%
Procurement (proposed)	0.25%	0.83%
Procurement (as-is)	0.20%	0.69%
Payroll	0.10%	0.34%

Non-Pay	Investment as a % of Income	Investment as a % of non-pay
IM&T	1.16%	3.91%
HR	0.25%	0.84%
Finance	0.11%	0.38%
Gov & Risk	0.04%	0.13%
Procurement (proposed)	0.03%	0.09%
Procurement (as-is)	0.01%	0.03%
Payroll	0.00%	0.01%

Figure 92 – Future Corporate Services Investment

This investment sees an increase in pay spend of 0.05% of income and an increase in non-pay budget of 0.02% of income.

8.4 Return on Investment (ROI)

It should be noted that delivery of a return on investment will be impacted by rising costs and inflation. NHSEI are estimating £1.5bn of cost increases that have not been budgeted within 2022/23. The Association of British Healthcare Industries has reported that suppliers are pushing up prices to the NHS after they have consumed inflation pressures in recent years. A number of cash releasing benefits that could have been delivered by implementing the preferred option could now be delivered as cost avoidance inflationary benefits. Without implementing the preferred option the cost

pressure to the Partner Trusts would be higher. As such, inflation avoidance has to be a key strategy moving forward.

For the purpose of this business case, NOECPC and NHSSC both undertook analysis of spend areas and submitted documentation outlining potential savings opportunities across HNYPC. Utilising the data available as well as benchmarking information, the data was analysed to identify potential savings opportunities:

Opportunity	2023/24	2024/25	2025/26	2026/27	2027/28
Cash Releasing					
Exiting Trust Savings Plan	£2,185,806	£2,185,806	£2,185,806	£2,185,806	£2,185,806
NOECPC Rebate	£90,000.00	£90,000.00	£90,000.00	£90,000.00	£90,000.00
NHS Supply Chain Collaboration	£151,545.00	£215,772.00	£215,772.00	£215,772.00	£215,772.00
Price Standardisation	£358,005.00	£463,628.00	£633,478.00	£633,478.00	£803,328.00
Volume Savings	£3,197,060.63	£5,888,493.94	£8,579,927.26	£11,271,360.57	£13,962,793.88
Value Based Procurement	£0.00	£50,000.00	£100,000.00	£150,000.00	£200,000.00
Capital Buyer Recharge	£116,191.76	£116,191.76	£116,191.76	£116,191.76	£116,191.76
Tail Spend Management	£43,000.00	£86,000.00	£86,000.00	£86,000.00	£129,000.00
Sustainability	£52,770.00	£52,770.00	£112,000.00	£112,000.00	£112,000.00
Stock Management Improvements	£54,000.00	£100,000.00	£250,000.00	£250,000.00	£250,000.00
Cash Releasing Sub-Total	**£6,248,378.39**	**£9,248,661.70**	**£12,369,175.02**	**£15,110,608.33**	**£18,064,891.64**
Cost Avoidance					
Inflationary	£100,000.00	£150,000.00	£100,000.00	£50,000.00	£10,000.00
Contract Management	£500,000.00	£2,000,000.00	£5,000,000.00	£10,687,002.49	£10,687,002.49
Supplier Rationalisation	£100,000.00	£100,000.00	£50,000.00	£20,000.00	£10,000.00
Cost Avoidance Sub-Total	**£700,000.00**	**£2,250,000.00**	**£5,150,000.00**	**£10,757,002.49**	**£10,707,002.49**
Total Benefit	**£6,948,378.39**	**£11,498,661.70**	**£17,519,175.02**	**£25,867,610.82**	**£28,771,894.14**
Cumulative Benefit	**£6,948,378.39**	**£18,447,040.09**	**£35,966,215.11**	**£61,833,825.93**	**£90,605,720.07**
Total Cost	£4,959,296.75	£4,816,396.75	£4,816,396.75	£4,816,396.75	£4,816,396.75
Return on Investment	1.40	2.39	3.64	5.37	5.97

Figure 93 – Return on Investment

There are a couple of caveats which should be highlighted with the savings figures presented in the figure above. Firstly, whilst the savings opportunities have been calculated using benchmarking and reference to what other ICS procurement structures have been able to deliver, it should be cautioned that the current levels of inflation could impact the cash releasing savings opportunities. This is not to say that benefits will not be delivered from implementing this recommendation, it may just result in mitigating the impacts of unfunded inflation. The second caveat is that the savings have been calculated using the accounts payable data from the three Partner Trusts. There remains some questions around data integrity and significant work is required on data quality but again, this should not stop the recommendation being approved.

8.4.1 Existing Trust Savings Plan

The existing Partner Trust savings plans and targets are maintained through future years and form the baseline for all opportunities delivered.

8.4.2 NOECPC Rebate

NOECPC charge suppliers a percentage against all work obtained under the frameworks let by NOECPC. This income is then redistributed to members based on their use of NOECPC frameworks. In 2021/22 both NLAG and YSHT received rebates which exceeded their cost of membership. The benefit listed above assumes the addition of HUTH to the membership model will deliver a rebate equal to investment.

8.4.3 NHS Supply Chain Collaboration

NHSSC identify a number of saving opportunities through moving to lower cost clinically acceptable products and through signing commitment deals across organisations that increase savings. The current savings workbook sets out around £1m of opportunity that could be delivered however this will need input from the Clinical Procurement Specialists to lead change programmes.

Many of the NHS Supply Chain contracts have price breaks by volume bands. By procuring collaboratively there is a £287k saving opportunity without having to change product, through moving the trusts into a higher volume band.

8.4.4 Price Standardisation

There is a lack of harmonisation across HNYPC which is contributing to procurement inefficiencies and missed opportunities – historically there has been little collaboration between the HNYPC Partner Trusts for the same project areas which has led to un-harmonised pricing across the trusts for the same products, with price variations ranging up to 57%. This difference has been found in a very small sample of catalogue prices. This presents a substantial opportunity for the HNYPC and highlights areas where benefit can be delivered without the need to conduct clinical trials or impact the customer.

The three Partner Trusts have historically negotiated contracts with suppliers individually which has allowed suppliers to charge different prices for the same product. Standardising the cost across the three Partner Trusts will deliver a financial benefit. The NHS SCS identifies £3.3m in opportunity moving the three trusts spend to the national median price paid (HUTH £1.9m, NLAG £537k and YSTH £960k). All of these opportunities will need to be reviewed.

Some of the opportunity here will duplicate with the opportunities identified by NHSSC so the total opportunity has been reduced by the NHSSC value to avoid double counting.

NOECPC have undertaken a review of the Partner Trusts temporary staffing expenditure and identified a savings opportunity of £3.3m in aligning the Partner Trusts rates to the national capped rates. There will also be further opportunity through demand management.

8.4.5 Volume Savings

Suppliers will often offer a lower price for the sale of a greater volume of product. Collating the requirements of the three Partner Trusts and buying once for all three should lead to a collective lower price. This will take time to deliver as existing arrangements come to an end.

An assessment of addressable spend across clinical and non-clinical categories identified several opportunities to deliver savings over a 5-year timeframe, with the analysis being undertaken by NOECPC and NHSSC. The existing HNYPC

procurement teams also have produced an initial work plan for FY 2022/23. This work plan has applied an increasing savings target between 1% and 3% annual saving opportunity across £538m of spend, across both clinical and non-clinical projects.

To avoid double counting this opportunity has been reduced by the value of the existing Trust savings plans.

South Yorkshire ICS have undertaken a review of orthopaedic implants with standardisation occurring across the ICS. This activity has saved £2m per annum based on current usage.

8.4.6 Value Based Procurement

HNYPC will implement value based procurement into the procurement decision making process. Value based procurement is an approach that delivers tangible, measurable financial benefit to the health system over and above a reduction in purchase price; and/or a tangible and measurable, improved patient outcome derived through the process of procurement (tendering, contracting, clinical engagement and supplier relationship management). This will mean that procurement also considers:

1. Reduction in consumption - A product, which is higher quality or innovative, results in lower like for like consumption of this product type;
2. In patient to day case - A product results in a pathway change, where a procedure changes from inpatient to outpatient or similar;
3. Change in patient pathway - A product or solution that enables migration of patients from an acute to a community setting;
4. Operational productivity - A product or solution or supporting service provided by the supplier enables the Trust to improve operational productivity and efficiency;
5. Reduction in infection - A product or solution causes a reduction in infection for a specific procedure or patient cohort.

It is appreciated that some of the changes could have unintended consequences such as a change in an acute setting could increase costs within the community sector or for Commissioners. Value based procurement and the consequences of change will be mapped out and understood as part of the Procurement Initiation Document. This will be undertaken through a conversation about the outcomes people want, and then a procurement strategy can be agreed. End of year spend is often a blocker to such planning with funds having to be spent at speed. Procurement activity should be linked to Partner Trust objectives as suppliers are rarely asked how they can support delivery of these.

Value Based Procurement has been undertaken elsewhere in the NHS. In one example Barts Health worked with Johnson & Johnson to review the patient pathway for elective primary hip and knee replacements and revisions. The results of this review were:

- An improvement in Oxford Hip scores from 93.4% to 95.5%;
- An improvement in Oxford Knee scores from 88.9% to 93.6%;
- 1,795 bed days saved;
- Increase in surgical utilisation by 10%;
- 23,000 extra minutes of operating theatre time which allowed an addition 192 procedures to be scheduled.

North Devon have undertaken a similar process with Zimmer Biomet which delivered:

- A reduction in length of stay on total hip replacements from 4.2 to 2.1 days;
- A reduction in length of stay on total knee replacements from 3.9 to 1.6 days;

- A theatre operational capacity increase of 40%.

8.4.7 Capital Buyer Recharge

Those buyers working on capital projects can have their salaries charged back to the projects they are working on. This will need to be evidenced through timesheets identifying the amount of time spent working on any one project. Depending on the grade of individual either their whole salary, or half of their salary, has been used to calculate the benefit.

8.4.8 Tail Spend Management

It should be possible to deliver a reduction to processing costs by moving some of the tier 4 suppliers (less than £10k) into other contracts. At the moment £187.3m is spent on transaction less than £10k.

HUTH have forecast 106,634 invoices to be paid in 2022/23 and NLAG 96,400. The cost charged by the outsourced provider to manage processing ranges between 50p per invoice and £2.30 per invoice with 53% of the invoices charged at the higher rate. Moving the highest charged invoices to the lowest cost would save £87k.

The Pan Government Policy on procurement cards suggests moving transactions under £20k with a limit per card of £100k per month onto a procurement card. Not only would this reduce invoice processing costs but this can also generate an annual rebate from the card provider based upon the volume of spend put through the card and the promptness of the settlement at the end of the month. Across the three Partner Trusts 98.2% of invoices are below £20k.

As an example of efficiencies that can be delivered YSTH have moved to consolidated invoicing with AAH and receive one invoice a month per site. HUTH receive 4,870 invoices per annum and NLAG 6,483. These are predominantly charged at £0.50 (£5,676.50) per invoice. Moving to consolidated invoicing for just one supplier can save £5,646.50.

8.4.9 Sustainability Savings

A number of changes to product, packaging and energy consumption can be made which will reduce the cost of consumption or the cost of managing waste. These actions will reduce the cost to the three Partner Trusts. Changes will take time and will need to be tracked.

8.4.10 Stock Management Improvements

Better stock management can deliver non-recurrent benefits to the efficiency of the stock management process as well as delivering cost reduction through a lower stock holding. Whilst it has been identified that removing stock management responsibilities to clinical teams would release resource in ward areas, this saving is not included in this case. It is assumed that resource will be repurposed to better focus on patient care.

NLAG have also calculated that moving stock areas to materials management which are managed by Materials Management staff can deliver an 11% saving to stock holding positions. Stock rotation is also undertaken by Materials Management staff to ensure product does not go out of date which will reduce wastage.

As of October 2022 HUTH had rolled out stock management to around 25% of clinical areas across the Trust. This identified £143k of stock which was out of date and a

further £80k of stock due to expire within the next 90 days. Other trusts who have implemented a stock management system have reported a return on investment between 3:1 and 6:1.

8.4.11 Inflationary

In September 2022 inflation was running at 10% with many suppliers seeking price increases in excess of this figure, recovering cost pressures for previous years. HNYPC will work to push back on the request for price increases. Where inflation has been budgeted for this will form a cash releasing saving, where inflation has not been budgeted for this will be a cost avoidance saving. As an example of some of the cost pressures received to date:

Product	Supplier	Increase Requested
Couch and Wiper Rolls	Essity UK Ltd	60%
Surgical Sutures	Johnson & Johnson	5%
Disposable Continence	Ontex Healthcare Ltd	8.76%
Uniforms and Workwear	MI Hub Ltd	10%
Disposable Continence Care	Attends Healthcare Ltd	9%
Electrophysiology	Johnson & Johnson	6.60%
Disposable Accessory Products	Attends Healthcare Ltd	20%
Laparoscopy Stapling	Johnson & Johnson	5%
Clinical Waste Containers	Mauser UK Ltd	TBC
Flexible Endoscopy	Pentax UK Ltd	10%
Neonatal Equipment	GE Medical Systems	10%
Uniforms and Workwear	Meltemi Limited	10%
Patient Monitoring	Draeger Medical	10%
General Wound Care	Vernacare Ltd	TBC
Haemostats	Johnson & Johnson	5%

Figure 94 – Inflationary Pressures

8.4.12 Contract Management

Good contract management can deliver benefits of 5-10% of a contracts value. The contract management team will focus on the higher cost, higher risk contracts to ensure that HNYPC Partner Trusts are obtaining the value promised from the supplier at the point of tender.

From the data currently available the trusts top 20 contracts account for around £200m of expenditure. This position will change as data is improved and centralised contracts are negotiated.

8.4.13 Supplier Rationalisation

It was identified that within multiple category areas, the spend is fragmented across a number of suppliers, which further highlights the need for pan-HNYPC projects to rationalise the supplier base and implement standardisation initiatives in order to drive efficiencies and deliver maximum benefits. At the time of producing this business case, HNYPC procurement teams had an informal project work plan in place for the upcoming financial year, however very limited pipeline visibility over the next 36 months. This lack of forward planning supports the inconsistent approach to project strategy, which in some cases regarding clinical projects, will require product trials to be undertaken, and reduces the capacity for the HNYPC Partner Trusts to cohesively manage key strategic suppliers and work collaboratively on projects.

8.5 Apportionment of Savings and Additional Costs

Savings will be calculated at cost centre level and the benefits apportioned on that basis back to the cost centre which gets the benefit. The process for covering the additional costs required to set up HNYPC and achieve the benefit is discussed in the governance section above.

Through the implementation of HNYPC increased procurement savings will be delivered, given that the structure, processes, systems and governance will be aligned to supporting and driving a cross-HNYPC approach to procurement.

8.6 Limitations & Caveats

Working through the data sets provided, in order to scope out the benefits available, the following key assumptions, caveats and limitations have been identified and underpin the opportunity assessment undertaken.

8.6.1 Data

Getting access to reliable datasets which show spend, contracts and suppliers used has proved difficult. A number of contracts listed in the contract registers do not contain details of the supplier, the expenditure or the start or finish dates. There is inconsistency between finance and procurement data regarding expenditure and also the spelling of a supplier name. One of the key pieces of work required to deliver the benefits will be the collection and cleansing of data.

8.6.2 Contract Visibility

The limited contract visibility and inaccurate information in the contract registers has proved difficult to effectively map contractual commitments and understand when, if any, contracts can be aligned and/or tendered together in the future. This also presents challenges as assumed savings cannot be profiled accurately where the contracts register is incomplete or indicates a lapsed contract.

8.6.3 Collaboration

The opportunities presented are on the basis that the projects will be undertaken pan-HNYPC with all applicable Partner Trusts involved and working collaboratively.

8.6.4 Clinical Engagement

Successfully delivering savings across the clinical categories is dependent upon providing an appropriate structure is in place to support clinical engagement, orchestrate clinical change and drive project delivery. It is noted that the role of Medical Directors is key in ensuring that the inter-lock between Procurement Business Partners and the customers is effective. To achieve this, it is assumed that Medical Director (or suitable alternative) attendance is mandatory at the Procurement Board when reviewing Clinical Category Strategies. A high level commitment from all Partner Trusts to engagement in standardisation and compliance will be required.

8.7 Non-Financial Benefits

Alongside the financial benefits outlined above, several non-financial benefits will be realised as part of the establishment of HNYPC. The creation of a new procurement service will support a multitude of areas.

8.7.1 Strategy & Organisation

Clearly there is considerable duplication of activities between the Partner Trusts, much of which can be aggregated or streamlined to reduce costs and create improved outcomes for all. The shared service vehicle will have the capacity to work at a strategic level within the Partner Trusts to support delivery of core outcomes, through transformational market management, improved engagement with clinicians and raising the bar in terms of expectations from supply chain partners. Working nationally and at an ICS level enabling and supporting system change looking at collaborative arrangements which extend beyond borders to challenge and influence supply partners. The shared service will create common spend policies and underpinning procurement processes, shared access to key data sets and have category-based procurement management in place.

There will be a greater level of spend under control, with a single accountable team for all procurement and commercial activities across the HNYPC. The improved team structure will support procurement engagement and has defined roles and responsibilities which will be fit for any future requirements to support alignment of contracts and specifications.

The appointment of Procurement Business Partners and Trust aligned Clinical Procurement Specialists will drive cultural change which will align against the cultural principles and contribute towards responsiveness, reliability, and customer satisfaction. Engaged key stakeholders to support procurement activity with clear communication channels between key stakeholders, clinicians and procurement which will reduce non-compliance.

A single procurement strategy will be deployed which will deliver increased value as a strategically aligned business partner to the Partner Trusts.

8.7.2 Policies & Procedures

Integrated and aligned procurement processes and policies that will improve customer experience and eliminate confusion and in turn improve procurement compliance with reduced uncontrolled spend and use of waivers. A single, effective, approval forum with appropriate governance and delegation to simplify approvals, enable aggregation and support delivery of HNYPC benefits will be established.

Clear policies and governance will be established to enable HNYPC to deliver projects successfully and efficiently. A Governance and Assurance Manager will ensure that the policies and procedures are updated in line with changes to Procurement Regulation and will provide training to the procurement teams.

8.7.3 Sustainability and Social Value

A Sustainability & Social Value Lead will have clear responsibility to develop processes and governance for a class-leading approach to sustainable procurement, delivering ahead of the NHSEI roadmap. This will provide improvement of environmental and social value impacts on the whole HNYPC supply chain lifecycle.

This will enable HNYPC to be proactive and leading the discussion on delivery of sustainability throughout the supply chain which will support improvement on the Green Plan development.

It is essential that for every pound spent of public money we are able to deliver demonstrable value, excellent products and services as well as contribute to the overall

wellbeing of our stakeholders through reference to Social Value. From 1st April 2022 all organisations have had to include at least 10% weighting of their tenders towards social value. HNYPC need to establish a robust approach to including social value in contracts and capturing the benefits delivered.

8.7.4 Data & Technology

A consistent data architecture to support future procurement systems changes will be put in place which will enhance data quality and catalogue management to underpin business partnering. Utilising existing assets where possible and planning for digital enablement will provide simplified HNYPC processes, reducing variance in systems and applications and better data management.

Improved performance data that supports the identification and realisation of procurement opportunities will be put in place to reduce cost, resource demand and processing costs.

8.7.5 People & Skills

A number of new roles are proposed to improve collaboration and reduced duplication of work and to motivate staff, with clear opportunities to develop as part of a shift to a high-skilled procurement function.

Procurement capabilities will be deployed across the Partner Trusts with staff having roles dedicated to delivery across all Partner Trusts rather than being Trust specific. Training and development will be core to the new offer to foster a high performance culture and develop a dynamic, innovative procurement team who are able respond to customer needs, influence senior leaders and provide creative commercial solutions which deliver best value and continuous improvement.

Managing and tracking performance of resources is also necessary. Key performance indicators, individual objectives and performance monitoring systems will be put in place. Talent performance reviews will be carried out at regular intervals and development plans put in place to motivate and increase capability. Clustering and centralising resources and activity into a larger organisation allows for clear career progression opportunities and development pathways for staff.

In addition there will be a “grow your own” strategy for talent development and retention, ensuring that we are building a resilient, sustainable team and developing leaders of the future.

8.7.6 Strategic Procurement

Managing value and performance through SRM will be key to focussing on strategic, high value or high risk suppliers and markets. Benefits will include improved engagement with markets so that they understand and are better able to meet current and future requirements of the NHS. There will be focus on key areas of improvement including whole of market strategies to support and drive transformational change.

There is currently limited evidence of proactive supply chain risk management, benchmarking is limited to ad-hoc use of NHS spend comparison tools, and there is no should-cost modelling (calculating what the cost of a good or service should be in advance to ascertain value for money). Reactive work has been established during Covid-19 where the three Partner Trusts work together when there is a stock shortage to provide mutual aid to one another.

With regard to procurement risk the HNYPC will increase the scope and level of compliance across each organisation. In terms of procurement challenge from the market, utilising existing expertise and upskilling of staff regarding high-value procurement will be required. It is essential to recognise that risk is not just a matter of potential impact but also the likelihood of a challenge and by whom. Intelligent procurers are able understand legal constraints, articulate risk and provide sound yet creative advice as to how processes can be structured to mitigate risk whilst delivering the objectives of customers.

The approach to risk, benchmarking, should-cost modelling, whole-life cost modelling and specification development will be set out in the Procurement Initiation Document for each procurement activity.

8.7.7 Supply Chain Management

A standardised and clear inventory management approach will deliver improved inventory availability and reduce amount of wastage, improved delivery to customers with reduced stock outs and deliver financial benefit.

Management information and KPIs will support materials management decision making and improve customer experience with better business decisions based on data and continuous improvement to Inventory Management.

This business case has not proposed a centralised warehouse for all Partner Trusts but this is something which should be explored in the future. Having a central warehouse managing deliveries for all sites will reduce vehicle movements at each hospital site. The central warehouse can then issue product on a just in time basis and can explore the option of using electric vehicles to minimise the impact on the environment. This approach has been undertaken across other ICS's with models ranging from Trust operated to outsourced solutions.

8.7.8 Benefits Measurement & Realisation

Savings plans are approached differently within each Partner Trust. Whether this is a target given to procurement or no target but just reporting on delivery, the approach is generally reactive and limited to one financial year. The objective is to move into a more informed planning programme for savings working with the business to identify contracts which are for renewal and review both demand and supply across a multi-year period. From this a should-cost can be established which will inform the savings plan. All savings will be recorded on a central system for reporting purposes and align to a centralised Savings Methodology Policy.

Although it has been possible to establish a work plan across the three Partner Trusts the maturity of the plans and the planning process that sits behind it is different at each organisation. It is therefore not possible to say with confidence that the work plan generated is a complete picture. The aim is to have a single work plan driven by a single contracts register which sits on a single IT system accessible to all. This will allow for one version of the truth to be presented and resource allocated to deliver the work plan.

The remit for the DoP has been to develop the business case and focus on creating the new organisation whilst Trust procurement leaders have continued to work on Trust specific savings plans. Pending approval of the business case, Trust specific

procurement leads will be required to demonstrate leadership, proactively work with their peers and release resources to create a collaborative work plan.

8.7.9 Improved Stakeholder Engagement

The structure of the HNYPC will be focussed on developing a business partner approach for customers. Procurement and SRM professionals will work with care groups. Systems and supplies teams will develop greater understanding of areas for improvement through listening to customers and a focus on continuous improvement.

Stakeholder engagement within the Partner Trusts needs to be improved to ensure all budget holders are aware of their procurement obligations and the commercial implications of their decisions and behaviours. Engagement with clinicians can be improved; at present procurement-clinical meetings are either sporadic or there is an expectation that clinical teams will come to procurement if they need their help. Better engagement with clinicians and recruitment of a Clinical Procurement Specialist role to be based in each Partner Trust will ensure that clinical outcomes and patient safety are at the heart of all we do.

In order to develop a shared procurement service which satisfies the operational and strategic targets of the three Partner Trusts it has been essential for the DoP to engage with customers and senior leaders. Feedback from this process has shaped the development of the business case and created a proposition which provides a sustainable delivery model for the future. There is considerable consensus between each professional group, and clear support for the ambitions of the HNYPC, recognising the potential to support delivery of some of their strategic and operational targets.

8.7.10 Reputational Benefit to Partner Trusts

The vision is to create a service which is regionally and nationally recognised as a centre of excellence, able to influence and lead strategic activity as well as contribute to the national procurement agenda via involvement with NHSEI. In this way the HNYPC will positively contribute to the reputation of the three Partner Trusts. The creation of a collaborative procurement team fits with NHSEIs PTOM programme as well as the future CCF.

HNYPC will put in place firm channels of communication with neighbouring ICSs across the region. Extending those channels to the National team to ensure ICS needs are met via existing (and new) nationally let contracts/ agreements where that scale will drive value.

9. The Process of Change

9.1 Key Principles

This section describes how HNYPC will be implemented and in particular how transition will be managed to ensure that business as usual continues to be delivered. A number of key principles have been agreed around the establishment of the HNYPC which influence the content of this business case.

9.2 Communication Strategy

Communications have been undertaken through the Heads of Procurement at each Partner Trust as part of the establishment of this business case. All procurement staff have also been engaged through a monthly newsletter which has aimed to provide reassurance around the changes which are to follow. The key messages shared to date include:

- Establishment of the HNYPC;
- HNYPC aims;
- HNYPC performance and achievements;
- Changes to procurement practice and process;
- Ensure Partner Trust procurement staff are informed about and involved in changes to roles.

A further communications strategy which includes all stakeholders will be required which promotes HNYPC:

- To the public and external stakeholders that the establishment of the HNYPC is a way to achieve better value for the NHS for reinvestment in care;
- The establishment of the cluster to professional stakeholders to enhance the reputation of the HNYPC Partner Trusts.

Audiences will include but will not be limited to:

- HNYPC Trust boards;
- HNYC procurement staff;
- HNYPC Trust non-procurement staff - customers;
- Supply Chain and markets;
- NHSEI;
- Staff side;
- Public Sector partners such as Local Government.

9.3 Staff Engagement

As experienced across clinical and other professional groups there is a shortage of good procurement and supply chain professionals. The public sector on the whole, has ceased to invest, train and develop new procurement and supply chain talent and generally vacancies across are filled at the expense of neighbouring organisations.

There are clear skill sets which are required to understand the Public Contract Regulations 2015 and as such there is little interest from the private sector which further limits recruitment potential, however, this sector should not be overlooked as part of the recruitment process. Further, despite contract regulations covering the whole of the public estate and the onset of devolution, there is surprisingly little migration from one sector to another. It is therefore crucially important that where possible, we retain existing high-performing staff from all Partner Trusts to ensure that we can continue to provide a good service during the change programme and support the development of the new organisation.

9.4 Staff-Side Engagement

The DoP has met with HR leads at each Partner Trust who confirmed that a formal consultation process including staff-side engagement was not required based on the changes set out within the preferred option. An informal engagement of staff-side representatives can be undertaken and would be managed through HR representatives when the time is right.

9.5 Branding & Corporate Identity

It is recognised by the Board that 'Humber & North Yorkshire Procurement Collaborative' is a working title for the collaborative programme. The DoP will work to develop a new identity, if required, for the HNYPC following business case approval.

Branding and corporate identity is a key element to the change programme and supporting the individuals within the team in identifying and having ownership of the new organisation.

9.6 Risk Management

Creating shared services can be very successful but also brings risks; working collaboratively is more complex, requires new skills, can take more time and will require compromise and trust. Development of the business case has included engagement with Executive Leaders across the Partner Trusts as well as all members of the procurement teams to ensure that key stakeholders views are accommodated and trust and understanding are embedded at the heart of the new organisation.

Risk registers have been developed through the process to ensure that all such risks are captured, mitigated and managed. Addressing such issues has been essential to the business case and has contributed to developing a structural model best placed to develop a truly shared organisation able to deliver benefit to all Partner Trusts.

9.7 Transition

Resourcing is currently not aligned to deliver collaborative objectives and it is not clear whether that necessary capability exists within the existing procurement teams. HNYPC will provide substantial changes throughout the procurement cycle, including introducing activities not currently taken at scale, or at all. Successful deployment of HNYPC will depend upon the delivery of this transition in a timely fashion.

It is noted that with go-live for HNYPC in 2023, there is the risk that transferring staff into a new structure could impact business as usual. Prior to any transfer an impact assessment will be undertaken to minimise disruption to business as usual.

Development of the procurement systems solutions is a key enabler to improving pan-Partner Trust working and the savings delivery programme. Embedding new systems, providing training and transferring existing data will take time and effort.

9.8 Implementation Plan

The proposed time plan is set out below in terms of further action.

	2022		2023											
	N	D	J	F	M	A	M	J	J	A	S	O	N	D
1. Business Case														
Finalise business case for approval process														
HUTH Performance & Finance Committee		19												
HUTH Exec Management Committee		21												
HUTH Board Meeting				14										
NLAG Trust Management Board			23											
NLAG Finance & Performance			26											
NLAG Board Meeting				7										
YSTH Exec Committee			4											
YSTH Finance & Performance			17											
YSTH Board Meeting			25											
2. Resourcing														
Write job descriptions for new posts														
New posts A4C banded														
Recruitment Process														
Candidates in posts														
Slotting-in process														
Review all existing job descriptions														
3. Systems Implementation														
PEPPOL Access Point														
Review existing service offering														
Compare to functionality within inventory management system														
Develop gap analysis														
Review position and requirement														
Purchase to Pay														
Write specification of requirements														
Discuss with existing provider(s) the ability to meet the specification														
Embed all Trust cost centres, requisition points and approval hierarchy														
System testing														
Go-lice for single purchase to pay system														
Catalogue Management System														
Review existing Trust catalogues														
Develop single catalogue for all trusts														
Review local masking decisions														
Supplier negotiation														
Go-live for new managed catalogue system														
Inventory Management System														
Place order for system														
NLAG Implementation														
YSTH Implementation														
Helpdesk System														
Write specification for system														
Agree IT standards with HUTH IT department														
Undertake procurement for system														
Contract award														
System Implementation														
4. Other non-pay														
NOECPC Membership														

IT & Telecoms Equipment														
Training and development														
Legal Fees														
Travel & subsistence														
Equipment lease & maintenance														

Figure 95 – Implementation Plan

Procurement Business Case – Committee and Board Questions and Responses

A. HUTH Performance & Finance Committee 19th December 2022 (business case updated to v1.1)

Q.	Question	Response
A1	Will this mean we are able to review IT spend? At HUTH credit card payments are made, whereas in NLAG a normal purchase order and invoice process is followed - I would hope the introduction of a single catalogue system as well as supplier standardisation will subsume all IT spend.	Yes all spend will be able to be reviewed as will the procurement route to identify whether it is appropriate. A review of credit card usage should be undertaken and where there is operational or financial efficiency from using credit cards this should be explored, as an example by implementing lodge cards with our top 10 invoicing suppliers we can save £79k and generate an income of £358k.
A2	Would there not be an opportunity to negotiate better prices also, referring to slide 127, I'm unclear where (if at all) possible savings from better prices is shown (notwithstanding that inflation will be detrimental to this)?	Better pricing forms part of multiple savings groups. Better pricing should be achieved through price standardisation, volume discounts and tail spend management but are likely to be impacted by inflationary pressures.
A3	A lot of the savings look as if they're back ended. I think the savings you just described get us up to the value which just about covers costs but there is still a leap in faith for how savings increase up to the £17/18 million. I'm not sure based on what you described what gets us to that sort of level of savings.	The cumulative savings look back ended but in terms of cash releasing savings we are increasing steadily year on year by around £3m. To date, savings of £1.1m have been identified which cover the costs set out in the case. The majority of the savings will be addressed through product standardisation and buying in volume. Cost avoidance does increase as we move towards year five. The reason for this is it will take time to embed a new contract management and supplier relationship management function and how we quantify benefits that have been delivered. It is making sure the supplier is doing what they should be doing, that doesn't necessarily mean that we're going to be seeing cash releasing savings.
A4	The business case is asking for about a quarter of a million per Trust which equates to about four or five additional people per hospital. You talked about category managers in the paper as well so I assume these are that level of person maybe 4-5 people per Trust.	In total there are five business partners but those business partners will cover all three trusts and not be linked to a specific Trust. The Clinical Procurement Specialists however will be linked to a Trust to build relationships and understand local clinical practice. There will also be shared resource for data analytics and materials management. We should see a small reduction in some of the administrative work that is undertaken as we will be doing

		this once rather than three times. This will allow us to focus on strategic work.
A5	The business case refers to a single IT solution but I'm not clear whether there are any costs included in the case to cover this as I haven't seen any substantial costs.	The costs of a standardised IT solution are included in the business case. We have been talking to suppliers in the market and there are a couple of routes we can take. The cost is low due to us only looking at an e-procurement solution rather than replacing the trusts e-financial systems. Two of the three trusts are using ABS for e-procurement and finance and all three trusts are using ABS for catalogue management. To minimise disruption moving all three trusts to ABS would be the natural solution. Other ICSs who have undertaken this consolidation have purchased a third party software solution which sits across Trust finance systems, this is as simple as just purchasing a procure-to-pay solution.
A6	In terms of the other trusts that have embarked on this journey, what's their financial success look like or is it too soon or is there anybody out there who's kind of nailed it?	The shared service which is probably closest to us in terms of structure is Lancashire Procurement Collaborative who have brought their trust procurement teams together into a shared service and they report a 2-3% efficiency from doing so. Nobody's quite gone as far as having a single ordering system in the way that we're proposing here and it is a big frustration as they think they could get greater efficiencies by doing so.
A7	Where do you expect the bulk of the savings to come through, is it better negotiation and smart purchasing or is it more efficiency?	So I expect the majority of the savings to will come through bringing our volume together and negotiating as one and being a bigger customer to a supplier than we currently are separately. But due to inflation, there is a risk that a lot of that moves down into cost avoidance rather than cash releasing. So we just need to track that carefully.
A8	We have not really invested in our procurement service for quite some time and it provides a cheap and cheerful and service, particularly around materials management, getting widgets to the wards but it doesn't strategically support the business. On page 34 you can see the historic position and we have got a very interesting structure with senior person in charge of the department, then a lot of band twos and threes with not a lot in between and that causes problems, as you can imagine. What	We've been careful to try to avoid any double counting in savings by reducing estimates where there is a likelihood schemes could overlap, for example the volume savings have been reduced by the value of the existing Trust savings plans.

	this business case is trying to do is to address that and to provide a service that will work with the clinical teams. Without this business case, you don't get any of that. Do I think that we will deliver £90 million in savings in five years, no. If you go to page 127, there's a nice little table and you'll be able to see that the volume savings and the contract management savings are by far and away the biggest elements within the table. There is a question as to double counting because on the volume side, you're saying there is 1-3% of £500 million of spend but then the contract management talks about £200 million of that £500 million being done through contract management.	
A9	My initial worry is about going to my EMC and saying I want to invest £400,000 into procurement at a time where money is very difficult and hard to come by. What I'd say is that by being a little bit smarter with the way we do things such as the procurement card and rebate is a good example, and just by acting a little smarter, a little bit more organized, the £400,000 it will cost to do this should be generated immediately or pretty quickly. So from an organisational perspective it washes its face as a result of some organizational changes within procurement itself without having to touch the frontline per se. So I ask “why wouldn't you do that” - it gives you more resource at the front line and I particularly like the procurement business partner and the clinical procurement specialist roles. With the Clinical Procurement Specialist role, and making that a part time opportunity, I think will be attractive to senior clinicians, so I think you'll be able to recruit that. I’m more worried about the Procurement Business Partners because you put them as agile people who work across the three sites, they'll need to, but they'll need to have a unique set of skills. They'll need to be procurement specialists, so need to be professionally qualified, but they're also going to have to be able to talk and engage, and sometimes those skills are not forthcoming. Are you confident you will be able to recruit those five individuals?	When you talk to the procurement teams, they all say recruitment is tough in this neck of the woods. I think having met all three teams, there are internal candidates who could step into those roles and would do a good job. I'm really keen that we attract new talent as well because this is about changing years of culture and ways of working. I'm aware having spoken to colleagues across the North East, there are people who would love to come and work on this and work with us to deliver it. So we've got people from other trusts approaching me asking when the case is approved. We've also had a recent change to the NHS supply chain offering, where the category towers that were outsourced are now being insourced and all of the people who were working in that engagement piece on procurement through engaging clinicians and procurement approached me and said we'd really like to jump ship at this point before it's all in-sourced. So I think now is a good time to do it and I'm quietly confident there's some really good people out there looking for roles. We just need to be flexible on location and not expect them to be sat in in an office five days a week.

A10	Assuming that we put this in place, there are two or three things that need to happen. One is you talked about a suite of KPIs that you would want and that would need to be built into a dashboard and reported through the Procurement Board. I suppose the first question is when will that happen? The second question is one of the big issues that we have which is how you overcome clinical preference when trying to standardise products. The third question is what impact does the investment have on national metrics as at the moment we look good as the service is cheap. I think I've spotted the table in the document, but I couldn't quite follow it. I couldn't follow whether or not it makes us the most expensive in the country or it just takes us to a more competitive place.	The KPIs will be put in place to ensure that we are delivering efficiently and effectively what each of the three trusts want us to. One of the things I'm really keen to do is that we provide the golden thread that comes out of each of the trusts, aims to objectives each year and to embed that within our procurement activity so suppliers are asked how they will help and support us in delivery. This will also come through the procurement KPIs and we'll see that go into individuals' aims and objectives. The conversations I've had with the supplies to date suggests they would hugely welcome that because they don't necessarily just want to sit there and provide product and disappear until it's up for tender again. The KPIs will be recorded in a national single system called Atamis which has been purchased on behalf of the NHS by the Department of Health and NHS England. We will put our KPIs in there and we will start building those dashboards so that we can report both at a trust level but also as a collaborative as well. We are aiming to have all three trusts up and running by the 1st of April on that system. York and Scarborough are much further ahead in achieving this with some challenges at HUTH that we will be looking to address early in the new year. In terms of how you overcome clinical preference, we will be using the knowledge and experience of the Clinical Procurement Specialists to challenge these preferences with fact. Escalation of issues can go through the Business Partners to be discussed at Care Group Management meetings and then further escalated to the Procurement Board if required. A final audited decision can be made at the Board meeting. The impact on the metrics is covered to some extent on page 113. We still look heavily resourced at Band 2 compared to the national average, but our position moves us closer to the national average for bands 5-8. Once we've got all of the changes that we are proposing in place it would only be right to re-evaluate the structure to ensure it remains appropriate. One of the things I

		know you were keen to do was to benchmark this against other trusts. Manchester had a look at the case in terms of the investment that we're looking for and the feedback was this brings us proportionately into line with what Manchester spend on their procurement function based on their non-pay spend.
A11	One of the things that I spotted when I was out and about is just the amount of manual effort staff put in raising requisitions and stuff like that. Therefore there is a big bit of efficiency in that area and removal of angst from their day-to-day work for sorting stock out.	From the clinical engagement I have had to date this is a constant message across all trusts. We need to make Procurement easier to engage with and release clinical time back to treating patients. The new structure has been developed to do this.
A12	What I do sense is that everybody's behind this direction of travel and we need to make it work. So you've got our support to move on to the next stage and getting this ready for the board meeting which I think you said is in February?	Thank you very much, yes the Board meeting is in February.

B. YSTH Business Case Panel 16th December 2022 (business case updated to version 1.2)

Q.	Question	Response
B1	The BC at 140 pages is overly long, and proved difficult to easily disseminate the pertinent information that the decision-makers need to help them make their decision. This would appear to be partly due to what appears to be the inclusion of a lot of operational content (e.g. charging arrangements between organisations, etc) explaining how it might work in practice if the decision was made to proceed, which in the view of the panel could have been reserved for a later conversation once the main decision(s) asked of the EC are agreed. Using the Trust's experience of the recently established SHYPS (the joint pathology service between HUTH and York, which York hosts), a lot of the operational details were agreed between the parties after the main decision(s) of BC had been agreed, and these were captured through a series of documents (e.g. business transfer agreement, partnership agreement, SLA, etc.). The BC was therefore saved the inclusion of the operational detail. Could a similar approach be employed here? It was thought by the panel that by excluding the operational detail for later discussion and/or placing some other aspects (e.g. salary comparisons) into appendices, it may help slim the main document down and help the EC to focus more on the pertinent information linked to decision(s) it is being asked to make.	I am unsure on the basis to which the business case is viewed as overly long or what the comparator is. Five other ICS procurement business cases were reviewed in the development of this case, as well as the SHYPS Board paper. Many of these papers are over 100 pages long, including the SHYPS papers where only 2 trusts functions were brought together, not 3. In seeking feedback around SHYPS I was informed the integration had not be as successful as hoped and there are performance issues which are being addresses. As such, I would expect the Exec to ask around lessons learnt and as such there is greater content relating to the operational aspects which hopefully provides reassurance. I would argue that many of the operational details need to be addressed and agreed now as there are significant changes that the Exec need to be aware of and be able to agree as part of the business case approval process and not just discussed when they have already approved the business case as these decisions affect the efficiency of the collaborative, the savings that can be delivered and therefore justifying the investment decision. This is also reflected in the subsequent questions which also focus on the operational details and not the strategic basis of the case. Agreeing many of these operational elements also supports the three trusts is progressing against NHS England metrics for collaborative procurement which have to be reported bi-monthly.
B2	In terms of financial assessment of each option, the ultimate comparative benchmark resolves around Return on Investment. Unfortunately, the panel struggled to follow the arithmetic on how the ROIs quoted were arrived at from the figures available in the	This is calculated as the Total Benefit divided by the Total Cost in any particular year and is the same calculation throughout all options.

	case. This aspect needs to be made more transparent in the case.	
B3	Given the length of the BC, the Executive Summary is likely to be as far as the most EC will read, it is vital that this section provides sufficient summary information to enable EC members to make a decision. The ES refers to a preferred option, which we are assuming is option 5 although it's not clearly stated. However in section 1.6 (Decisions Required), the first decision still appears to keep the prospect of other options still being on the table for further analysis, which appears strange. Should the business case not have closed down the other options at this stage, and is just presenting the preferred option for approval? The other decisions appear be geared about supporting the preferred option, so why persist with the prospect of other options?	Decision 1 in Figure 1 is asking for the Trust Board's confirmation that option 3, 6 and 7 are not explored in full detail and discounted from the long list. This is why there is no cost for any of these options in 4.4.2, 4.7.2 and 4.8.2. A table with an overview of all options clearly stating option 5 as the preferred option has been included in the executive summary.
B4	It would be useful if a table could be included in the ES to provide detail behind the investment ask.	A table has now been included in the executive summary setting out the investment ask.
B5	Under section 1.5 (Benefits Summary), it would be helpful to have a summary of the projected benefits adding up to the prospect of £90m saving over 5 years…the table on page 127 should be replicated in the ES, which has the additional benefit of illustrating that there is a split between cost avoidance and cash releasing in arriving at the £90m. Depending upon inflationary pressures the cash releasing may reduce and become cost avoidance, so it is important to bring the split out and the potential impact of inflation in order to manage expectations. Without it, EC members might be forgiven for thinking that it's all cash releasing.	The table on page 127 has been included in the executive summary.
B6	Page 126, Section 8.4 ROI - in light of the £1.5bn cost increases not budgeted for by NHSE should the overall cash releasing savings be 'tempered' to reflect this?	NHS England have not provided any breakdown or impact assessment to a specific Trust on this figure. Trying to estimate the impact upon the three separate trusts and adjust the savings proportionately will prove time consuming and will be incorrect. The aim of this sentence is to make the Exec aware of the risk this poses to cash releasing savings, however, there is still a benefit to the trusts as this will deliver cost avoidance benefit.

B7	Page 135, Section 8, 8.7.8 Benefits Measurement and Realisation: our interpretation is that the Procurement Team will draw up the benefits realisation plan and this will be shared with the relevant provider Trusts, and the budget holders will be responsible for taking this forward. From a transactional point of view this is how the savings will be recognised in the provider Trust?	Procurement will not draw up the benefits realisation plan in isolation but will work with budget holders to identify opportunities. Once the benefits plan is agreed Procurement will support budget holders to deliver this but will also record missed opportunities so these can be reported. All savings and missed opportunities will be recorded at a budget level
B8	For the options that are not recommended (5.3.1 and 5.3.2) the detail as to why these options are not being considered and the risks appears light. For example, for 5.3.2 to just say that it will be unsettling process, when logically it is the most simple approach, is not sufficient risk on its own to discount the option. There must have been other reasons not to explore this option further?	HR and Employment – leaving staff as-is was discounted on the basis that it would be impractical to recruit to vacant posts which are spread across three separate organisation and the impact this would have on a single team ethos. Full centralisation was discounted on the unnecessary need to put individuals through a TUPE process when the majority (54.5%) will see no change to their role or base (receipt and distribution & materials management staff).This was discussed and agreed with all three trust HR teams.
B9	There are potential risks with the recommended approach (5.3.3) that have not been articulated. Section 5.3.3 does not appear to address the risks of having a variation in employment practice e.g. new staff working under Hull's policies and procedures whilst existing staff work under York's. This might see York managers having to use two sets of policies: one for new, and one for existing staff. How might this be mitigated?	Personally I think the risk assumed within the question is overstated. All staff are on NHS Agenda for Change terms and whilst there will be some minor local policy changes, the underlying principles are the same. In my previous role I managed staff on two completely different set of terms and conditions, one public sector, the other quasi-public/private. The line manager will know which organisation that individual is employed by, which policies to follow and therefore which HR team to speak to if they need support. This was discussed and agreed with all three trust HR teams.
B10	There also appears to be a lack of clarity regarding if the Hull HR team would deal with all new starters based at York who would fall under their policies and procedures, which would have to happen as the York HR team would not be familiar with these. For example, if Manager A (existing York employee) needs to address a grievance raised by Employee B (a new hire and therefore a Hull employee), who does the manager go to for HR advice as the member of staff will be employed under Hull's T&C's and so the grievance will need to follow Hull's? This	Please see response to B9.

	manager will need to be familiar with both processes as they will also have existing staff. This has the potential to get complicated and messy. We accept that as primarily an operational issue, this would probably need sorting out after the BC has been approved, but is an example of the type of issues that would need addressing before the BC went live.	
B11	There also appear to be potential support costs that are not covered, or not immediately clear in the costings. We know from the creation of YTHFM LLP, SHYPS and other hosted alliances that these entities always require an increased level of corporate function support, always initially, and sometimes longer term. Given Hull is to host this venture, this may not be an issue for York's corporate teams, but is it realistic that Hull's corporate services can support HNYPC at their current levels of resourcing? Has this been considered in the option costings?	All current support costs will be transferred centrally to the single entity. This can be picked up with the HUTH corporate services teams however HUTH employ around 11,000 staff with the total procurement staff in YSTH and NLAG representing an increase of less than 1%, with the decision not to TUPE all of the staff, the majority sitting in Receipt & Distribution and Materials Management unlikely to ever transfer, there is a possible increase of 37 staff who may transfer in. Given the savings we have already identified in corporate areas (over £500k) I would hope this could offset any support costs on such a small number of staff.
B12	It states that it is likely the host org will want to use the same IT hardware for support and they have put some costs in for this however if we follow the model adopted for SHYPS then it is more likely that each organisation continues to use its own hardware and this is then supported under an SLA between the Trusts and the procurement org. An amount for replacement of this kit (PCs in the main) will need to be budgeted for on a 3 – 5 year replacement cycle.	This will form part of the trusts IT replacement cycle. Budget has been requested to use the same hardware. Procurement is not a heavy IT user in the same way SHYPS is.
B13	Other considerations would be who provides service desk support, are smartcards needed to log in and who manages this.	Service desk support would be provided by HUTH and agreement will need to be reached around network access and issues. Smartcards are required to access personal information such as payslips but this would be managed as and when individuals move across as an employee of HUTH.
B14	Reference has been made in the executive summary to accounts payable data being used, which year?	Business case updated to make it clear this is for calendar year 2021.
B15	What does addressable spend mean?	Business case updated to define this.
B16	The executive summary says 41% of this expenditure is with the top 10 suppliers. Does this refer to the addressable spend?	Business case updated to make it clear this refers to addressable spend.

B17	In the executive summary it says 60% is covered by contract. Is this 60% of the 41% or 60% of the total addressable spend?	Business case updated to make this clear it is 60% of the addressable spend.
B18	It should be made clear within the executive summary that a reduction in stockholding would deliver a one off cash benefit rather than a “cost reduction”.	Business case updated to “one-off cash benefit”.
B19	What does SME mean?	Please refer to the list of abbreviations on page 13.
B20	The investment in the executive summary from the three partner Trust's over 5 years doesn't appear to add up to this sum...what else is included? Could a simple summary table be added to show how this built up in a transparent way?	Wording updated and table added to the executive summary to make the investment clear.
B21	On the basis that this is such a long document which the EC are unlikely to read in full, probably just looking at the Executive Summary, it would be useful to provide a simply summary to show from what initiatives the £90m will accrue...perhaps replicating the table on page 127 here. For transparency, it may also worth drawing out that of the £90m approx. is cash releasing v £30m cost avoidance.	Business case updated and the table from page 127 included in the executive summary.
B22	In section 1.9 update “£10.9” to “£10.9m”.	Business case updated to address typo.
B23	1.6 decision 3 - The three organisations are of different size...should all input equally to any additional costs, or should it be proportionate to size? Also, should outline now what the arrangements will be in the event of a closer alliance between HUTH and NLAG managerially and organisationally, which is being actively considered. How will this alter any contributions from the parties, and how can we ensure there remains an equitable contribution between the parties.	Section 5.2 shows all of the options which were considered for how the additional cost could be shared between the trusts but the Finance Directors agreed this should be split equally. Section 5.6 sets out how future changes to structure will be managed. At this stage HUTH and NLAG will only be sharing an Executive, they will remain two separate legal entities.
B24	1.6 decision 8 - singular...I assume this referring to HUTH Board as the host?	No, this is singular as the Trust Board reviewing the case will be confirming it meets the needs of their Trust Board only and will not be speaking on behalf of all three Trust Board’s.

B25	1.6 decision 11 – can we say what the assessed degree of risk of this is – high, medium or low?	This is on the risk register as a high level risk which is being escalated by the Directors of Finance to the NHS England Director of Finance. We will continue to monitor this risk. Business case updated with additional wording.
B26	1.6 decision 19 – confirm that this will have links into the respective resource management teams?	Business case updated with additional wording.
B27	1.7 section 4 – remove an additional “the”.	Business case updated to remove typo.
B28	2.1 - I appreciate there is an abbreviation glossary at the front, but it interrupts the flow of the reader in having to check back to another part of the document to find what an abbreviation means. Where an abbreviation is used first time around can it be spelt out in full to help the reader maintain flow?	This was spelt out in full 4 lines above this question where the abbreviation was first used.
B29	2.2 – in listing the HNYICS footprint reference is not made to Harrogate?	This is taken directly from HNYICS published material.
B30	Figure 9 – “£ per WTE” should be changed to “£m per WTE”.	Business case updated to add the “m” into the row description.
B31	Figure 22 - Is this a good basis for comparison? It does not recognise that the Trusts' other corporate services may be over/under resourced, and their grade mix different to national averages.	This is why the comparison to other corporate services is made in Figure 21 above.
B32	4 - Has the cost of any transitional support been built in i.e. dedicated finance, HR, legal, etc.? What about long term dedicated support…FM, HR, etc.	It has been assumed that the current cost for support is built into existing budgets which will be centralised. Additional legal cost has been included within the business case to support the transition.
B33	Figure 26 - How is ROI calculated, I can’t see the figures from which the resulting ROI is derived? Same applies to ROI for options below.	This is calculated as the Total Benefit divided by the Total Cost in any particular year and is the same calculation throughout all options.
B34	4.4.2 – need to explain why it is unlikely to be approved although this is explained in the conclusion.	As the conclusion is only half a page away from the statement no change has been made to avoid unnecessary duplication.
B35	Figure 30 - Assume reduction over year 1 down to one off capital in year 1? If so the difference here is £142,900, whereas capital above stated as £132,900	There is also a one off legal cost of £10k for year one as part of the transition and implementation.
B36	4.9 - May be worth stating for clarity that option 5 is the preferred option on which the following sections are based.	The current text reads “option 5 is identified as the preferred option and therefore explored in further detail in the following sections”.

B37	5.7 - Do we need a Finance Manager presence (if a host Trust) at this or the other Groups below? What about dedicated HR resource, particularly during transition/ implementation…has this been built into the costs?	The governance structure presented is the future state and not a transitional/ implementation board. We will review all groups on an ongoing basis to ensure representation is appropriate with the terms of reference and extend the invite list where required.
B38	6.1.2 - What about corporate support from the host Trust e.g. finance, HR, OD, etc.?	This is assumed to be already budgeted by each Partner Trust and will therefore transferred into the central function.
B39	This is a long business case. The Exec Summary would really benefit from a summarised position (comparison table) of all options considered and reference to the preferred option. The summary does go into the investment of the preferred option, but doesn't clearly state that the figures used in this section are relevant to the preferred option. In relation to how I can see the preferred option has been identified: Option 1 - discounted as doesn't meet objectives Option 2 - as above Option 3 - discounted as wouldn't get approval Option 4 - discounted as insufficient benefits Option 5 - preferred option Option 6 - discounted as no other collaborative sufficiently advanced Option 7 - discounted as wouldn't provide a centre of excellence and staff development opportunities. It was difficult to see a summary of the options scored against the objectives to clearly show options 1 & 2 were discounted. There is a table in 4.9 that assesses the options against some criteria, are they Critical Success Factors? They don't appear to match the objectives in figure 8, which is what I assume options 1 & 2 were discounted against? table 4.9 Scores options 4 - 7 between 13 & 20, and whereas options 6 & 7 have scored a red	Business case updated to include a summary table of options in the exec summary. As per 4.1 the options were scored against criteria set out by the Trust Executive Leads which were stated as part of the recruitment of the Director of Procurement. These will be the critical success factors for delivering the Procurement Collaborative. Table 8 takes the published objectives of the three Partner Trusts to establish overarching objectives for the Procurement Collaborative to ensure that these align back to the Partner Trusts and the golden thread can be followed. The table in section 4.9 has been updated to make the scoring of the options clearer.

	against some of the criteria, options 3 & 4 haven't so this doesn't seem to support the discounting of these options. There's a lot of needing to jump back and forth in the case to understand why options have been discounted and why 5 comes out on top. This could be made clearer for the reader from the outset.	
B40	Exec summary – check wording "On average across Partner Trusts back office functions have 1.86% of non-pay spend invested and 0.39% on their non-pay budget."	Business case updated by removing the second reference to non-pay.
B41	Exec summary - Equal regardless of size? Investment figures of preferred option only. Figures differ for each option. Table to summarise all this?	Please see response to B23.
B42	Exec summary - Is this for the preferred option? It's not clear? The preferred option (option 5 has an ROI of Y1 1.40 / Y2 2.39 / Y3 3.64 / Y4 5.37 & Y5 5.97? Also, £5.8m investment I assume is pay and non pay above x 3 Trusts x 5 years plus NR capital of £44.3 per Trust? This is £5.6m? However costs included in option 5 are relatively static year on year (some discrepancies), which would suggest the £44.3k capital cost has been included recurrently? This would be a total investment over 5 years of £6.1m?	Wording in the business case has been updated.
B43	1.5 - Option 1 - Cumulative Benefit £10.9m - however option 1 is discounted, and most other references to figures in this exec summary are in relation to option 5 so this is confusing. Option 5 (preferred option) cumulative is Benefit £90.6m.	Wording in the business case updated to make this clear.

B44	Why is option 3 discounted if it scored 13 against the criteria (4, 6 & 7 each scored 15 and only 6 & 7 are discounted)?	The table in section 4.9 has been updated to make the scoring of the options clearer.
B45	Figure 8 - Where is the assessment against these objectives for each option which then goes on to discount options 1 & 2	The options are not scored against the Trust objectives but are scored against the criteria set out by the Trust Executive Leads which were stated as part of the recruitment of the Director of Procurement. These will be the critical success factors for delivering the Procurement Collaborative.
B46	2.4 - Do Manchester have the standards HNYPC are trying to achieve? Would 132.92 WTE be recommended over 118.54m per the table above?	Manchester has been working collaboratively for a number of years and were used by the Finance Directors as a benchmark for the investment ask. 118.54 in the table above represents the 'as-is' position and therefore a higher level of resource is recommended.
B47	4.2.6 - Not because it doesn't meet all of the criteria in 4.9?	Wording in the business case updated.
B48	4.3.6 - Not because it doesn't meet all of the criteria in 4.9?	Wording in the business case updated.
B49	4.4.1 – update "York Facilities Management LLP" to "York Teaching Hospitals Facilities Management LLP".	Wording in the business case updated.
B50	4.4.5 - Approval has been granted before? Are there not further advantages of setting up through an LLP? Has the potential to transfer to YTHFM been considered?	This was discussed with the Finance Director for YSTH who discounted the option due to the requirement to get special approval from NHS England and the Treasury and felt that this was unlikely to be given.
B51	Figure 30 - Amount before offset of other non-pay adjustments? Options 1-3 included this adjustment? Why the change?	This is included in table 29 above which is consistent with options 1-3.
B52	Figure 30 - Where is this figure in the above table? What is the change in costs?	The total cost figure was incorrect, all component parts within the cells were correct. The total figure has been updated and this now cross references to figure 31 which had the correct total.
B53	Figure 31 – change the word "increase" to "investment".	Wording in the business case updated.
B54	Figure 32 - Total cost in table above is £4,804,523? Figure is before other non pay adjustments of £154k? Why?	The total cost figure was incorrect, all component parts within the cells were correct. The total figure has been updated and this now cross references to figure 33 which had the correct total.
B55	Figure 32 - Where is this cost in the table above? What is the change? £11.8k as per option 4 when compared with total costs, or £142k compared with Year 1 costs?	The total cost figure was incorrect, all component parts within the cells were correct. The total figure has been updated and this now cross references to figure 33 which had the correct total.
B56	4.6.6 – add wording "Criteria in table 4.9 as agreed by the Trust's executive leads and contained in the HNYPC Procurement Strategy".	Wording added.

B57	4.9 – add wording “Criteria in table 4.9 as agreed by the Trust's executive leads and contained in the HNYPC Procurement Strategy”.	Wording added.
B58	Figure 33 - Where options 3-5 have not scored red in any element, why have options 3 & 4 been discounted? Option 3 - as this would not receive approval? Although this isn't in the summary table above? Option 4 - due to insufficient benefits? Also not included in table above? Both appear to be discounted as they do not meet criteria that is not summarised and assessed here?	The table in section 4.9 has been updated to make the scoring of the options clearer.
B59	4.9 - In summary - based on the assessment against objectives / criteria and an assessment of investment costs, cash releasing benefits and cost avoidance. Option 5 is the preferred option... A statement to summarise section 4 would be useful here, including a table with each option assessed against each element to clearly show option 5 as preferred, this could then be replicated in the exec summary.	Additional wording added to the business case. A separate table only replicates the information already contained in section 4. A separate table has been added to the executive summary.

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Minutes

Executive Committee
18 January 2023

Members in attendance: Simon Morritt (SM) (Chair), Andrew Bertram (AB), Karen Stone (KS), Melanie Liley (ML), James Hawkins (JH), Gerry Robins (GR), Amanda Vipond (AV), Srinivas Chintapatla (SC), Jo Mannion (JM), Mark Quinn (MQ), Ed Smith (ES), Donald Richardson (DR), Stuart Parkes (SP), Mike Taylor (MT)

Attendees: Lisa Gray (LG) (minute taker), Jamie Todd (JT), Gail Dunning (GD), Dave Oglesby (DO) (145-22/23 item only), Astrida Ndhlovu (AN) (146-22/23 item only), Damian Mawer (146-22/23 item only), Sue Peckitt (SPe) (146-22/23 item only)

135-22/23 / Apologies for Absence: Polly McMeekin (PM), Lucy Brown (LB), Heather McNair (HM),

SM requested the meeting is kept brief due to today's industrial action therefore only items for urgent escalation or requiring a decision should be discussed.

136-22/23 / Declarations of Interest

No declarations of interest were declared.

137-22/23 / Minutes of the meetings held on 07 December 2022

The minutes of the meeting held on 07 December 2022 were agreed as an accurate record.

The committee:

- **Agreed the minutes of the meeting held on 07 December 2022 were an accurate record.**

138-22/23 / Matters arising from the minutes and any outstanding actions

Action 8 – AB confirmed funding for the final quarter has been allocated for BC2022/23-45, and it is on the planning for next year as is BC 2021/22-94 so the action can be closed.

Action 20 – SM to discuss with KS offline now that KS has replaced James Taylor, the previous owner of the action.

Action 21 – KS to pick up the approach for job planning for next year with the Care Group Directors.

Action 23 – AB confirmed conversations taken place, and this is included in the planning for next year so the action can be closed.

Action 24 – AB confirmed conversations taken place, believes this is included in the planning for next year but will check before the action is closed.

Action 25 – close action as the protocol for changes to in-year revenue financial forecast has been shared.

Action 27 – AB confirmed £300k has been secured. The first phase will be finalised in the next few weeks, with a portacabin being situated on the Scarborough site. The issue remains with those needing to transfer to the York site as talks remain over where they will be allocated. Conversations continue with the national team in relation to completely vacating the whole building as there is not a solution for this yet.

Action 28 – KS noted this action was not yet complete and confirmed that this sits with Care Group 1, so once a Care Group Director is in place this will be progressed.

Action 29 – AB noted this will be picked up with the planning work and the report that is due to the committee which outlines everything that is being planned in relation to parking/access to Trust sites so the action can be closed.

Action:

- **LG to update the action log.**

139-22/23 / Items an escalation from Board and other committees

No matters of escalation received.

140-22/23 / Chief Executives Update

SM noted there was nothing additional he wished to highlight given the many conversations that have taken place outside of the meeting in relation to operational pressures and industrial action. Noting staffing levels on both the York and Scarborough sites looked OK over the two days of industrial action.

The committee:

- **Noted the update.**

141-22/23 / Care Group Reports

SM requested the updates to be by exception only.

Care Group 1
JT noted there was nothing for escalation to the committee for decision today however, gastroenterology remains a challenge. A meeting between Care Group 1 and 2 is taking place at the end of the month and a report with detailed options and a request for support will come to the committee following this.

Care Group 2
GR flagged the Care Group are hearing rumours the UTC contract will rollover therefore there is a need to think about it quickly as an organisation, as there is a need for a replacement contract. Rolling the contract over would create real issues. SM confirmed it

was not his understanding or the systems that the contract will be rolled over, and it has been made clear that this should not happen. SM agreed to discuss with Amanda Bloor to progress the conversation.

Bridlington Care Unit has expanded to 28 beds, however there is only approved financial support until the end of March 2023. A decision needs to be made as to whether this remains open at risk, with the expectation funding will follow retrospectively.

GR flagged that there continues to be ongoing issues with locum rates, as existing and new locums ask for higher rates. The Care Group has received proof of rates they have been offered elsewhere which is making it difficult to negotiate them down and could leave some services at risk. MQ and SC highlighted the same is happening in their Care Groups. AB noted NHSE are aware of the issue, which is countrywide, and they will be introducing a cap on rates which all Trust's must stay within as well as working with Trust's to bring the rates down.

Care Group 3
AV flagged that due to the amount of activity the Care Group have had to cancel over the last three weeks, they are no longer confident that they will achieve the 78-week target however the Care Group continues to do everything it possibly can do.

Care Group 4
SC noted the one escalation which he wished to highlight from the Care Group report was the ever-increasing lists for CT/MRI/colonoscopy, which SC is extremely concerned about.

Care Group 5
JM noted an escalation report is included in the pack for the committee's attention.

The Care Group has not yet shared the CQC action plan response with the committee which is what the Care Group have been focussing on. JM provided an update on the work that has been ongoing and the dedicated support they have received from the regional team. The CQC will be coming in to speak with staff members next week, following this being deferred at the beginning of January. A lot of work continues to take place in relation to the Section 31 notice.

JM flagged the Care Group require the committee to discuss the paper on the investment needed to provide the revenue and capital for everything that is required linking to the CQC and maternity transformation programme. JM noted not all committee members have had sight of the report as it has only been circulated this morning but that it equates to £1.8m, with £1.3m being for the scrub nurses which has previously been approved. There is a need for an urgent decision, to allow for the Trust to update the CQC at its next update on 23 January 2023. SM highlighted a decision could not be made at today's meeting as there was a need for some more check and challenge on the expenditure to make sure it is associated with the CQC actions, and that there isn't anything else that could be done to bring costs down. It was agreed that AB, HM, KS, JM, and CA would meet separately to do this, to allow for a submission to be made on 23 January which highlights to the CQC the Trust is addressing its primary concerns. JM is to share the report with the committee and provide an update at the next meeting.

JM added the paediatric consultant rota in Scarborough is a big concern due to staff leaving, and the Care Group are looking to formulate a plan.

Care Group 6
MQ noted an escalation report is included in the pack for the committee's attention, flagging that the Care Group has successfully appointed a dermatologist which will help

with the dermatology pressures. There are still 28 vacant consultant PAs therefore there is still a way to go. Fast track rates have reduced to two week waits from five over the last month due to insourcing.

MQ flagged similar issues with locum rates, highlighting one of the locums requesting more money was also the consultant who has been undertaking the insourcing work on a weekend.

The Care Group have also recruited an ophthalmologist in VR however one of the other vacant posts was not filled.

Admin remains a challenge, with issues with the DNA policy, which is currently being looked into, and the number of those effected remain unknown. A report will come to committee with more detail and possible solutions when ready.

The committee:

- **Noted the Care Group escalation reports.**

Action:

- **SM to discuss the UTC contract with Amanda Bloor to progress this conversation, flagging the current one cannot be rolled over.**
- **AB, HM, KS, JM, and CA to meet to go through the maternity investment case in advance of submission to the CQC o 23 January 2023.**
- **JM to share the maternity investment case with the committee and provide an update at the next meeting.**

142-22/23 / Business Cases

2022/23-89 York ED Clinical Model

JT highlighted he has briefed the committee on several occasions in relation to the York ED build and the subsequent clinical model the Care Group are looking to deliver, to transform the way the acute and emergency care pathways are run.

The business case is seeking £3.9m budgetary investment to create the preferred option outlined in the case paperwork, other options are listed.

JT noted there are risks with proceeding with the preferred model which include not being able to recruit additional staff into the professional roles described. There are also outstanding issues in the delivery of the model as there is still no outcome in the preferred model for patients who are surgical or non-medical waiting in the emergency department too long. There is still six months before the model would be mobilised and the urgent and emergency care steering group are working through these issues to find a solution.

JT stressed the model will provide a better level of care, equally understanding the level of investment is high meaning the committee may not be able to commit to it and asked for the committee to discuss and agree a way forward.

The committee had a lengthy debate, and confirmed it was not able to commit to investing £3.9m at this stage given the resource envelope for next year is not yet known. The committee agreed:

- JT will meet with KS to talk through the model in more detail given she was not a part of previous discussions having only recently joined the Trust.
- JT will meet with SP to review pharmacies input and support as this appears to be lacking.

- KS to chase PM in relation to the consultant pay review as no update has been received for some time, and it would be helpful to have this in place as soon as possible.
- JT to review what the current budget profile would look like in the new build footprint as the reality may be that this is what the Care Group need to work with next year.
- The model is to be included as part of the Annual Planning 2023/24 – Prospective Revenue Investments discussion as a decision on this cannot be made in isolation.
- AB and LG to plan in a time for the committee to meet in February to go through next years planning to agree what investments are prioritised.

The committee:

- **Confirmed it was not able to commit to investing £3.9m at this stage given the resource envelope for next year is not yet known and that this should be included in the Annual Planning 2023/24 – Prospective Revenue Investments discussion as a decision on this cannot be made in isolation.**

Action:

- **JT to meet with KS to talk through the model in more detail.**
- **JT to meet with SP to review pharmacies input and support.**
- **KS to chase PM in relation to the consultant pay review.**
- **JT to review what the current budget profile would look like in the new build footprint.**
- **JT to add the model to the prospective revenue investments list.**
- **AB and LG to plan in a time for the committee to meet in February to go through next year's planning.**

143-22/23 / CQC Update

The CQC update report was noted in the absence of HM.

It was agreed the Information Request – Risk & Action Summary paper would be deferred to the next meeting.

The committee:

- **Noted the report.**
- **Agreed to defer the Information Request – Risk & Action Summary paper**

Action:

- **LG to add the Information Request – Risk & Action Summary paper to the next meeting.**

144-22/23 / Initial Staff Survey Results

GD noted PM had wanted the committee to have sight of the initial results however these are embargoed therefore these should not be circulated wider.

The initial results show the areas of concern that have deteriorated are around compassion, inclusive, reward, recognition, staff engagement and moral. All of these are being worked on throughout numerous work streams however there is more that needs to be done.

GD highlighted herself and Jenny Flinton will be presenting to the committee on 15 February in relation NHSE's Culture and Leadership programme and what this looks like. Feedback from the Improvement Academy from the work undertaken on ward 15 is

awaited, as this will give the Trust some helpful data. GD noted it is key to get the Leadership Framework embedded which was presented to the committee recently to help address some of these issues throughout the organisation.

Improvements shown were always learning, working flexibly and appraisal data.

SM noted a more detailed discussion will take place once the full report is received along with the peer comparator data.

The committee:

- **Noted the initial staff survey results.**

SM asked AB to pick up chairing duties as he was required to deal with an urgent matter and left the meeting.

145-22/23 / Cellular pathology service option

AB welcomed DO to the meeting.

DO informed the committee that two feasibility studies have taken place for improving the cellular pathology accommodation on the York site however both have been rejected due to either unaffordability or being unfeasible. Therefore, a range of different options have been pulled together which DO would like to explore in more detail with the committee's approval.

DO highlighted some of the options listed within the report start to explore things that are outside of the scope of the original business case for forming the SHYPS network, and that some are sensitive both in terms of workforce and politically. There would eventually also be a requirement to change the target operating model for SHYPS which may in turn have a financial impact.

It is proposed the options are put through the standard options appraisal process, which will include engagement with key stakeholders within the Care Groups.

DO confirmed he is seeking the committee's approval to pursue the options outlined in the report, for the committee to highlight any other options they would like considering, and any the committee would like to remove.

The committee had a discussion in relation to the options and confirmed their support for DO to progress with this important piece of work as the committee recognised the need for this to be done. There is a need at a future meeting to take the time to review the fallout from the options appraisal given the committee has some concerns about some of the options and how they might impact. The committee additionally felt there was the need to reduce the number of options, noting the options appraisal would likely do this.

The committee:

- **Confirmed support for DO to progress with the options appraisal, asking for this to be submitted to a future meeting for consideration with reduced options.**

Action:

- **DO to submit the options appraisal once complete to a future meeting.**

146-22/23 / Infection Prevention & Control Update

AB welcomed AN, DM and SPe to the meeting.

AN presented an update on the progress against the IPC improvement plan which is included in the meeting pack.

SPe informed the committee the performance against the Trust's trajectories are not improving with C.Diff and MRSA having now exceeded the trajectories set, with ten weeks still to go. In addition, the Trust has seen three cases of MSSA bacteraemia this year, meaning there is significant work needed to be undertaken for improvements to be made.

Both the regional and national teams are concerned by the Trust's performance and NHSE have requested an improvement plan.

SPe highlighted IPC will be requesting more engagement from clinicians to help inform practice moving forward.

DM flagged one of the challenges is ensuring staff at all levels understand and are engaged in IPC. Moving forward there will be a focus on getting the basics right, as this is something those on the frontline can make a real difference in. Given the IPC team is now fully established they will look to get into clinical areas to engage and provide education however, there is a need for the Care Group Directors to champion IPC within their areas too. KS stressed the need to get the basics right as this is not currently happening, and without the basic's, improvements will not be seen, adding there is a need to stop blaming the estate.

IPC have asked previously for Care Groups to develop their own IPC improvement plans to allow them to have a better understanding and ownership within their areas, and DM suggested the Quality Improvement (QI) team support this work.

The committee discussed the update and recognised the requirement for action and agreed:

- IPC to speak with NLaG and Bradford to see if any lessons can be learnt given their performance is better.
- A focus on getting the basics right.
- QI to support development of individual Care Group IPC improvement plans.
- Share best practice with Care Groups where improvements have made a positive difference.
- Re-introduce Post Implementation Reviews for MSSA bacteraemia.

The committee:

- **Noted the update.**

Action:

- **IPC to speak with NLaG and Bradford to see if any lessons can be learnt given their performance is better.**
- **A focus on getting the basics right.**
- **QI to support development of individual Care Group IPC improvement plans.**
- **Share best practice with Care Groups where improvements have made a positive difference.**
- **Re-introduce Post Implementation Reviews for MSSA bacteraemia.**

147-22/23 / Annual Planning 2023/24 – Prospective Revenue Investments

SM re-joined the meeting.

AB noted the annual plan had been discussed earlier in the meeting, flagging again that the numbers for next year are staggering. The Trust has proceeded with £22m worth of investment at risk this year which needs to be reviewed first before looking at the £48m worth of important investment which teams have submitted for 2023/24, leaving the Trust with a £70m problem which the committee need to consider. This does not include the £3.9m discussed as part of the York ED Clinical Model business case.

AB requested the committees support in managing expectations as there is a lot on the list which will not be able to be taken forward next year. As discussed earlier in the meeting, time will be put in the diary to go through the list in detail in February to condense it to the absolute priorities for the Trust.

AB asked for Care Groups and Corporate areas to review the list to check everything is on there and review the scores indicated to check they are correct. Finance managers are working through the list to validate what is on there as there may be duplication in some areas and to identify those that may be able to be allocated additional pots of money that become available to support capacity. AB noted this may help deal with some of the £22m invested at risk for things such as the Bridlington & York Care Units.

AB confirmed he will work with HM in relation to the one's that are CQC must dos, to ensure they are, before the Trust looks at approaching the ICB for additional growth funding to support these. The ICB will put a process in place to receive business cases and make assessments on growth funding once allocations are known.

The committee had a lengthy discussion and agreed to pick up in more detail in February once allocations are known.

The committee:

- **Noted the update.**

Action:

- **Care Group and Corporate areas to validate the list - checking everything is on there and review the scores indicated.**
- **AB and LG to liaise and book in time in February for the committee to meet to discuss annual planning.**

148-22/23 / Heating Energy, Temperature and Thermal Comfort Policy

The committee noted the Sustainable Development Group minutes and approved the Heating Energy, Temperature and Thermal Comfort Policy which AB informed them was based on best practice.

The committee:

- **Noted the Sustainable Development Group minutes**
- **Approved the Heating Energy, Temperature and Thermal Comfort Policy**

149-22/23 / Issues to escalate to Board and other committees

SM noted the Executive Directors would escalate the below to Board:

- Annual Planning 2023/24
- IPC
- Initial Staff Survey Results

Action:
- **Executive Directors to escalate to Board.**

150-22/23 / Issues to escalate for BAF & CRR consideration

MT to pick up work in relation to linking the annual planning 2023/24 prospective revenue investments to the BAF & CRR.

Action:
- **MT to pick up work in relation to linking the annual planning 2023/24 prospective revenue investments to the BAF & CRR.**

151-22/23 / Items to note

NHSEI Agency Report
The committee noted the report.

Business cases approved outside the meeting:

The committee noted the below business cases were approved outside of the meeting:

- 2022/23-84 NHSE Cardiac Network funded specialist nurse
- 2022/23-98 York HCP, Nimbus and YSTHFT Joint Wound Care Service Proposal (Wound Care C)
- 2022/23-111 Bariatric Equipment Purchase v Hire Project
- YTHFM 22/23-10 Public Transport Options

The committee:
- **Noted the NHSEI Agency Report.**
- **Noted the business cases approved outside of the meeting.**

152-22/23 / Any other business

No other business was discussed.

153-22/23 / Time and Date of next meeting

The next meeting will be held on 01 February 2023, 8.30am-12pm in the Trust Headquarters Boardroom.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

March 2023

Jan Wright, Waiting List Manager | **York** | **Nominated by Gemma Flood, colleague**

I managed a recent redeployment and as the staff member needed to be immediately redeployed, we needed a temporary position. My colleague let me know that Jan is always grateful for additional help during this challenging time and so I contacted her to enquire. Jan willingly accepted additional support and my redeployee was placed in her team within days.

The redeployee was understandably anxious about moving into a new role with unfamiliar systems and new faces. Jan worked hard to welcome the team member and make them feel at ease, ensuring the tasks and responsibilities met their skillset and capabilities. Jan also provided pastoral support to the redeployee and supported them with the transition carefully monitoring their development and adapting the role in line with this. My redeployee has several pre-existing issues and Jan accommodated these superbly acting with compassion, encouragement and without prejudice at any point.

Her input with the temporary member of staff was key in their ability to build confidence both professionally and personally which led them to gain a potential permanent redeployment elsewhere in the Trust. I believe that without Jan's input this would not have been possible. I know the redeployee is personally also extremely grateful and attributes his experience in the waiting list team with his ability to move on.

I cannot praise Jan enough and feel she has gone above and beyond. It's a real success story.

Ward 11 Team **York** **Nominated by Anne-Marie Becker, colleague**

I visited the ward for a scheduled meeting with Charlotte and noticed some gifts on the table. Charlotte explained the ward had decided they wanted to ensure all the patients with them over the Christmas period had a present, in addition to the Trust gift. To make this possible they organised a raffle and raised funds of over £250 which allowed them to purchase all their patients a gift to be delivered on Christmas Day.

Charlotte was very modest about this achievement but was clearly pleased that her team could do this 'extra' nice thing for their patients. I think this is a great example of the living the Trust values and a genuine example of a team working together to go above and beyond to improve the overall patient experience.

I felt it was worthy of a star award nomination, and told Charlotte this, but I believe the ward would not put themselves forward. So, I am making this nomination to offer them some recognition of all their hard work and to shine a spotlight on the creative idea which shows the genuine care the ward 11 team have for their patients.

Sharon Jackson, Domestic **Scarborough** **Nominated by Andy Brough, colleague**

Sharon works throughout the emergency department and minor injuries on nights. Always ready to help both service users and staff in any way she can. She helps with the transfer of patients to wards, and makes sure food and drinks are available for those that need it.

Alex Trousdale, Specialist Audiologist | **Scarborough** | **Nominated by Kate Iley, colleague**

A patient attended Scarborough hospital instead of Springhill House for a hearing aid review appointment. The appointment had been arranged urgently as the patient's father had passed away and the funeral was the next day.

The patient was struggling to hear with her current hearing aids.

Scarborough outpatients contacted the audiology department as the patient had arrived at the main hospital in error. They had also travelled by bus and were unable to travel onward to Springhill House. The operational manager had tried to book a taxi to transfer the patient across to Springhill but were advised of a 45minute wait for the taxi.

The head of audiology then contacted one of the audiologists on site for a different clinic. Alex was on site at Scarborough with a paediatric audiology list which was concluding. With the audiology head of service reviewing the ear nose throat (ENT) clinic list Alex was able to accommodate the patient at Scarborough and review their hearing aids without further travel across to Springhill.

What we thought was going to escalate into a complaint was diffused by Alex stepping in to review the patient's hearing aids. The scenario ended well with the patient being seen and leaving happier.

Laura Farrell, Healthcare Assistant | **Scarborough** | **Nominated by Nicholas Griffiths, colleague**

Whilst working a busy shift in the emergency department, Laura went out of her way to ensure the best possible care for a vulnerable patient in the waiting room.

The patient being brought into the department was in a dishevelled state and Laura continuously tried to help and care for the patient in every way, bringing her a change of clothes, food, and drinks. Eventually she managed to persuade the patient to let her shower and wash her. Going above and beyond what is expected and ensuring the dignity of the patient.

Laura did this whilst continuing to provide the best possible care for every other patient in the waiting room.

Sarah Ackroyd, Healthcare Assistant | **York** | **Nominated by Charlotte Hipkin, colleague**

Sarah volunteered to accompany me to open an admissions ward in the middle of the night despite having already settled in to working with a full team of patients.

She went above and beyond to help ensure patients would be received into a facility which was ready and able to meet their needs by setting up appropriate bed spaces and personal care equipment. She assisted nursing staff to welcome and admit patients from accident and emergency safely despite difficult circumstances.

She was professional and gave the same excellent standard of care which she always displays on our usual ward.

Marcus Moore, Anaesthetist	**Scarborough**	**Nominated by a colleague**

Marcus provided excellent individualised care to a woman on the labour ward with an in-depth detailed birth plan.

Throughout her care Marcus went above and beyond to respect her well-being, dignity, and autonomy.

He went out of his way to reassure a woman with significant PTSD, supporting her complex plan allowing to her achieve the delivery she chose.

Victoria Clark, Midwife	**Scarborough**	**Nominated by Charlotte and Tom, relatives**

My daughter was born at 33 weeks. It was a very traumatic experience for both me and my partner. Due to covid restrictions my partner was unable to attend certain factors such as the spinal block.

Victoria made such a difference in supporting me when I was alone and also in the hours of care, she gave us both after delivery when our daughter was taken to the special care baby unit (SCBU).

She really changed this experience in a positive way for us.

Samantha Reddy, Phlebotomist **York** **Nominated by Georgina Cherry, colleague**

Samantha supported a patient with learning disabilities who had really struggled having her blood taken and it had always been unsuccessful. I emailed before the scheduled date and the team let me know the best time of the day to come, so it wasn't too busy for the patient. I arrived early and Samantha was ready and waiting and told me she wasn't going to see anyone else and was keeping herself free for the lady.

She arrived with her mum and was very distressed and worried we would hurt her. Samantha was extremely patient and chatted to her about her Christmas outfit and their matching baubles and lots of other things to make her feel comfortable and safe. The lady wanted to sit on the floor, so we sat with her. She was still very worried about the needles, so together, we acted out what would happen and what equipment would be used.

Samantha managed to get the paper torniquet around her arm and she was happy with this and played with it. After 45 minutes however, it was clear the lady didn't want to have her bloods done, but her mum said this was the furthest she had ever got, and she was reassured that today had gone well and the lady wasn't as distressed as previous attempts elsewhere.

I couldn't have supported my patient as well as we did without Samantha. Staff like Samantha really help us make reasonable adjustments to accommodate the needs of those with a learning disability.

Susan Wood, Healthcare Assistant **York** **Nominated by Beverley Thorpe, relative**

My mum Wendy Thorpe has been on Ward 26 for the last week. Sue has looked after her needs and brought her hot teas and delicious looking food. Mum is going through end-of-life care and eating is something she is still enjoying. Sue lives the values and delivers them with a smile. Thank you.

Renal Technicians **York** **Nominated by Janet King, colleague**

The renal technicians look after all equipment in the renal units at York, Harrogate, and Easingwold. They also look after the machines which my patients use to perform home haemodialysis.

I cannot stress highly enough that without their professional and caring input, my patients would not be at home and would need to attend hospital three times a week for dialysis. Because of their input, we have been able to grow our service to an all-time highest number on home haemodialysis, above the national average of home patients, and this would not be possible without them. They have expert knowledge in problem solving with the dialysis machines. They use this expertise and knowledge to support the nursing staff in performing and optimizing patient's treatment. They are an approachable friendly team, where nothing is too much trouble. They will come out with me to see patients if they are having problems with the machine. Their support is invaluable.

Katie Ward, Renal Assistant Technical Officer **York** **Nominated by Stephen Palmer, colleague**

Katie is a hardworking and dedicated member of the team who strives not only to improve the working environment for the other technicians in the department but also the service we provide to outpatients across all the renal sites and those patients who are treated at home.

She has come into this new role, and she consistently comes in to work early to ensure the rest of the department can do their jobs quickly and efficiently meaning better service can be provided to patients. She goes above and beyond in completing the water sampling, procurement, and the administrative services for the team, she does all of this alongside training to be a renal technician. Katie is always caring and supportive of the department and she consistently shows passion for its betterment.

Helen Kelly, Sister **Bridlington** **Nominated by Isabelle Emery, colleague**

Helen is a great asset to the Johnson Ward team. She demonstrates the Trust values throughout the whole of her shift and has patient safety at her core.

As a therapy team we would not be able to do our job without her, from her helping to complete the trusted assessor forms and having a good understanding of multidisciplinary working.

She is often in the mornings providing personal care and breakfast for patients whilst maintaining a good rapport with patients. She is always smiling and is a beacon of light throughout. She goes out of her way to help everyone on the ward and often stays late to ensure things are in order with any concerns raised.

Helen is exceptionally kind and open with all members of the team including bank staff, she is open and engages well with patients and their families.

She demonstrates a leadership quality ensuring she provides updates throughout discharge planning and being a role model to more junior staff.

Glen Mancrief, Staff Nurse **Scarborough** **Nominated by Fae Collins, colleague**

Glen has been so supportive as a colleague and works as part of the team every time. He is passionate and caring towards all staff and patients.

Ward 26 Team **York** **Nominated by a colleague and Lisa Egginton, patient**

Nomination 1
The team on ward 26 are always approachable and friendly. Always helpful, always willing to accept and accommodate patients wherever possible. No problem is too small.

They are a credit to the Trust and the hospital, and they should be proud of their hard work and dedication. I wanted to show our appreciation to the team.

Nomination 2
I have just had my first ever hospital stay. The staff, students and volunteers on Ward 26 were all amazing. You can see how much pressure they are under and how tirelessly they work, and they do it all with a smile!

I cannot thank them enough for their care and kindness during my short stay.

Emergency Department Team

York

Nominated by Emma Smith, patient and Vicky Mulvana-Tuohy, colleague

Nomination 1
I came to the emergency department in the early hours when it was busy, and staff were stretched as usual. However, the care I received was exceptional and second to none. I had breathing difficulties, unbeknown to me I had quinsy and a deep tissue neck infection, but staff at York hospital had me seeing a nurse within minutes, a doctor within 20 minutes and I was admitted and hooked up to IV antibiotics and steroids within 45 minutes which I have no doubt saved my life.

The NHS gets a bad press, but my experience has been amazing, and I am so grateful we have this available to us.

Nomination 2
I am nominating the staff who worked the day and evening shift on 5 February - I was the on-call site manager for this shift.
There were significant system pressures that day requiring staff to be flexible and accept a divert from Hull for over five hours. The teams were helpful and supportive with colleagues asking for help, demonstrating the Trust values whilst conniving to keep the flow through the emergency department steady and ambulance turnaround at pace.

The team worked really well as a team, and it was a pleasure to work alongside them. | just wanted to recognise the comradery and the excellent teamwork that was demonstrated - although we know it happens every day.

Urmila Rai, Staff Nurse **York** **Nominated by Emma Smith, patient**

Urmila was such an amazing nurse. Always positive, happy, and caring on shift. She was super patient with difficult patients on the ward and she made my five days in hospital totally bearable.

Michelle Allott, Associate Practitioner **York** **Nominated by Angela Rounding, colleague**

Michelle always goes the extra mile for the patients in the lymphoedema clinics. Michelle regularly receives positive feedback both verbally and written from patients stating how kind, caring, knowledgeable and professional she is.

Michelle always continues to expand her knowledge clinically so she can give the most up to date advice and products to the patients.

Robert Shaw, Head of Echo, Melvina Barsby, Head of Cardiorespiratory Unit and Paul Rafferty, CG2 General Manager

Scarborough

Nominated by Gemma Arnall, colleague

Six months ago, the Care Group 4 acute oncology team made the cardiorespiratory team aware of some challenges faced for acutely unwell chemotherapy patients awaiting urgent cardio investigations which would impact on the patients' chemotherapy decisions.

The cardiorespiratory team were proactive in their approach and agreed to create a steering group to see if we could all agree to create a streamline cardio-oncology pathway.

Paul Rafferty was so supportive and recognised the importance of the pathway for this small cohort of patients. For every meeting organised Robert and Melvina went above and beyond to implement short term improvements whilst waiting for the pathway to be launched.

It was so nice to approach another care group and work together to improve patient experience, have similar goals and for them to recognise our concerns and act upon them.

I am really pleased to announce that our project has now completed, and this will make such a difference to patient care. I just wanted to highlight what fantastic team they truly are, and they deserve the recognition for their work.

Sharon Sleightholm, Sister, Kate Ashworth, ED Receptionist, Natalie Lee and Claire Kilmartin Nurses and Dr Sam Konadu

York

Nominated by Rose Eyes, relative

Sharon, Natalie, and Kate in the emergency department were really kind when my baby Hamish was admitted with projectile vomiting due to a nut allergy. They helped me clean up all the sick, helped with my bags while my husband was parking the car and were really kind in a very stressful situation. I would also like to thank paediatric nurse Claire and Doctor Sam for seeing us quickly, treating us with compassion and giving Hamish lots of cuddles. We really appreciated the help that we got and are very grateful for the NHS.

Charlie Holmes, Trainee Associate Audiologist

York

Nominated by Kate Iley, colleague

Charlie joined the audiology clinical team in September 2022 having previously worked in the audiology administration team for several years.

The audiology administration team has recently had several staff move onwards in their careers and this has left new starters requiring training. The demands on the service have grown and the new starters have been under an enormous pressure as they train within their role.

Charlie has been pro-active, and although now on the clinical team, when she has had a chance, she has helped or at the end of her own training session has stepped in to help on the audiology worklist or typing. For this I am truly grateful.

Donna Rowan, Associate Audiologist | **York** | **Nominated by Kate Iley, colleague**

Donna trained as an associate audiologist over six years ago, previously to this she worked in the audiology administration team. Recently Donna has had to help the administration team, and to be able to recall her administrative role and then assist in the way she has, has been fantastic. Donna is a real team worker, and her work ethic has been fantastic. Despite recent health problems she has had the department in her mind and worked from home when she could.

Amongst all this Donna is also studying for her BSc in audiology and hopefully will qualify later this year. The department wants her to know how valued she is.

Gemma Gregory, Healthcare Assistant | **York** | **Nominated by Jonathan Stott, patient**

Gemma is fantastic at work. The emergency department (ED) was really very busy, and everyone was rushing around, yet Gemma remained calm under pressure. I will not forget my experience at ED. I was there with chest pain and Gemma took time to reassure me and put me at ease, as well as other people's minds at ease. Gemma took time to try and talk and explain to others, she understood how busy it was and I've never seen anyone show so much empathy. Gemma is in the right job, a very caring person.

We need more Gemma's in the world.

Sally-Anne Dawson, Plaster Technician	**Scarborough**	**Nominated by Katie and Lucy Jo, visitors**

We work with and look after children in residential care who have spent quite a bit of time at the hospital. Sally has gone above and beyond to treat our young person with kindness, compassion, and respect. She has been able to keep the young person calm and has built up a great relationship with her that has helped staff.

Dave Tose, Occupational Therapist	**Scarborough**	**Nominated by a colleague**

Dave has been incredibly supportive to fellow staff members and consistently works hard to empower patients. Dave often goes out of his way to support, teach, and encourage.

Jeannette Husband, Therapy Assistant	**York**	**Nominated by Fiona Skelton, colleague**

York Community Response Team (YCRT) has been under huge pressure in the last couple of weeks and Jeannette who is a full-time generic therapy assistant with York community therapy team has unselfishly offered support over and above the ask. This has meant two full weekends of bank shifts either side of her full-time week, plus bank support on the end of one of her substantive shifts. She has shown fantastic resilience and positivity when scheduled her visits. Always has a smile on her face when I have met her in the YCRT office and a pleasure to work with. Your help has been massively appreciated.

Thank you, Jeannette.

Victoria Messruther, Sister | **York** | **Nominated by Penny Furness, colleague**

I would like to nominate Vicky after a tragic incident that occurred involving a young man who unfortunately lost his life very unexpectedly. Vicky was nurse in charge that shift and showed so much passion and care towards the family who were understandably in shock and grieving. Vicky ensured a quite side room for the family to say their goodbyes and always upheld her professionalism.

A true credit to the department and an inspiring nurse.

Pam Corkill, Staff Nurse | **York** | **Nominated by Blessing Amadi, colleague**

Pam is a hardworking and very jovial staff member. She is my mentor in the head and neck department. I am an international nurse from Nigeria, who came into the department not feeling too confident.

Pam guided me and ensured I felt confident. Simply her personality made me feel included. She made sure I photocopied the scrub policies and ensured I interacted with other professionals to have more knowledge of things happening in the department.

I saw a nurse willing to pass her knowledge without reservations and always willing to see others around her are also comfortable. I saw a nightingale nurse shinning a light for others to see. She has made a difference in my life, and I am a better scrub nurse thanks to her.

Lilly Barker, Operations Manager	**Community**	**Nominated by Fiona Skelton, colleague**

York Community Response Team (YCRT) has been under huge pressure in the last couple of weeks. I was one of the covering managers last week and I have to say I could not have done it without the support of Lily.

Lily based herself in the YCRT operational office, with her finger on the pulse .... being highly responsive and flexing capacity beyond where we thought it could be flexed alongside the shift leads and coordinators. She showed enormous resilience and was never afraid to put challenge into the system from handling phone calls, to reviewing caseload with the shift leads, to being our ear and voice in meetings.

So, a massive thanks Lily and a pleasure to work with you.

James Gilbert, Anaesthetist	**York**	**Nominated by Hayley Simpson, patient**

When coming in for c-section prep and eventually the surgery I was terrified: worried that I'd have a bad experience, be awake during surgery or have a reaction to the spinal. So much so that I viewed it as more of an ordeal than anything else. But James changed that for me. He was so reassuring and took the time to explain the procedure ahead of surgery. On the day of the surgery, he was so upbeat and talked us through everything that was happening.

I was able to remain calm and enjoy the process of my daughter being brought into the world. The experience was magical, and we can't thank him enough.

Becca Cussans, Midwife | **York** | **Nominated by Hayley Simpson, patient**

Becca really helped get my breastfeeding journey off to a great start. I had previously breastfed, but I'd forgotten what it was like to feed a new-born and had a couple of issues getting baby to latch effectively. I was also worried about baby being admitted if she lost too much weight. Becca took the time to talk me through techniques and was so reassuring. This resulted in me feeling confident to breastfeed and my little one thriving. Becca provided the right kind of support at the right time, we're now seven weeks into our breast-feeding journey and going strong.

John Hobson, Senior Audiologist | **York** | **Nominated by Jade Harris, a patient**

John does his very best to help me with sorting my hearing aids out when they are breaking or need sorting out. He tries to get me in as quickly as he can then we sometimes come up with a different solution for my hearing aids. But the ones I have now are perfect.

Home Haemodialysis Nurses Team | **Community** | **Nominated by renal technicians, colleagues**

This team go above and beyond for their patients including visiting them out of hours to drop off prescriptions or supplies that they may need, giving lifts to the hospital if they need them and always answering the phone no matter what time of night or day it is.

They are always welcoming and friendly with everyone and go out of their way to make sure their patients, patients' families, and the people they work with are cared for to the best of their abilities.

Tamsin Green, Radiographer | **York** | **Nominated by Michael Wood, patient**

Tamsin went above and beyond her duties along with the rest of her team ensuring I was looked after and more importantly had an appointment for treatment all sorted before I left the hospital.

I had come for a scan with Tamsin, but Jenny Pyatt was also meeting me to give me some paperwork for my upcoming drain. However, on my arrival they could see I was not right, and I now have my procedure tomorrow.

A credit to the NHS and I cannot thank them enough for talking to the consultants and helping to get everything sorted and potentially saving me from possibly getting a bad infection.

Jennifer Pyatt, Radiology Interventional Booking Coordinator | **York** | **Nominated by Michael Woof, patient**

On arrival for my scan Jennifer met me as she had some paperwork for my upcoming abdominal drain. However, when she saw me, I was clearly in distress.

Along with one of the nuclear sciences scan ladies Tamsin Green they made various calls to my consultants and the cardiovascular department and took me down to get a blood test as I could not walk far. I'm now booked in for a drain procedure tomorrow.

These two ladies are a credit to the NHS, and they were so caring and compassionate, I would like to thank them from the bottom of my heart for their time and effort.

Maria Woodmansey, Ward Clerk

Scarborough

Nominated by Jamie Edwards, colleague

I think Maria needs an award for all the hard work she does on the ward, she keeps the ward organised and is quick at answering the phone every time it rings. The ward wouldn't run without her. She always helps everyone no matter how busy she is and always makes everyone laugh and keeps morale high.

She’s a star and I think she deserves some recognition.

Cancer Information Team **York**

Nominated by Christine Norris, colleague

This team have implemented the new Trust cancer information system Somerset in a few short months which was a priority for the Trust. They were professional, understanding, positive and supportive in the project development phase, maintaining the Trust values and always striving for the best to ensure patient records were kept up to date, relevant and accurate.

They worked evenings and weekends to manually transfer thousands of records on all active patients to ensure we met the go live on 5 September. This was to make sure there was continued support for the cancer multi-disciplinary teams (MDTs) and the Trust's reporting requirements with as little interruption as possible. This was on top of exceptionally high volumes of patient numbers in their routine day to day work that needed to be completed and managed at the same time.

They have taken on the challenges of learning a new system with professionalism, enthusiasm and with a sense of humour at times, supporting each other and the project team. They have supported the clinical MDTs in transferring over to the system for managing MDTs with professionalism, respect, kindness and understanding as such a major change is challenging for everyone. As with any new system, much of the learning and understanding is done once the system is live and the team have taken to that with enthusiasm too.

Supporting their colleagues and other colleagues in the wider Trust, whilst also working through challenges identified, has led to a positive, stable platform some four months on. There is still much to learn and develop with the new system, but their enthusiasm continues.

Maternity Ward and Surgical Team **York**

Nominated by Hayley Simpson, patient, Gemma Olliman, patient and Abigale Hickton and Jamie Noble patients

Nomination 1
I came in for a planned c-section and the team were so reassuring and supportive throughout. From arrival to surgery to going home, the team were on hand to get my baby and I off to the right start. I felt very well looked after throughout and they made the experience a very positive one.

Nomination 2
I have birthed five babies as a surrogate at York Hospital, my most recent born by c- section. The surgical team and everyone linked to G2 are world class. They showed a level of care second to none, but they also go over and above to understand our situation. They respect our friendship, show such care, kindness and we will always be so grateful at how far they work with us. Surrogacy is still so unknown but the team at York Hospital truly set a standard for the rest of the country.

Nomination 3
My partner and I had our first baby in January and every single member of staff who helped in any way, made this experience phenomenal. They were extremely attentive to my partner, they didn't belittle nor not believe anything that she asked, they took every request seriously regardless of how small, and the task was completed as speedily and as safely possible. Every member of the team including midwives, student midwives and healthcare assistants went above and beyond without even thinking twice. This expertise followed us into labour ward and was equally as experienced and reassuring and so supportive and attentive. I cannot complain about a single thing and would love to thank everyone who was involved with baby's delivery as it was an incredible experience.

Rachel Pickup, Staff Nurse | **Scarborough** | **Nominated by Tori Dawson, colleague**

Rachel was nurse in charge of the emergency department on a very busy and extremely challenging shift. Amongst the business, remaining calm and running the department, she still notices when staff are struggling to cope with the pressures and offers to help in any way that she can. Her kindness in helping me to give personal care to a patient meant that I could carry out my role and maintain high standards of care for the patient.

Victoria Beattie, Staff Nurse | **York** | **Nominated by Amy Stones, patient**

Vicky was a good listener, kind, thoughtful, proactive, and supportive as I experienced an urgent appointment at the gynaecology ward. Through her words and her actions, she reduced the stress and anxiety I was feeling about my symptoms and made sure an action plan was achieved with signposting to other support should it be needed. Vicky made the whole process a much more positive, comfortable, and dignified experience.

Helen Stannard, Receptionist | **Selby** | **Nominated by Joanne Chatham, colleague**

I have nominated Helen for all her hard work and dedication to Selby Hospital. Helen goes above and beyond working efficiently and effectively whilst still taking time to make sure the patients are looked after. During a busy waiting room Helen can be seen asking young children if they would like some paper and pencil crayons to help pass the time and keep young minds occupied. She will also generously offer water or chocolates to patients who have waited some time emanating the Trust values. Although Helen has had some upsetting issues to deal with recently, she still comes to work with a positive attitude and a huge smile. She really is a Selby Star.

York SCBU Team	**York**	**Nominated by a colleague**

I would just like to nominate the special care baby unit (SCBU) team at York for their continued support in helping staff the paediatric ward and paediatric emergency department during the winter pressures.

This support has not gone unnoticed especially as you had to close your transitional care ward which you had worked hard to open. Every staff member who has been reallocated to support these areas - a great big thank you for going above and beyond and helping in an area unfamiliar to yourselves. Keep being your brilliant selves.

Scott Bond, Cleaning Operative	**York**	**Nominated by Natalia Domyslawska, colleague**

Scott has been going the extra mile for the past few months. Not only undertaking extra tasks when we are experiencing staff shortage but helping our rapid respond team in a very busy time. We want to thank you for your hard work and for demonstrating our Trust values. We are grateful to have you as part of the team. Thank you for helping us going through the busiest and hardest time.

Hannah Longman, Deputy MLA	**Scarborough**	**Nominated by a colleague**

I am nominating Hannah Longman as in my opinion she is a great deputy manager. She is kind, supportive and really listens to her staff. She goes above and beyond dealing with issues even when she is not at work, often covering shifts at short notice without complaint.

She is hardworking, knowledgeable, and essential to the smooth running of the laboratory.

Juniper Ward Team **Scarborough** **Nominated by Amanda Rayner, visitor**

My friend was admitted to Juniper Ward two weeks ago and has now been discharged to a nursing home. The love and care she received on the ward was excellent, and the love and care and support to her family members and friends was outstanding.

Nothing was ever too much trouble, even though they are under so much pressure.

I just wanted the nurses and healthcare assistants to be recognised for all their values in caring for people, you really have a diamond team there.

Many thanks to the team for taking so much care of my best friend. I'm writing this on her behalf too as she can't do this, and I know she would want me to.

Zoe Dunning, Clinical Coordinator **Bridlington** **Nominated by Gillian Ratcliffe, colleague**

What a lovely person always there to help and support me and other team members.

Karsten Weston, Security Officer | **York** | **Nominated by Transfer Team, colleagues**

We were asked to transfer a patient to another ward, however on arrival to the ward we discovered he had a form of autism spectrum disorder which made him extremely anxious and non-trusting of us as it was the first time, he had met us.

We tried to explain what was happening and that he was safe however this was not working.

We were told by the ward staff that the security team normally help when the patient needed treatment or to go for procedures.

We phoned security and Karsten and a colleague came up, the patient recognised Karsten and almost straight away appeared less agitated.

Karsten explained again how we were going to move him to a different ward, and he would be safe, and he would be escorted by himself and his colleague. Karsten showed compassion and understanding, and the patient began to trust him, we managed to get him up to the other ward which was very distressing for the patient and again Karsten tried to reassure him until he settled into the new room.

It was gratifying to see someone put so much care into what is an extremely challenging job.

Ward 39 Team **York** **Nominated by Karen Buttle, visitor**

I am nominating all the staff on Ward 39. The staff looked after my dad, Trevor Buttle after he was admitted with a broken hip.

They were all amazing from the very first minute he arrived after a long corridor wait, it was midnight, but they were there to welcome him. They allowed me to stop with him into the early hours to help answer the questions he couldn't which was so reassuring for the family.

Dad has aphasia so it is hard to communicate with him, but they all spent time trying to understand him and making sure he had the care he needed to recover. When he first arrived, he had Covid, and I was concerned about how the staff would treat him but they were so compassionate.

They were all so kind and caring and went above and beyond, we couldn't have asked for better staff to have looked after him, they are a credit their profession and to the hospital. Please thank them on behalf of my dad and the whole family.

Cherry and Chestnut Ward Domestics Team **Scarborough** **Nominated by Jamie Edwards, colleague**

The weekday domestics that work on the cherry and chestnut wards are amazing.

They are always working hard and always on time with meals and coffee and tea rounds. The wards always look clean and tidy, and the teams are always quick to help or clean, if there has been a spillage, always helping patients and really very helpful in general.

They are an amazing team and I think they deserve a star.

Karen Smith, Midwife **York** **Nominated by Rebecca Davies, patient**

Karen is a fantastic member of staff at York hospital. In 2020 I had my second child and Karen was my midwife; she was fantastic. On 22.1.23 I had my third child, and I cannot tell you the relief when I saw Karen walk through the door and knew she was my going to be my midwife again. I have suffered crippling anxiety since having my two-year-old, but felt I was in safe hands and all my anxieties and worries went away. I loved every second of my labour: it was very special. Karen is calming, friendly, brilliant at her job and does it to such a high standard. I also had a student midwife called Abbi who was in her second year, and she too was amazing! You wouldn't have known she was a student and her and Karen worked so well together.
Karen has helped in all three deliveries of my children and to me that is something we will keep and all three have been such a joyful special experience thanks to such a fantastic midwife. Karen made a real difference to my births she made them enjoyable and made me at ease. I'm so grateful to have the birth memories I have and a massive part of that is down to Karen. Thank you so much!

Jennie Wilkinson, Sister **York** **Nominated by Jane Price, patient**

After I came round in recovery, Jennie, a sister in the department was looking after me and what an absolute star, she made me feel so comfortable, and constantly checked I was ok. As I was staying overnight, she kept checking when a bed on a ward was available for me. I eventually got a bed on ward 12, the extended stay unit, and even though Jennie's shift had finished, she and another colleague whose shift had also finished took me up to the ward. She was so cheerful and chatting to me the whole time. Once on the ward my sheets needed changing and Jennie just cracked on with everything to even finding my bag for me.

This wonderful lady is amazing, and I want to say a massive thank you.

Cheryl Robson, Outpatient Service Administrator **York** **Nominated by Darren Every, colleague**

Cheryl took a call in the contact centre where a child was waiting for what they thought was a fast-track scan and the mum was beside herself with worry. The patient had been seen as a fast track in the head and neck department but needed a scan, yet the referral for the scan was rejected twice as it had incorrect information. Cheryl called head and neck and radiology and took it upon herself to go to radiology and speak to them where the scan had been marked as routine. Cheryl spoke with the radiology team who were able to book the scan within three days. Cheryl then owned the issue by calling the patient back who was so relieved.

This is just one example of what Cheryl has done numerous times. She is kind, she is open, and she strives for excellence not only in herself but in everyone to ensure the best patient experience.

Emma Chappell, Associate Practitioner **York** **Nominated by a colleague**

There hasn't been just one singular thing that Emma has done to deserve a nomination for the star award - she is the type of person who goes above and beyond in everything she does. She is an incredible teacher and is always willing to help others learn within the vascular imaging unit (VIU), in fact most of the new starters get paired up with her in the lab so that we can ensure they are being taught to a high standard.
She is caring and empathetic with all patients and really takes time to talk and reassure them throughout their stay with us. If she ever notices a patient in distress, she is straight over to give them a hand to hold or a gentle conversation to keep them distracted.

I am constantly impressed with Emma's attitude towards work and urge her to chase her dreams and progress in her career - the nursing world needs more people like Emma.

Caroline Dobson, Admin Assistant | **Community** | **Nominated by a colleague and Jenny Hughes, colleague**

Nomination 1

The unsung hero of the team, Caroline has been with us for a very short time but already has made a huge positive impact to our working lives. She is the smiling face that greets the team, the listening ear if we have any problems and sorts out so much non-clinical work to offload from our busy days.

Caroline always accepts so much responsibility from team managers and goes above and beyond her grade to support them. She deserves so much recognition for what she has done in so little time.

Nomination 2

After such a long period last year with no admin support in the community therapy team (CTT) we had become quite self-sufficient and had forgotten how beneficial it is to have a friendly, supportive contact in the office who can help with many of the administrative tasks that enable us to focus on the clinical care.

Right from the start Caroline has had a "how can I help" attitude and has really made an effort to get to know each of us and has a genuine interest in our work and wants to learn about the team and the role of the CTT and how she can make valuable contributions to our effectiveness. She has proactively and sensitively identified areas of potential improvements that can be made within the office and put them in place for the benefit and wellbeing of the whole team, from birthday lists and tea funds to sending patient letters, answering, and making calls to much more.

Absolutely deserving of a great star award.

Sarah Arthur, Healthcare Assistant	**Community**	**Nominated by Lisa Dunwell, relative**

Sarah has been visiting my dad at home to do regular blood taking. He has a very complex medical history due to his long-term conditions and it can be very difficult to get a blood sample from him which can be very stressful.

Sarah always shows kindness, is professional and understanding and makes my dad feel at ease taking time to chat to both him and my mum even though they know that she is always so busy. Her kindness and bubbly personality are very much appreciated, and my dad always looks forward to her visits and she always gets the blood sample needed.

Both my parents feel that she is fabulous and want her to be recognised for as this as she is exceptional in what she does.

Nelsons Court 1 Nursing Team	**York**	**Nominated by Natasha Bradley, colleague**

The Nelsons Court nursing staff have recently rolled out the use of Nucleus electronic record keeping. In January 2023 they achieved 99% in their first Nucleus audit. The team also achieved 95% in their commissioning for quality and innovation (CQUIN) audits reviewing compliance with assessing patients skin integrity and pressure area management and the management of malnourishment.

These results demonstrate an excellent adherence to the Trust values and behaviours in providing outstanding levels of patient care and in striving to achieve excellence.

This is reflected in the patient feedback received in the recent matron's assurance audit where patient's report the ward as outstanding and staff going above and beyond to treat all patients as individuals.

Donna Coop, Healthcare Assistant | **York** | **Nominated by Okonkwo Doris, colleague**

Donna is such an exceptional lady who not only does her job efficiently but also goes out of her way to ensure that all her team members are always sorted out. Donna is that one person that will give up her off days to ensure the ward is not short staffed. She is teachable, reliable, hardworking and the best to work with. She deserves this award and more.

Nina Wilson, Administration Assistant | **Scarborough** | **Nominated by Laura Blissett, colleague**

Nina has provided me with lots of help and support over the last few months. This has included her coming through to York for staff cover and going above and beyond to support me to get things done in Scarborough when I'm not able to get across.

Nina has also supported two new starters to the team with their induction and following policies and procedures. I just want to say thank you so much for all your support Nina, I really appreciate it.

Joanne Berry, Administrator | **Community** | **Nominated by Jo Wheeler, colleague**

Jo has worked so hard over the last couple of years in trying to purchase the ear suction machine for our housebound patients. She arranged staff training, liaised with St Monica's, the ear care centre and hospital to ensure the correct equipment was ordered and delivered to the health centre.

This was a very long process, with many hurdles along the way, but Jo stuck at it knowing of the benefits to our housebound patients and the opportunity for additional training for our nurses.

Ward 33 Team **York** **Nominated by Victoria Love, patient**

The whole team are always so happy, positive, and willing to go above and beyond for you. I arrived on that ward broken both mentally and physically, but they put me back together, from kneeling on the floor massaging my cramps, staying for a chat, giving me hugs to witnessing the way they dealt with difficult patients with kindness and humour and making patients with no family feel loved.

It really is an amazing team who work on there and I would love for them to know how appreciated they are.

Robert Maloney, Richard Dearing and Maricar Gay, Biomedical Scientists

York

Nominated by Phillipa Burns, colleague

Rob, Maricar and Richard supported the regional teaching of registrars from across the Yorkshire region by designing and delivering a weekend filled with mock patient cases; this involved preparing cultures, designing clinical scenarios, transporting, and setting up equipment at Hull University. The weekend was a roaring success with all attendees reporting that they feel more confident undertaking their Royal College Examinations because they have experienced some hands-on microbiology.

The Scarborough Hull York Pathology Service (SHYPS) strives to be recognised as a service that is innovative, high quality and able to deliver world class pathology services to healthcare professionals; it achieves this because we have dedicated and knowledgeable biomedical scientists like Rob, Maricar and Richard who are willing to give up their time to educate and support others through their training programmes. The teaching programme was designed to support medical registrars who have had disruptions to their training due to the COVID pandemic; I outlined the enormity of the challenge to Rob, and he took a lead in developing the programme, enlisting support from Richard and Maricar.

I am incredibly proud to work with such a wonderful team of biomedical scientists, who I know have made a real difference to registrars from across the whole of Yorkshire.

Luke Bridge, Stroke Consultant | **York** | **Nominated by Jen Owen, colleague**

On behalf of the Care Group 1 research team, we would like to nominate Luke for his outstanding contribution to research over the past few months. We were struggling to recruit participants to a study which was nearing its closing date and Luke gladly came on board to help. Not only did he complete the necessary training promptly, but he actively sought out suitable participants and recruited them to the study. Without his assistance, we would not have met our target recruitment number for this study.

Luke always goes above and beyond to help the research team. He is an absolute pleasure to work with and deserves this recognition. We look forward to working with him on other research studies in the future.

Jemma Cropley, Senior Sister | **York** | **Nominated by a colleague**

During these busy times in the emergency department, it has been a struggle as a newly qualified nurse and the support I have received from this individual has been amazing.

She has gone out of her way to support me which I have greatly appreciated. She has gone above and beyond and needs the recognition.

Donna Exton, Sister | **York** | **Nominated by a colleague**

After a tough shift in the department, Donna went out of her way in her personal time to contact me to make sure I was okay and to say how well I did during the shift. This does not happen very often, and it was a confidence boost I really needed at the time.

Lisa Noble, Deputy Sister **Selby** **Nominated by Christine Watson, colleague**

I would like to nominate Lisa for a star award as I have worked with Lisa now for a few years and our relationship was strained at times. This lady was promoted to a band 6 deputy sister role, and I am super proud of how this young lady has taken it on. Lisa is proactively gaining the skills she needs for this role, and you can see her flourishing. Lisa possesses all the qualities I would expect from her as a line manager; she's fair, consistent, treats everyone the same and is not afraid to speak up. Lisa is approachable and displays all the Trust's values and assists the team to achieve these.

I am so proud of what this young lady has achieved to date, which over covid, was not easy. Lisa values all members of the team and always offers support appropriately. Lisa actively organises events to boost staff morale and encourage teamwork. The respect that this lady has from members of the team for her dedication and passion towards her role and her hard work needs to be recognised. I am proud to call this lady my line manager and this is echoed from the team she directs. Lisa is destined for a great future in nursing.

Alison Goodall, Staff Nurse **York** **Nominated by Darren Every, colleague**

We put out a plea to the care group as we had nobody available to staff the main desk at the front of the hospital. Alison came forward and volunteered her services, and what a great job she did always smiling under pressure and such a great manner with patients. She mentioned how difficult it was for one person and volunteered to come forward and help on additional days where we only have one person.

Jen Harford, Healthcare Assistant	**Scarborough**	**Nominated by Stuart Ward, colleague**

Jen, whilst off-duty, provided excellent cardiopulmonary resuscitation (CPR) in her local community to a patient in cardiac arrest. Jen provided uninterrupted chest compressions for a minimum of ten minutes prior to my arrival as a community first responder. On scene, Jen was professionally calm and focused. Her CPR delivery was outstanding. Following the application of several automated external defibrillator (AED) shocks and further rounds of CPR, the patient achieved a return of spontaneous circulation (ROSC). The patient was transported to the emergency department for further management and after a few days spent in hospital, was successfully discharged home.

Without Jen's prompt action and commendable efforts, this patient would have undoubtedly died. As far as I am concerned, Jen deserves a star award!

Mel Broadley, Healthcare Assistant	**Community**	**Nominated by Emma Seabourne, colleague**

Mel had been working with a patient on the caseload who had mental health difficulties and was struggling accessing support at home. Mel had asked if she could be present when the patient had a telephone consultation with her GP as the patient did not feel she could tell them how she is feeling and did not have any family or friends who could support this. Mel has given this patient encouragement and support to seek help. The patient has contacted the GP herself, sought advice and the mental health team is now involved. The patient feels that without Mel giving her the “push” she would have never contacted them and for this she is very grateful. Mel is such a kind person and is always seeking the best for her patients - this is another example of how she goes above and beyond and thinking outside the box.

Sharon Hurst, Matron	**Community**	**Nominated by Kayla Philips, colleague**

I would like to nominate Sharon, my previous matron for a star award as I have really enjoyed working with her over the past six months and I learnt so much from her which has helped me develop professionally.

She has helped me learn how to communicate more efficiently in meetings and ensure that information is understood by all. She has also taught me to have courage to speak up if I don't understand what has been said or give my professional opinion for the benefit of patients. Sharon has always had time to listen to me when I have needed to discuss any issues I have had, as well as challenging me without being confrontational when I could be doing better. Everything that I have learnt and observed from working with Sharon, I will take with me into my new role. Any success I achieve within my new role will be contributed to, by what I have learnt from Sharon. It has been such a pleasure to work with Sharon and she is truly a star.

Bereavement Office and Palliative Care teams	**York**	**Nominated by Martin Sainty, colleague**

A young gentleman was in the last days of his life on ward 33, too unwell to leave hospital. He and his wife have two German shepherd dogs that they called 'their children.'

The palliative care team arranged for the two dogs to be brought into the hospital to the bereavement suite where the patient, on his bed, with oxygen therapy was waiting for them. This would be the last time he had contact with his two dogs. The bereavement team could not have supported the palliative more in making this dying man’s last wishes come true.

It was a true example of collaborative working between teams and keeping the patient at the centre of everything we do.

Marie Conlon, Patient Services Operative | **York** | **Nominated by Jane Padbury, visitor**

I am nominating the lovely Marie for a star award. The kindness shown by Marie made a very difficult time more bearable.

I was staying with an elderly dear friend on Ward 39 as she was in end-of-life care. Marie took extra time to ensure that Louise was given great care in the last week of her life. She is a dedicated, hard-working care assistant who went out of her way to help support myself and Louise's son. I stayed on the ward during Louise's last few days, so I saw her passion for her job.

Every morning, she would enter the ward with a happy greeting which made all the patients laugh. With her infectious, happy personality, she made confused dementia patients at ease and made them forget their worries. She was like a breath of fresh air.

Marie was so dedicated, caring and went out of her way to give outstanding care to Louise and others on the ward. She really supported me and Louise's son during the week. Louise was treated with great dignity and given the respect she deserved.

Marie is an outstanding member your team and she fully deserves recognition for what she did because her kindness really did make all the difference and, in our case, our lasting memory of Louise is that she died peacefully, surrounded by dedicated people who really do care and have a passion for their job.

You are amazing Marie. You should be very proud.

Isabela Dailo, Staff Nurse **York** **Nominated by Jane Padbury, visitor**

The care and love given by Isabela to someone in the last few days of life, made a very difficult time more bearable.

I was staying with an elderly dear friend on Ward 39 as she was in end-of-life care. Isabela showed such passion, care, and dedication to ensure that Louise was given outstanding nursing care in the last week of her life.

I stayed on the ward several nights, so I saw her passion for her job. Every evening when Isabela started her shift, she would come and chat to us and check Louise was comfortable and pain free. Isabela showed great care and love for Louise during the night, stroking her hair and giving reassurance. She acted promptly with pain relief and personal care and constantly checked to ensure Louise was comfortable. Her loving touch made Louise's face smile and light up-even in the last few days. Louise was treated with great dignity and given the respect and love she deserved.

Isabela is an outstanding member your team and she fully deserves recognition for what she did because her kindness, passion, and dedication to ensure the end of life is a dignified and peaceful one.

She made Louise smile and feel at peace. You are amazing Isabella! You should be very proud.

Marius Bouwer, Patient Services Operative | **York** | **Nominated by Christina Sloper, colleague**

I was working on the transfer team on my own (there is usually two of us) so it was very difficult to move the patients who were in beds. On the acute medical unit (AMU) I had patients in beds to move to other wards and the team were extremely busy, but Marius who was also very busy offered to help me move these patients.

I felt that Marius who is so kind and helpful deserves recognition for his time, kindness, and thoughtfulness in assisting me with the transfers, he is a valuable member of the team who goes above and beyond his job role.

Sophia Bunyan, Healthcare Assistant | **Scarborough** | **Nominated by Ollie Page, colleague**

Sophia deserves a star award for her care and compassion when assisting a patient with complex needs in an outpatient environment.

The team around her planned to ensure the patient's needs were met and Sophia took the lead in terms of communication, interaction, and treatment to ensure that the patient's visit had rapport, was stress free and made easier. Her actions demonstrated the Trust values especially when specialist cover was unavailable to assist. Sophia is an asset to the outpatient's team.

Andy Manson, HR Support Team Manager **York** **Nominated by Katie Gaeta, colleague**

During a recent round of recruitment for the operational HR team, Andy went above and beyond in providing support for the organisation and smooth running of the assessment centre and interviews.

Andy was asked to support in helping to co-ordinate the assessment centre and interview schedule. He utilised his previous experience of working in recruitment to ensure that the whole day ran smoothly from sending out professional invites to greeting the candidates when they arrived, this was outside of Andy's role and what was expected.

The day ran with precision and several candidates commented that the way the day was organised and the contact that Andy maintained with the candidates in the run up to the day gave them a positive and professional experience and when they were offered the job made them want to join the team. Andy has continued to provide support during the onboarding process and has been a massive help in ensuring that the induction is also a positive experience.

Victoria Mulvana-Tuohy, Head of AHP Standards **York** **Nominated by Steve Lord, colleague**

Vicky was on-call manager on Sunday. She kept us informed of the situation around the integrated care systems (ICS), engaged with the team in the emergency department in a positive manner and discussed options and listened to ideas before enacting them. She was aware of the situation on site and gave us confidence that diverts would not negatively impact us. Did this all with a smile and engaged manner.

Anna McIntosh, Healthcare Assistant | **York** | **Nominated by Rose Eyes, colleague**

Anna always works really hard, but on my first day back at work she was extra helpful, picking up any jobs she could help with and generally being a great team player. It really made my first day back a lot easier and I want to say thank you.

Eileen Angus, Midwife | **Scarborough** | **Nominated by Jo Chambers, colleague**

Eileen cared for a lady that was admitted to delivery suite in extreme mental health distress. The couple who she cared for expressed how wonderful Eileen was with them, she was patient, supportive and really showed care and compassion. She spent time with them, listening and using alternative therapies to ease their distress. Eileen ensured that all the necessary actions were put into place to support this family whilst in hospital and on their discharge.

Eileen's communication skills with her colleagues with informing them of the admission was excellent. Following on care in the community the couple have expressed to me that Eileen's care has made such a difference to their recovery, and they now feel confident and safe in being able to contact delivery suite at any point and when their baby arrives. Eileen is such a star, despite the unit being under extreme pressure, she ensured this family received amazing care.

Graham Walker, Volunteer | **York** | **Nominated by a patient**

A wonderful man cheering everyone up in the emergency department while delivering meals at lunchtime. It really perked up people's spirits and made the world of a difference.