Trust Board in Public
Tuesday 14 February 2023

Item	Description/Presenter	Note/ Approve	Time	Ref
	Business Matters			
1	**Apologies and Welcome** Sean Lyons, Chair		09:00	Verbal
2	**Chair's Opening Remarks** Sean Lyons, Chair			Verbal
3	**Declarations of Interest** **3.1 Changes to Directors' interests since the last meeting** Sean Lyons, Chair			Verbal
	3.2 To consider any conflicts of interest arising from this agenda Sean Lyons, Chair			Verbal
4	**Minutes of the previous meeting** **4.1 Minutes of the meeting held 8 November and 14 November 2022 and 25 January 2023** Sean Lyons, Chair	Approval		Attached
	4.2 Board Work Programme 2022/23 Rebecca Thompson, Head of Corporate Affairs	Approval		Attached
	4.3 Board Development Framework Rebecca Thompson, Head of Corporate Affairs	Approval		Attached
	4.4 Matters Arising Sean Lyons, Chair			Verbal
	4.5 Action Tracker Sean Lyons, Chair	Approval		Attached
	Patient Story			
5	**Patient Story** Makani Purva, Chief Medical Officer	Assurance	09.10	Verbal
	Governance			
6	**6.1 CEO Report/Covid Update** Chris Long, Chief Executive Officer	Assurance	09.30	Attached
	6.2 CQC Update Suzanne Rostron, Director of Quality Governance	Assurance		Attached
	6.3 Standing Orders Report **Scheme of Delegation Change** Rebecca Thompson, Head of Corporate Affairs	Approval		Attached
	6.4 Audit Committee Summary November 2022 Tracey Christmas – Audit Chair	Assurance		Attached
	Strategy			
7	**7.1.1 Collaborative of Acute Providers CIC TOR, HNY CAP Operating Model, HNY CAP Working Arrangements** Chris Long, Chief Executive Officer	Approval	09.50	Attached
	Quality			
8	**8.1 Quality Report** Jo Ledger, Acting Chief Nurse/Makani Purva, Chief Medical Officer/Suzanne Rostron, Director of Quality Governance	Assurance	10.05	Attached
	8.2 Infection Prevention and Control BAF Greta Johnson, Director of Infection Prevention and Control	Assurance		Attached

	8.4 Summary from the Quality Committee David Hughes, Quality Chair	Assurance		Attached
	Break		11.00	
	Workforce			
9	**9.1 Our People Report** Simon Nearney, Director of Workforce and OD **9.2 Summary from the Workforce, Education and Culture Committee** Una Macleod, Chair of Workforce, Education and Culture Committee	Assurance Assurance	11.10	Attached Attached
	Performance			
10	**Performance Report** Ellen Ryabov, Chief Operating Officer **10.1 Finance Report** Lee Bond, Chief Financial Officer **10.1.1 Procurement Business Case** Ed James, Director of Procurement **10.2 Charitable Funds Summary** Tony Curry, Chair Charitable Funds Committee	Assurance Assurance Approval Assurance	11.25	Attached Attached Attached Attached
	10.3 Summary from the Performance and Finance Committee Mike Robson, Chair of Performance and Finance	Assurance		Attached
11	**Questions from the public relating to today's agenda** Sean Lyons, Chair		11.55	Verbal
12	**Chairman's summary of the meeting** Sean Lyons, Chair			Verbal
13	**Any Other Business** Sean Lyons, Chair			Verbal
14	**Date and time of the next meeting:** Tuesday 14 March 2023, 9am – 11am			

Attendance 2022/23

Name	10/5	16/06	12/07	03/08	13/09	11/10	08/11	14/2	14/03	Total
Sean Lyons	✓	✓	✓	✓	✓	✓	✓			7/7
S Hall	✓	✓	✓	✓	✓	✓	✓			7/7
T Christmas	✓	✓	✓	x	x	✓	✓			5/7
T Curry	✓	x	✓	✓	✓	✓	✓			6/7
U MacLeod	x	✓	✓	✓	✓	✓	✓			6/7
M Robson	✓	✓	✓	✓	✓	✓	✓			7/7
L Jackson	x	x	x	✓	x	✓	✓			3/7
A Pathak	x	✓	✓	✓	✓	x	✓			5/7
D Hughes	✓	✓	x	✓	✓	✓	✓			6/7
C Long	✓	✓	✓	✓	x	✓	✓			6/7
L Bond	✓	✓	✓	✓	✓	x	✓			6/7
M Purva	✓	x	✓	✓	✓	✓	✓			6/7
J Ledger	✓	✓	✓	✓	x	✓	✓			6/7
S Nearney	✓	✓	✓	✓	✓	✓	✓			7/7
E Ryabov	✓	✓	x	✓	✓	x	✓			5/7
M Cady	✓	✓	✓	✓	✓	x	✓			6/7
S Rostron	✓	✓	✓	✓	✓	✓	✓			7/7
S McMahon	✓	x	✓	✓	✓	✓	✓			6/7
R Thompson	✓	✓	✓	✓	✓	✓	✓			7/7

Attendance 2021/22

Name	11/5	10/6	13/7	14/9	9/11	11/1	8/3	Total
Sean Lyons	-	-	-	-	-	Stood down	✓	1/1
T Moran	✓	✓	x	-	-	Stood down	-	2/3
S Hall	✓	✓	✓	✓	✓	Stood down	✓	6/6
T Christmas	✓	✓	✓	x	✓	Stood down	x	5/6
T Curry	✓	✓	✓	✓	✓	Stood down	✓	6/6
U MacLeod	✓	✓	✓	✓	✓	Stood down	✓	6/6
M Robson	✓	✓	✓	✓	✓	Stood down	✓	6/6
L Jackson	✓	x	x	✓	✓	Stood down	✓	4/6
A Pathak	✓	x	✓	✓	✓	Stood down	✓	5/6
David Hughes	-	-	-	-	-	Stood down	✓	1/1
C Long	✓	✓	✓	x	✓	Stood down	✓	5/6
L Bond	✓	✓	✓	✓	✓	Stood down	✓	6/6
M Purva	✓	x	✓	✓	✓	Stood down	✓	5/6
B Geary	✓	✓	✓	✓	✓	Stood down	✓	6/6
S Nearney	✓	✓	✓	✓	✓	Stood down	✓	6/6
E Ryabov	✓	✓	✓	✓	✓	Stood down	✓	6/6
M Cady	✓	x	✓	✓	✓	Stood down	✓	5/6
S Rostron	✓	✓	✓	✓	✓	Stood down	✓	6/6
R Thompson	✓	✓	✓	✓	✓	Stood down	✓	6/6

Hull University Teaching Hospitals NHS Trust
Minutes of the Trust Board meeting
Held on 8 November 2022

Present:	Mr S Lyons	Chairman
	Mr S Hall	Vice Chair
	Mr T Curry	Non-Executive Director
	Prof U Macleod	Non-Executive Director
	Mr M Robson	Non-Executive Director
	Dr D Hughes	Non-Executive Director
	Dr A Pathak	Associate Non-Executive Director
	Mr C Long	Chief Executive Officer
	Mr L Bond	Chief Financial Officer
	Mrs E Ryabov	Chief Operating Officer
	Prof M Purva	Chief Medical Officer
	Mrs J Ledger	Interim Chief Nurse (from item 8)
	Mrs S Rostron	Director of Quality Governance (from item 8)
	Mrs S McMahon	Joint Chief Information Officer
	Mr S Nearney	Director of Workforce and OD
	Mrs M Cady	Director of Strategy and Planning
In attendance:	Mrs L Cooper	Head of Midwifery
	Mr A Best	Head of Estates and Facilities
	Ms F Moverley	Head of Freedom to Speak Up
	Mrs R Thompson	Head of Corporate Affairs (minutes)

No	Item	Action
1	**Apologies:** Apologies were received from Mrs J Ledger, Interim Chief Nurse and Mrs S Rostron, Director of Quality Governance	
2	**Chair's Opening Remarks** Mrs Lyons welcomed the members of the Board to the meeting.	
3	**Declarations of Interest** **3.1 Changes to Directors' interests since the last meeting** There were no declarations made. **3.2 To consider any conflicts of interest arising from this agenda** There were no conflicts raised.	
4	**4.1 Minutes of the previous meetings held on 13 September/11 October 2022** **13 September 2022** Page 2 – Audit Committee Summary – "work was ongoing within India and Pakistan…" Page 7 – spelling of colectomy Following these changes the minutes were approved as an accurate record of the meeting. **11 October 2022** The minutes were approved as an accurate record of the meeting.	

4.2 Board Work Programme 2022/23
Prof Macleod requested that Under Graduate Education be added to the work programme annually.

Action: Mrs Thompson to discuss the timing with Prof Macleod. **RT**

4.3 Board Development Framework
Mrs Thompson presented the framework and advised that she had removed the February session to make way for the January 2023 Board meeting.

There was a discussion around adding a joint development working session with the NLAG Board and also CQC learning.

4.4 Matters Arising
There were no matters arising.

4.5 Action Tracker
Mrs Thompson advised that the first item 01.09 should have March 2023 rather than 2022 as the target date.

5 Patient Story
The patient story related to the time it took to get a death certificate and how this impacted on the family.

Prof Purva explained that the current process was that the last clinician to see the person needs to complete the death certificate and this was the main problem. Work was ongoing to ensure that consultants take responsibility to write the death certificates in the future as the Junior Doctors were completing them at the moment.

Prof Macleod expressed her concern regarding the lack of ownership and stated that it should form part of the Junior Doctor induction programme. Prof Purva agreed and added that the Coroner was also offering his support to the Trust.

Action: It was agreed that Prof Purva would bring a follow up report to the Quality Committee. **MP**

6 6.1 CEO Report/Covid Update
Mr Long presented the report and advised that the CQC had visited the Trust as part of an unannounced inspection. The inspection was centred around ED, Medicine and Surgery. Areas being inspected were management of the deteriorating patient, fundamental standards of care and management of patients waiting in the department. Mr Long advised that the CQC had given notice of intent for a section 31 enforcement linked to ED and an action plan had been required by the Trust detailing how patients were being kept safe. There was also a meeting with system partners as the patients with no criteria to reside were still hindering flow through the hospital.

Mr Curry asked if it was time for more radical changes and Mr Long advised that the community response is the most important issue.

The Board also discussed the staff and how they were coping with the pressures and the added scrutiny from the CQC.

6.2 Committee in Common Summary
Mr Lyons presented the summary and highlighted programmes 2 and 3 and how these had been put back to June 2023 due to local Government elections.

Work was ongoing on the Integrated Clinical plan and a number of service strategies had been received.

Mrs Cady advised that the clinical teams in both organisations were showing a great willingness to work together for the best interest of patients. She added that there had been some healthy argument along the way with opportunities to address their concerns. There was a significant amount of learning coming out of the programme.

6.3 Standing Orders Report
Mrs Thompson presented the report and requested retrospective Board approval for the use of the Trust seal.

Resolved: The Board approved the use of the Trust seal.

6.4 Board Assurance Framework Q2
Mrs Thompson presented the Q2 BAF and advised that there had been no changes to any of the risk ratings in Q2.

There was a discussion around social care constraints and the impact on the Trust. This would be reviewed again at the end of Q3.

Mr Bond expressed his concern regarding the underlying financial position and it was agreed that this would be reviewed in Q3 with a view to increasing the risk rating if necessary.

6.5 Collaboration of Acute Providers Paper
Mr Long informed the Board that the paper outlined the formation of a Committee in Common and Provider Leadership Board. Prof Macleod expressed her concern regarding the amount of leadership time that was required.

Mr Bond asked how the CAP would operate in the context of the ICB and the 6 PLACES. Mr Long explained the matrix model of governance currently being developed across the ICB. Mrs Ryabov added that individual trusts still had accountability and there was an element of duplication to all the work being carried out. Mr Bond asked about the costs of the CAP and Mr Long replied that the ICB would have to develop quickly to manage these costs.

Resolved: The Board agreed to the Provider Leadership model set out in the report.

6.6 EPRR Annual Assurance
Mrs Cady presented the annual statement of compliance which was at 91%. The Trust had scored well on the assessment and deep dive as well as

receiving positive feedback from the ICB confirm and challenge session. An action plan was in place to address any areas of non-compliance.

Mr Bond asked if there had been an independent review of the assessment and Mrs Cady advised that a peer review had been completed.

Resolved: The Board received the report and annual assurance relating to EPRR and approved it.

7 Estates Update

Mr Best updated the Board regarding the Capital programme for 2022/23.

The presentation included the new day surgery unit which was on track to be operational by the end of the financial year along with the front entrance development and the solar farm at Castle Hill.

Mr Best highlighted a number of risks with the Capital Programme that included material cost increases, contractor availability, project manager availability and energy prices. He added that the ageing workforce still remained an issue.

Prof Purva asked about power cuts and how these would be managed if they go ahead. Mr Best advised that the standby generators were being tested and work was ongoing with the Emergency Planning team to ensure business continuity.

Dr Hughes asked how much of a threat the backlog maintenance was and Mr Best advised that the Trauma Theatres was the biggest risk and would be challenging if the Trust did not get the additional funding. Mr Bond advised that that the back log for Hull Royal Infirmary is currently £70m.

Mrs Ledger and Mrs Rostron joined the meeting

8 8.1 Quality Report

Dr Purva presented the report and advised that the Serious Incident backlog was now under control and this would be helped further by the transition to PSIRF.

The Trust is still an outlier for HSMR and SHMI, the aggregated score takes 12 months to exit from and an investigation of patients that had died in April 2022 had been completed. The 3 main areas of death are still sepsis pneumonia and stroke and steering groups for sepsis and pneumonia had been established.

The CQUIN programme was being used to underpin improvement work. Work was also ongoing to improve the number of procedural documents published on time.

The Quality Governance Team were overseeing the response to complaints and focussed work was being carried out to clear the backlog.

From a Clinical Quality Improvement point of view a celebration event was planned, the 3rd cohort of QSIR training was being rolled out and training in PSIRF and the Human Factors Hub had commenced.

The Board discussed falls and tissue viability. Although the amount of falls were rising due to the different working environments, an improvement action plan was in place.

Mr Long asked how the Trust gained assurance that patients with mental health conditions were receiving good quality care and Prof Purva agreed to speak to Ms Rudston (the lead in this area) to provide a report to the next Board meeting.

Action: Mental Health patient care assurance report to be received at the next Board meeting in February 2023.

KR

8.1.1 Maternity Update
Mrs Cooper gave a presentation that provided an overview of Maternity Services to complement the reports she had provided to the Board.

The perinatal Mortality Review Tool (PMRT) Q2 data showed that the Trust was 100% compliant.

CNST overall standards had changed and the next submission would be 2 February 2022. The current position was that there were 4 green areas and 6 amber areas. The main risk was around achieving 90% training for medical staff. The team were working through the audits and having confirm and challenge meetings with the Trust and the ICB.

Mr Bond asked how confident the team was and Mrs Cooper advised that they were on track to deliver the CSNT standards, although staffing was a key risk.

Incident reporting was high, but the results were showing a low level of harm.

Mrs Cooper also presented the East Kent report and the poor behaviour and poor reporting that was highlighted. Work was ongoing to ensure exit interviews with staff were held and there was a programme of work in place relating to civility, professionalism and general behaviours.

The Board discussed the recruitment plan which included 19 new starters, international recruitment and using different ACP roles.

8.2 Summary from the Quality Committee
Dr Hughes presented the summary and advised that the Committee had undertaken a Neonatal deep dive and how the biggest risk was around the workforce but this was being actively managed.

The Bristol model for boarding patients was now in use across the Trust and related to regularly moving patients onto wards so that risks were managed on the wards as well as ED.

There had been an IPC update and an increase in MRSA numbers, although the numbers were very small.

The East Kent report had been discussed and how the findings should not just be used in a maternity setting but through all services.

Research and Innovation had presented to the Committee and highlighted the risks to opening the new interventional trials and the additional demands on pharmacy and radiology.

9 9.1 Our People Report

Mr Nearney presented the report and advised that the RCN had voted in favour of strike action which could happen by the end of November 2022.

Post meeting note: Each individual Trust has been balloted and HUTH and NLAG will not be striking.

The Trust's vacancy rate is at 3%.

The vaccination programmes are going well and 4000+ vaccines had been given for flu and Covid.

The National Staff Survey showed that staff morale was getting worse and this was included in the Board Assurance Framework.

Mr Bond asked about the over recruitment of nursing staff and Mr Nearney advised that the no criteria to reside ward establishments had increased which accounted for the extra staff costs.

9.2 Summary from the Workforce, Education and Culture Committee

Prof Macleod presented the summary and advised that reports had been scrutinised such as the Responsible Officer Report, the Guardian of Safe Working Report and the Freedom to Speak Up Q2 report.

The Committee had gained assurance form the leadership programme update but there was more work to do regarding Undergraduate Education.

Prof Macleod also mentioned the new Menopause Steering Group that had been established.

9.2.1 Responsible Officer Report

The report had been scrutinised at the Workforce, Education and Culture Committee and was presented to the Board for approval and sign off by the Chief Executive Officer.

Resolved: The report was approved by the Board and Mr Long agreed to sign it.

9.2.2 Guardian of Safe Working Report

The report had been scrutinised by the Workforce, Education and Culture Committee and was presented to the Board for assurance.

9.3 Freedom to Speak up Report Q2

Mrs Moverley presented the report and advised that there had been an increase in referrals with 42 reported to date. A number of the queries related to general support or questions about improvement ideas and who to raise them with.

A number of activities had taken place such as establishing the Speak Up Champion Network and a further 20 staff had booked onto the sessions.

Mrs Moverley advised that she was part of the Speak Up Guardian network both locally and regionally and had also taken part in an ICB sharing meeting.

Mrs Rostron highlighted the Speak Up Champions training videos (which had been filmed using the Trust Drama Group) and praised the content.

Mr Nearney asked if HR gave their support to find the solutions and Mrs Moverley advised that in the majority of cases this was true.

10 Performance Report

Mrs Ryabov presented the report and advised that performance was fairly static other than the Trust had been stepped down from Tier 1 for RTT due to improved performance

Cancer Tier 1 numbers were also coming down and work was ongoing with SHYPS

The main area of concern was still ambulance handovers. Mrs Ryabov had attended a regional conference where expectations were discussed to improve flow. She added that work was ongoing with the Medical Directors to implement the Bristol Model in the hospital.

Patients with no criteria to reside were still a key challenge as more and more space was required. The Trust was working with Social and Community Care colleagues and had come up with a number of schemes to reduce the figure down to 100 by December.

ED was under continued pressure but the impact work was expected to provide more flow and ward based care rather than patients being cared for in ED.

Prof Macleod asked about diagnostics and Mrs Ryabov advised that the wait for routine x-rays was 16 weeks.

10.1 Finance Report

Mr Bond presented the report and advised that the Trust was £1.1m behind plan at month 6. There was £5.9m expected expenditure risks which would be covered by releasing reserves.

Key areas of concern were outsourcing activity and the current pay award. Mr Bond added that CRES shortfall, financing the new Daycase Surgery unit and the £44m underlying position were major risks for the Trust.

Mr Hall asked how the Nurses strike would impact on the Trust and Mr Nearney advised that it could impact on elective recovery and there were limited resources to call upon.

10.2 End of Life Care Report

Mrs Watson presented the report and highlighted the work and communications with the Community Teams, attendance at the local and regional End of Life meetings and the digitalisation of the End of Life plan for patients.

Usage of the plan had dropped slightly due to the pandemic but face to face training was to be implemented.

There had been 1787 End of Life referrals las year and 830 of these were cancer patients.

The national audit results from the End of Life audit had reviewed 20 patients each with individualised plans of care. Risks arising from the audit related to access to carers and staff support.

Mr Long was keen that the Trust offered a world class service with measures and outcomes in place. Mrs Watson advised that work was ongoing to provide this and the End of Life Care Steering Group was tasked with innovations.

10.3 Performance and Finance Summary Report
Mr Robson advised that the Performance and Finance Committee had discussed 104 week waits and the achievements made, work had now turned to 90, 78 and then 52 week waits. There was still limited assurance for performance and finance but assurance had been gained regarding the actions being taken.

The committee also received a presentation relating to the Procurement Business Case from the new Group Director of Procurement. The Committee supported the Business Case.

10.4 Tier 1 and Tier Elective Recovery Programme – Board Self Certification
Mrs Ryabov presented the self-certification to the Board. She advised that there were 8 dimensions, 4 rated green and 4 rated amber. The appendix set out the dimensions and the ratings which the Board reviewed. She added that theatre utilisation would be reviewed in detail at the next Performance and Finance Committee.

Mr Bond asked if Outpatient Transformation should be amber rather than green due to the diagnostic turnaround times. Mrs Ryabov advised that it was rated green as the plan was on trajectory.

Resolved: The Board approved the self-certification for sign off by Mr Long and Mr Lyons

11 Questions from the public relating to today's agenda
There were no questions asked.

12 Chairman's summary of the meeting

13 Any Other Business
There was no other business discussed.

14 Date and time of the next meeting:
Tuesday 14 February 2023, 9am – 12pm

Hull University Teaching Hospitals NHS Trust
Minutes of the Trust Board meeting held in public
Held on 14 November 2022

Present:	Mr S Lyons	Chairman
	Mr S Hall	Vice Chair
	Mr T Curry	Non-Executive Director
	Prof U Macleod	Non-Executive Director
	Mr M Robson	Non-Executive Director
	Dr D Hughes	Non-Executive Director
	Dr A Pathak	Associate Non-Executive Director
	Mr C Long	Chief Executive Officer
	Mrs E Ryabov	Chief Operating Officer
	Prof M Purva	Chief Medical Officer
	Mrs S McMahon	Joint Chief Information Officer
	Mr S Nearney	Director of Workforce and OD
	Mrs M Cady	Director of Strategy and Planning
	Mrs S Rostron	Director of Quality Governance
In attendance:	Mrs R Thompson	Head of Corporate Affairs (minutes)

No	Item	Action
1	**Welcome and apologies:** Apologies were received from Mr L Bond, Chief Financial Officer and Mrs J Ledger, Interim Chief Nurse Mr Lyons welcomed all staff and members of the public to the meeting.	
2	**Proposal to develop a group leadership model: Final case for change** Mr Lyons presented the papers and advised that the model had been presented to stakeholders and staff as part of an engagement process and that this meeting was to reflect on the feedback and approve the final case for change. The engagement feedback document had been consolidated and attached to the papers as well as a letter of concern from the NLAG consultants. The risks and mitigations document had also been attached. Mr Long stated that the response was broadly what was expected and that although staff welcomed it there was some apprehension too about positions. He added that next year would be financially challenging and this would need to be taken into account. Mr Lyons thanked Chris for his supportiveness with the stakeholders. Mrs Ryabov stated that it was encouraging that there was broad support for the change, but was keen that the communications going forward were clear and supportive to avoid staff becoming unnecessarily stressed with the situation. Prof Purva advised that the consultant body was not surprised by the direction of travel but were frustrated that there was no clear timeline as to when each stage would happen. She added that the consultants	

believed that the amalgamation of services was a good idea and was the right thing to do for patients. They also wanted to move forward without compromising the current services.

Mr Lyons advised that the future model was all hinged on the recruitment of the Group CEO and Executive Team.

Mr Robson suggested that a plan be based around the feedback already received, he added that regular communication with all staff was key.

Mr Nearney asked the Board not to underestimate the cultural transformation required and time was needed to stabilise and make changes in a balanced way. He added that the model would, in time, boost morale and job creation.

Dr Pathak stated that it was important to add value to the services and not to bombard them with excessive communications so not to dilute the messages. Mrs Christmas cautioned the Board not to overcommit and be too specific as flexible working could mean better improvements and outcomes.

Mrs Jackson highlighted the 4 key themes coming out of the consultant feedback which were: not losing the NLAG journey and the work carried out over the last 5 years and improvements made, losing their ability to influence, concern that the group model would be seen as a HUTH takeover and the refocus required regarding the ICP, making sure actions were in place. Dr Pathak added that the process must be equitable with jobs not threatened.

Mr Lyons responded to the HUTH takeover comment by stating that there were safeguards in place with NED and Council of Governor representatives on both sides.

Mr Long reported that it was important to bring the communications together with the changing environment following the budget and potential recession. He added that winter, local government elections and the HASR programmes would add to the already complex agenda. Looking after staff during all of this would be the priority.

Mr Lyons took the Board through the Council of Governors feedback which included queries about timings, a takeover, safeguarding patients, location of the new CEO and costing implecations.

Mr Lyons also presented the risks and mitigations document and stated that this was a live document that had emerged as a consequence of conversations with stakeholders.

Mr Lyons asked the Board if they still wanted to approve the document following the discussions that had taken place. Mr Curry stated that the consultant support for the model was a major factor that needed to be addressed.

Resolved:
The Board approved the case for change document.

3 Next Steps

Mr Lyons reported that the next step was to approve the Group CEO process and this would be approved at the Remuneration Committees at both HUTH and NLAG this week.

Mr Lyons asked if any member of the public or staff had any questions. There were no questions asked.

Mr Lyons thanked the Board for their support.

4 Any other urgent business

There was no other business discussed.

5 Date and time of the next meeting:

Tuesday 14 February 2023, 9am – 12pm via Teams

Hull University Teaching Hospitals NHS Trust
The minutes of the Trust Board
Held 25 January 2023

Present:	Mr S Lyons	Chairman
	Mr S Hall	Vice Chair
	Mr P Walker	Deputy Chief Operating Officer
	Mrs L Jackson	Associate Non-Executive Director
	Mrs S Rostron	Director of Quality Governance
	Mr M Robson	Non-Executive Director
	Mr C Long	Chief Executive Officer
	Mrs M Cady	Director of Strategy and Planning
	Mr L Bond	Chief Financial Officer
	Mr D Hughes	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Prof M Purva	Chief Medical Officer
	Mrs S McMahon	Joint Chief Information Officer
In Attendance:	Mrs L Cooper	Head of Midwifery

1. Apologies:

Apologies were received from Mr T Curry, Non-Executive Director, Mrs E Ryabov, Chief Operating Officer and Prof U Macleod, Non-Executive Director

2. Maternity CNST Year 4 – Self Certification

Mrs Ledger introduced the item and advised that the self-certification had been through a robust governance process with the Health Groups and the ICB.

Dr Hughes advised that the Quality Committee had received regular updates throughout the year and stated that submission was positive and reflective of the work carried out.

Mrs Cooper advised the Health Group held fortnightly CNST meetings, papers were presented to the Quality Committee and then on to the Trust Board.

There are 10 standards for year 4:

- Mortality – achieving all standards
- MSDS Data – collaborative digital strategy with NLAG
- Transitional Care and avoiding term admissions into NICU – one of the best performing Trusts in the LMNS
- Clinical workforce planning – achieving all the standards although there are some challenges with obstetric medic staffing
- Midwifery workforce – uplifted clinical midwives and the Trust is in a good position
- Saving babies lives care bundle – lot of work and investment has gone in to making the Trust fully compliant
- Gather service user feedback – positive feedback from the Maternity Voices Partnership. MVP to undertake the 15

steps in maternity and review from a service user point of view.
- Mandatory training – standard achieved, although challenges due to the pandemic.
- Safety Champions – ward to board feedback.
- Notify all appropriate cases to HSIB and the early notification scheme – standard achieved.

The Trust is declaring full compliance and there has been no challenge to the information provided.

Mr Walker asked if there was a counter measure to patients that should be in NICU but have been avoided. Mrs Cooper advised that cross checking with Datix and BadgerNet is carried out to ensure nothing is missed.

Mr Hall asked for assurance around the green rating for workforce planning. Mrs Cooper advised that the service had vacancies and high levels of maternity leave but the criteria for the rating was linked to clinical and managerial staff. The establishment had been uplifted to ensure that the service had enough clinical staff. There was a national shortage of midwives and there was work ongoing to attract, recruit and retain staff.

Mr Lyons asked about the nationally funded recruitment and retention pastoral midwife and Mrs Cooper advised that the post would be with the Trust for 2 years. Important cultural work was being carried out and the role worked closely with the HR Business Partner for the Health Group. The Board thanked Zoe, the Recruitment and Retention Pastoral Midwife and Nicola the HR Business Partner for their hard work.

Prof Purva asked about the method of reporting any shortage of consultant obstetricians and Mrs Cooper informed the Board that when consultants were not present it is recorded on Datix.

Mr Nearney advised that a lot of work has been undertaken in Maternity Services and a programme of work around cultural transformation and leadership was ongoing. Mr Nearney added that a restructure had also been undertaken with new management posts being established.

Mr Lyons asked if any support was required from the Board and Mrs Ledger advised that the current focus would remain on retention and the review of neonates.

The Board discussed shared learning with other organisations and Mrs Cooper advised that she had quarterly meetings with other Trusts to share information and any lessons learned.

There was a discussion around the ICB confirm and challenge meeting and Mrs Cooper advised that Emma Smith was supporting the Health Group as a Senior Business Manager and had a central

repository of evidence which was provided to the ICB. Mrs Cooper confirmed that the meeting was positive.

Mrs Ledger (on behalf of the Board) thanked Mrs Cooper for her work and leadership. Mr Lyons added that the Trust was very grateful for all the work being carried out.

Resolved: The Board approved the assurance documentation and agreed to sign off the self-certification.

Item	Sponsor	Lead	Jan	Mar	May	EO June	Jul	Sept	Nov	Fequency	Purpose of the report	Considered by another Committee	Why is this report required to go to Trust Board	Action
Opening Items														
Declarations of Interest	Chair	Chair	✓	✓	✓	✓	✓	✓	✓	Every Board Meeting	To declare any interests the Board may have	No	Statutory	Nothing
Minutes of the last meeting	Chair	Chair	✓	✓	✓		✓	✓	✓	Every Board Meeting	To ensure an accurate record of the meeting is kept	No	Statutory	Nothing
Action Tracker	Chair	Chair	✓	✓	✓		✓	✓	✓	Every Board Meeting	To ensure actions are completed	No	Statutory	Nothing
Trust Board work programme	Director of Quality Governance	Head of Corporate Affairs	✓	✓	✓		✓	✓	✓	Every Board Meeting	To ensure all statutory items are received	No	Statutory	Nothing
Trust Board Development Framework	Director of Quality Governance	Head of Corporate Affairs	✓	✓	✓		✓	✓	✓	Every Board Meeting	To aprise the Board of future Development sessions	No	Statutory	Nothing
Chief Executive Briefing	Chief Executive	Chief Executive	✓	✓	✓		✓	✓	✓	Every Board Meeting	To update Board members on Trustwide matters	No	The report covers a wider remit of what is happening around the Trust and the wider health economy	Nothing
Regulatory, Compliance and Corporate Governance														
Board Assurance Framework and Corporate Risk Register	Director of Quality Governance	Head of Corporate Affairs	✓	✓	✓		✓		✓	Three times per year	To receive assurance in relation to the management and mitigation of the risks as approapriate and that the BAF remains reflective of the current risks to the achievement of the strategic objectives	Quality/Workforce, Education and Culture/Performance and Finance on a quarterly basis		
Trust Annual Report including Annual Governance Statement and Quality Accounts	Director of Quality Governance	Head of Corporate Affairs				✓				Annually	To seek approval of the Annual Report	Audit Committee	The Trust is required to publish an Annual Report	Approval
Trust Annual Accounts including Going Concern Review and Audit Letter	Chief Financial Officer	Deputy Director of Finance				✓				Annually	To adopt the Annual Accounts	Audit Committee	The Trust is required to adopt and publish the Annual Accounts	Approval
Audit Committee Annual Report	Audit Chair	Head of Corporate Affairs			✓					Annually	To provide assurance to the Trust Board tha the Audit Committee is functioning in accordance with its Terms of Reference and in line with the requirements of the NHS Audit Committee Handbook	Audit Committee	In line with the requirements of the Audit Committee Handbook and contributes to the Annual Governance Statement	Approval
Audit Committee summary and minutes	Director of Quality Governance	Head of Corporate Affairs		✓	✓			✓	✓	4 times per year	To provide assurance on key work of Board-Committee and escalate matters as appropriate	No	As part of overall governance of the Trust	Assurance
Standing Orders	Director of Quality Governance	Head of Corporate Affairs					✓			Every Board Meeting	The report sets out the usage of the common seal of the Trust during the year and is provided for noting	No	Affixation is governed by the Trust's Standing Orders which dictate that a report detailing the usage of the seal shall be periodically submitted to the Trust Board	Noting
Care Quality Commission Registration Report	Director of Quality Governance	Head of Effectiveness and Improvement						✓		Annually	To provide and update on the Trusts current CQC Registration status and outline changes proposed to the system of statutory regulation	Executive Team Meeting	Compliance with the proposed fundamental standards of safety and quality	Assurance
Code of Business Conduct	Director of Quality Governance	Head of Corporate Affairs	✓							Annually	To seek commitment from the Trust Board on an individual and collective basis to comply with the provision of the Code of Conduct and Statement of Responsibilities for the Board of Directors	No	The document demonstrates the Trust's commitment to embedding world class governance and compliance with statutory requirements	Approval
Forward Work Programme	Director of Quality Governance	Head of Corporate Affairs		✓						Annually	To review and support the annual programme of work	No	To approve the annual programme of work	Approval

Timetable of Board and Committee Meetings	Director of Quality Governance	Head of Corporate Affairs			✓					Annually	To approve the annual timetable of Board and Committee meetings for the year ahead	No	As part of the overall governance structure for the organisation	Approval
EPRR Self-Assessment Assurance and Annual Report	Director of Strategy and Planning	AD of Strategy and Planning						✓		Annually	To identify the current status of EPRR within the Trust and present the workplan to ensure full compliance within the year	Emergency Planning Steering Group	It is a requirement that the report received executive support and is approved by the Trust Board	Approval
Health and Safety Annual Report and work programme	Director of Quality Governance	Head of Health and Safety			✓					Annually	To provide assurance given the overall responsibility of the Trust Board for Health and Safety and the potential individual and corporate consequences of health and safety breaches	Health and Safety Committee	The Trust Board has overall responsibiity for Health and Safety	Approval
Information Governance Toolkit Submission	Director of Quality Governance	Head of Corporate Affairs					✓			Annually	For the Trust Board to approve the annual submission of the Information Governance Toolkit	IG Committee	IG is a key component of the Trust's governance framework	Approval
Register of Gifts and Interests Annual Update	Director of Quality Governance	Head of Corporate Affairs					✓			Annually	To present the register of interests and gifts and hospitality to the Board for approval	Audit Committee	The Trust is required to hold and maintain a register of Interests and a register of gifts and hospitality for public inspection	Approval
Freedom to Speak Up	Director of Quality Governance	Head of Freedom to Speak Up		✓			✓	✓		Twice per year	To provide thematic reporting to the Board on the themes and issues that are being reported to the FTSUG	Workforce, Education and Culture Committee	Expectation for all Boards to have a FTSUG following the Francis report.	Assurance
Trust Self-Certification	Director of Quality Governance	Head of Corporate Affairs			✓					Annually	To receive assurance	No	To receive assurance	Assurance
Fit and Proper Persons Test	Director of Quality Governance	Head of Corporate Affairs			✓					Annually	To provide assurance that all members of the Trust Board meet the requirements set out in Regulation 5 of the Care Quality Commission fundamental standards	No	To provide assurance that all members of the Trust Board meet the requirements set out in Regulation 5	Assurance
Review of Standing Orders, Standing Financial Instructions and the Scheme of Delegation	Director of Quality Governance	Head of Corporate Affairs					✓			Annually	To present proposed amendments to the Standing Orders, Standing Financial Instructions and the Scheme of Delegation	Audit Committee	The document is the Trust's core corporate governance and describes how the Trust Board will conduct its business	Approval
Statement of Elimination of Mixed Sex Accommodation	Director of Quality Governance	Head of Corporate Affairs			✓					Annually	To provide assurance that there have been no MSA breaches	No	To provide assurance to the Board	Assurance
Patient Experience														
Patient Experience Quarterly Report	Chief Nurse	Assistant Chief Nurse	✓		✓		✓		✓	Quarterly	To highlight compliments, complaints, PALs, patient feedback and involvement	Patient Experience	Ensures the Trust Board has oversight of good practice and improvement areas	Assurance
Safeguarding Children and Vulnerable Adults Report	Chief Nurse	Assistant Chief Nurse						✓		Twice per year	To update the Board on Safeguarding activity, issues and risks	Safeguarding	To provide assurance to the Board	Assurance
National Patient Survey	Chief Nurse	Assistant Chief Nurse								Annually	To update the Board of patients views of healthcare experiences	Patient Experience	To provide assurance to the Board	Assurance
Patient Story	Chief Medical Officer	Chief Medical Officer	✓	✓	✓		✓	✓	✓	Every Board Meeting	To highlight patient experience from the patient	No	To align the Trust's values and behaviours	Nothing
Performance														
Integrated Performance Report	Director of Quality Governance	All	✓	✓	✓		✓	✓	✓	Every Board Meeting	To inform the Board of the performance against the key performance indicators	Quality/Workforce, Education and Culture/Performance and Finance on a monthly basis	The Trust has an obligation to meet operational, financial and contractual targets	Assurance
Performance Report	Chief Operating Officer	AD of Operations	✓	✓	✓		✓	✓	✓	Every Board Meeting	To inform the Board of the performance against the key performance indicators	Peformance and Finance Committee	The Trust has an obligation to meet operational, financial and contractual targets	Assurance

Finance Report	Chief Financial Officer	Deputy Director of Finance	✓	✓	✓		✓	✓	✓	Every Board Meeting	To inform the Board of the performance against the key performance indicators	Peformance and Finance Committee	The Trust has an obligation to meet operational, financial and contractual targets	Assurance
Covid-19 Recovery Report	Director of Strategy and Planning	AD Strategy and Planning	✓	✓	✓		✓	✓	✓	Every Board Meeting	To provide assurance on Covid-19 recovery plans	No	To update the Board regarding Covid-19 planning and activity	Assurance
Summary and minutes from the Performance and Finance Committee	Chair of Committee	Head of Corporate Affairs	✓	✓	✓		✓	✓	✓	Every Board Meeting	To provide assurance on key work of Board-Committee and escalate matters as appropriate	Peformance and Finance Committee	As part of overall governance of the Trust	Assurance
Quality														
Quality Report	Chief Nurse/Chief Medical Officer/Director of Quality Governance	Head of Corporate Affairs	✓	✓	✓		✓	✓	✓	Every Board Meeting	To inform the Board of the performance against the key quality indicators	Quality Committee	The Trust has an obligation to meet operational, financial and contractual targets, including SI s and Never Events	Assurance
Summary and minutes from the Quality Committee	Chair of Committee	Head of Corporate Affairs	✓	✓	✓		✓	✓	✓	Every Board Meeting	To provide assurance on key work of Board-Committee and escalate matters as appropriate	Quality Committee	As part of overall governance of the Trust	Assurance
IPC BAF	Chief Nurse	Director of Infection Prevention and Control	✓				✓			Twice per year	To provide an update on the Trust's Infection Prevention and Control activities and information on actions in place	Quality Committee	To provide assurance to the Board	Assurance
Infection Prevention and Control Annual Report and workplan	Chief Nurse	Director of Infection Prevention and Control					✓			Annually	To provide an update on the Trust's Infection Prevention and Control activities and information on actions in place	Infection Reduction Committee	To provide assurance to the Board	Assurance
Medical Revalidation and Appraisal Update	Chief Medical Officer	Senior E-Medical Workforce Officer						✓		Annually	Provides an update on Medical Appraisal and Revalidation within the Trust		Statutory obligation	Assurance
Mortality (SHMI and HSMR) update	Chief Medical Officer	Associate Chief Medical Officer			✓			✓		Twice per year	To monitor the Trust's mortality performance	Mortality and Morbidity Committee/Quality Committee	National Requirement to report mortality to the Trust Board	Assurance
End of Life Care Annual Report	Chief Nurse							✓		Annually	To update the Board on End of Life Care	End of Life Committee	To provide assurance around progress	Assurance
Complaints Annual Report	Chief Nurse	Assistant Chief Nurse						✓		Annually	To provide assurance on key work undertaken by the Patient Experience Team around the management of complaints	Quality Committee	To provide the Board with oversight of the Complaints	Assurance
Midwife Staffing Annual Report	Chief Nurse	Director of Midwifery					✓			Annually	To advise the board of the work undertaken over the year and measures in place to ensure safe midwifery staffing	Quality Committee	To provide assurance to the Board that measures are in place to ensure safe staffing for midwifery	Assurance
Guardian of Safe Working Report	Chief Medical Officer	Guardian of Safe Working		✓	✓		✓		✓	Annually	To demonstrate the work carried out to manage safe working hours for doctors	Workforce, Education and Culture Committee	To provide assurance around safe working compliance	Assurance
Summary and minutes from the Ethics Committee	Chair of Committee	Head of Corporate Affairs								If the Committee meets	To provide assurance on key work of Board-Committee and escalate matters as appropriate	No	As part of overall governance of the Trust	Assurance
Workforce														
Staff Overview Report (Including Nurse Staffing)	Director of Workforce and OD	Deputy Chief Nurse	✓	✓	✓		✓	✓	✓	Every Board Meeting	To inform the Board of the performance against the key workforce indicators	No	The Trust has an obligation to meet operational, financial and contractual targets	Assurance
Summary and minutes from the Workforce, Education and Culture Committee	Chair of Committee	Head of Corporate Affairs	✓	✓	✓		✓	✓	✓	Every Board Meeting	To provide assurance on key work of Board-Committee and escalate matters as appropriate	No	As part of overall governance of the Trust	Assurance
Equality and Diversity Annual Report	Director of Workforce and OD	Head of HR						✓		Annually	To inform the Board of the work of Equality and Diversity throughout the Trust	Workforce, Education and Culture Committee	Equality Act 2010 - progress against eliminating discrimination	Assurance
Staff Survey	Director of Workforce and OD	Director of Communications								Annually	To inform the Board of the Staff Survey results	Workforce, Education and Culture Committee		Assurance

Modern Slavery Statement	Director of Workforce and OD	Head of HR						✓		Annually	The Board to approve the Modern Slavery Statement for publication on the Trust's website	Workforce, Education and Culture Committee	As part of overall governance of the Trust	Assurance
Workforce Disability Equality Standard	Director of Workforce and OD	Head of HR						✓		Annually	To approve progress against the action plan developed to support the WDES reporting template	Workforce, Education and Culture Committee	To ensure disabled staff have equal access to career opportunities and receive fair treatment in the workplace	Assurance
Under Graduate Education	Director of Workforce and OD							✓		Annually	To provide assurance to the Board regarding the programme	Workforce, Education and Culture Committee	So that the Board have sight of Under Graduate Education and any new developments	Assurance
Workforce Race Equality Standard	Director of Workforce and OD	Head of HR						✓		Annually	To approve progress against the action plan developed to support the WRES reporting template	Workforce, Education and Culture Committee	To ensure BAME staff have equal access to career opportunities and receive fair treatment in the workplace	Assurance
Strategy and Planning														
Trust Strategy	Director of Strategy and Planning	AD of Strategy and Planning												
Update Digital Strategy	Chief Information Officer	Director of IM&T			✓					Annually	To provide and update to the Board regarding improvements within the IM&T infrastructure	Non-Clinical Quality Committee	Efficient IT infrastructure is critical to delivereing high quality clinical care, patient safety and experience and staff acces to essential information	Assurance
Operating Framework - Performance and Finance	Director of Strategy and Planning	AD of Strategy and Planning		✓						Annually	To approve the strategy and updates	Performance and Finance	The framework sets out the Trust's performance and finance targets	None
Capital Planning	Chief Financial Officer	Deputy Director of Finance		✓						Annually	To approve the strategy and updates	Performance and Finance Committee	To inform the Board of the annual capital plan	Approval
Winter Planning	Director of Strategy and Planning	AD of Strategy and Planning						✓		Annually	To approve the strategy and updates	Performance and Finance Committee	To inform the Board of the annual winter plan	Approval
Equality, Diversity and Inclusion Strategy	Director of Workforce and OD	Head of HR						✓		Annually	To approve the strategy and updates	Workforce, Education and Culture Committee	The Strategy articulates the Trust's commitment to Equality, Diversity and Inclusion	Approval
People Strategy	Director of Workforce and OD	Head of HR					✓			Annually	To approve the strategy and updates	Workforce, Education and Culture Committee	The Strategy articulates investment in the workforce, through training and development to improve the quality of leaders	Approval
Estates Strategy	Director of Estates and Facilities	Director of Estates and Facilities						✓		Annually	To approve the strategy and updates	Performance and Finance Committee	The Strategy sets out the Trust plans for the estates, facilities and IM&T services	Approval
Clinical Strategy	ICS	Director of Strategy and Planning								Annually	To approve the strategy and updates	Quality Committee	The Clinical Strategy articulates the organisational vision and aims and the desired model of delivery of healthcare	Approval
Quality Strategy	Director of Quality Governance	Associate Director of Quality	✓							Annually	To approve the strategy and updates	Quality Committee	The Quality Strategy sets out the Quality Improvements to ensure high quality care for patients	Approval
Risk Management Strategy	Director of Quality Governance	Head of Corporate Affairs	✓							Annually	To approve the strategy and updates	Operational Risk and Compliance	Risk Management Improvements to ensure risk management is embedded across the organisation	Approval

Research and Innovation

Research and Innovation Strategy	Chief Medical Officer	Director of Research and Innovation			✓					Annually	To approve the strategy and updates	Quality Committee	The Research and Innovation strategy sets out how the service will increase research activities, attract talent, integrate with clinical care and increase collaboration with partners	Approval
Research and Innovation Annual Report	Chief Medical Officer	Director of Research and Innovation			✓					Annually	To provide annual assurance to the Board of the work carried out relating to Research and Innovation	Quality Committee	To inform the Board of the work carried out by the Research and Innovation Team	Assurance

Hull University Teaching Hospitals NHS Trust
Board Development Programme 2023

Overarching aims:

- The Board to focus on the vision, values and goals of the Trust in all that it does
- The Board to provide strategic direction and leadership for the Trust to be rated as 'outstanding' by 2023

Board Development Dates 2022/23	Strategy Refresh	Honest, caring and accountable culture	Valued, skilled and sufficient workforce	High quality care	Great clinical services	Partnership and integrated services	Research and innovation	Financial sustainability	Other
February 2023									Freedom to Speak Up
April 2023	Trust Strategy								Board Assurance Framework
June 2023				BAF 3.2: Patient Harm/Recovery	BAF 4: Risks to recovery plan				
August 2023		BAF 1: Board Leadership/ Leadership and culture						BAF 7: Financial sustainability	Staff Survey
October 2023			BAF 2: Staffing			BAF 5: ICS			
December 2023				BAF 3.1: High Quality Care			BAF 6: Research and Innovation		

Other topics for discussion:

- **Group Model**
- **CQC**
- **Winter Pressures**
- **Quality Improvements (Deep Dives)**
- **Performance issues**

Principles for the Board Development Framework

Key framework areas for development (The Healthy NHS Board 2013, NHS Leadership Academy) looks at both the roles and building blocks for a healthy board.

Overarching aim:

- The Board to be focussed on the Vision, Values and Goals of the Trust in all that it does
- To provide strategic direction and leadership for the Trust to be rated as 'outstanding' by 2021-22

Area 1 – High Performing Board

- Do we understand what a high performing board looks like?
- Is there a clear alignment and a shared view on the Trust Board's common purpose?
- Is there an understanding the impact the Trust Board has on the success of the organisation?

- Do we use the skills and strengths we bring in service of the Trust's purpose?
- How can we stop any deterioration in our conversations and ensure we continually improve them?

- How can we build further resilience, trust and honesty into our relationships?
  Does the Trust Board understand the trajectory that it is on and the journey needed to move from its current position to an outstanding-rated Trust?
- What is required in Trust Board leadership to contribute to an 'outstanding'-rated Trust?

Our recent cultural survey (Barrett Values) gave us a clear blueprint of the culture that our staff desire. This is also embedded within our Trust Values and Staff Charter defining the behaviours we expect
from everyone in order to have a culture that delivers outstanding patient care

- Is this reflected at Trust Board level? Do Trust Board members act as consistent role-models for these values and behaviours?

- What else is needed at Trust Board level in respect of behaviours? Towards each other? To other staff in the organisation?

Area 2 – Strategy Development
Strategy refresh commenced

- Outcome: for the Trust Board to have shared understanding and ownership of the Trust's strategy and supporting strategic plans, and oversee delivery of these, to be rated 'outstanding' by 2021-22
- What is the role of the Trust in the communities it serves? What is the Trust Board's role in public engagement?

- How does the Trust Board discharge its public accountability?
- To link this to Area 4 (exceptions and knowledge development) as needed

Area 3 – Looking Outward/Board education

Providing opportunity for Board development using external visits and external speakers, to provide additional knowledge, openness to challenge and support for the Board's development and trajectory

- Outcome: to provide opportunities for Board knowledge development as well as opportunities for the Board to be constructively challenged and underlying working assumptions to be challenged
- To provide an external focus to the Board not just for development but also to address the inward-facing perception reported by the Board itself as well as by the CQC

Area 4 – Deep Dive and exceptions

Internal exceptions that require Board discussion and knowledge development and ownership of issues, as they relate to the Trust's vision and delivery of the strategic goals

- Outcome: Board to challenge internal exceptions
- Board to confirm its risk appetite against achievement of the strategic goals and the over-arching aim of becoming high-performing Trust Board and 'outstanding' rated organisation by 2021-22

Hull University Teaching Hospitals NHS Trust
Trust Board Action Tracking List (February 2023)

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
February 2023						
01.02	Board Work Programme	Under Graduate Education to be added to the Work Programme	RT	February 2023		To be added for the September 2023 Board meeting
COMPLETED						
December 2022	Trust Strategy Update	Gantt chart to show delivery timescales to be presented with the next Strategy update	MC	March 2023		
	Capital Developments	Capital development and business case approval - ICS process – Mr Bond to raise and clarify	LB	November 2022		
02.02	Quality Report	Mental Health patient care assurance report to be received at the February Board meeting	KR	February 2023		Board Development December 2022

Actions referred to other Committees

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
December 2022	Patient Story	Death Certificate patient story – follow up report to the Quality Committee	MP	December 2023		Completed

Hull University Teaching Hospitals NHS Trust

Trust Board

14th February 2023

Title:	Chief Executive Report
Responsible Director:	Chief Executive – Chris Long
Author:	Chief Executive – Chris Long

Purpose:	Inform the Board of key news items during the previous month and media coverage.	
BAF Risk:	N/A	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	✓
	High quality care	✓
	Great clinical services	
	Partnership and integrated services	✓
	Research and Innovation	✓
	Financial sustainability	
Key Summary of Issues:	New children's unit, international headache conference, microplastics research, RDI reputation enhanced	

Recommendation:	That the board note significant communications items for the Trust and media coverage

Hull University Teaching Hospitals NHS Trust

Chief Executive's Report

Trust Board 14 February 2022

Communications strategic objective:
To support the Trust's mission statement, which is: "to be a provider of outstanding treatment and care and contribute to improved population health, by being a great employer and partner, living our values and using resources wisely"

Priority areas 2021-2025:

- Compassionate care of patients and staff
- Equality, diversity and inclusion
- Research, development and innovation
- Sustainability – Zero30

1. KEY MESSAGES FROM DECEMBER/JANUARY 2022

COMPASSIONATE CARE

New children's unit opens at Hull Royal Infirmary

A new £4m paediatric unit providing first-class facilities for Hull's sick and injured children and their families opened at Hull Royal Infirmary in January.

HUTH has opened Ward H20 – known as Woodland Ward – with 23 beds as part of the major £19.3m construction project to redesign the front entrance and lower floors of the famous tower block.

Now located on the second floor following the major relocation from the 13th floor of the tower block, the new facilities have easy access link to Hull Women and Children's Hospital, its operating theatres and Acorn children's ward via the link bridge over Lansdowne Street.

Four high-dependency beds for the most poorly children and a larger Paediatric Assessment Unit (PAU), which now has nine rooms, are also part of the new unit on the same floor as Woodland Ward.

Pull-down beds have been added to single rooms so parents can stay with their children. The unit also includes accommodation for parents with children in the Neonatal Intensive Care Unit (NICU) with five ensuite bedrooms, including one fully accessible room, and a dedicated lounge, enhanced with furniture, soft furnishings and art work funded by hospital charity WISHH's By Your Side Appeal.

The opening of the paediatric unit is the latest stage in the major construction project to create a new three-storey entrance to Hull Royal Infirmary with an assessment unit, modern pharmacy, multi-faith area and restaurant and shops for patients, visitors and staff.

A much larger and self-contained assessment unit provides better facilities for patients with views over the front gardens and natural light. Pharmacy has moved to the back of the ground floor of the hospital, with a new robotic arm installed to pick prescriptions.

Two new lifts will take parents and their children directly to the second floor, without the need for them to use the main lift lobby, to help ease congestion at busy visiting times.

Hull Hosted Prestigious Headache And Migraine Conference
Global experts in headache and migraine visited Hull in January to discuss pioneering treatments and advances in clinical care.

The UK's biggest meeting on headache was organised by the neurology team at Hull University Teaching Hospitals Trust in conjunction with The Migraine Trust, The British Association for the Study of Headache (BASH), the International Headache Society (IHS), and Spire Hospital, Hull and East Riding.

More than 300 delegates from across the UK convened at Lazaat Hotel in Cottingham from 25th to 28th January. Here, they received the very first 'Vicky Quarshie Memorial Lecture' from Professor Cristina Tassorelli, President of the International Headache Society, who flew in from the University of Pavia in Italy. Vicky Quarshie served the community of Hull as a specialist headache nurse for 15 years before she passed away following an illness at the age of just 48.

Delegates heard from no fewer than 50 experts in headache and migraine from various UK centres of excellence, including King's College, London, and Addenbrooke's Hospital in Cambridge.

For some time, Hull has been leading the way in the care of people with headache, migraine and other associated neurological disorders. HUTH has a reputation as a major centre for headache research and clinical services, built over the last 20 years, and we are proud to have been organising the biennial Hull BASH Headache Meeting since 2005.

850 Lives Changed thanks to Hospital Apprenticeships
This month, to mark National Apprenticeship Week, we celebrated our achievement in helping hundreds of people into training and employment.

2023 marks 10 years since Hull University Teaching Hospitals NHS Trust, which runs Hull Royal Infirmary and Castle Hill Hospital, began offering apprenticeships as a route into healthcare careers.

In that time, over 850 people have embarked on apprenticeship programmes, which comprise both on-the-job training and study toward formal qualifications.

At HUTH we offer apprenticeships across the majority of our teams and services, from pharmacy to finance, communications to cardiac physiology, occupational therapy to estates. Many of those starting out as apprentices are still with us, having gained qualifications, secured permanent roles or promotions, and in many cases, they are now carving out careers for themselves within their chosen department or clinical speciality.

It's The Porters' Time To Shine!
Hull University Teaching Hospitals NHS Trust's 116-strong team of porters, working across both Hull Royal Infirmary and Castle Hill Hospital, have reached the finals of the MyPorter Awards in the 'Portering Team of the Year' category.

Great news on its own, but one team member who's shown outstanding dedication to his role throughout a sustained period of ill-health, Brendon Bielby, has also been shortlisted for 'Porter of the Year'.

In recent times, Brendon, who works at Castle Hill, has experienced not one but two life-changing health problems which have forced him to take time off work. Yet throughout his periods of illness, Brendon has remained passionate about his role and he maintained his commitment to returning to work to make a difference as soon as he could.

The judging panel said Brendon's nomination really stood out, and was 'a true testament to his great character and dedication to portering'.

The portering team work around the clock, 365 days a year, and we are delighted to see that their work and dedication to supporting our hospitals has been recognised at a such a high level. Well done to all concerned.

Hull 'First' As Hospitals Launch Innovative Digital Platform For Schools
The Trust has achieved a UK first by launching a major educational project for schools and academies to create its own workforce for the future.

HUTH has unveiled Med Shed – its online and immersive digital programme to introduce young people aged 11 to 16 to around 350 potential careers.

Med Shed showcases NHS careers throughout the Humber and North Yorkshire region, including engineering, catering, painting and decorating and administration alongside more traditional frontline roles such as doctors, nurses and physiotherapists.

The website, designed in a bright and bold style with animation, films and an NHS careers' spinning wheel, gives young people the chance to explore various roles to see what appeals to them.

It also offers practical advice and "next steps" to help students in Key Stages 2 and 3 progress to careers in their local NHS through work experience and apprenticeships.

Staff from apprentice engineers to consultant eye surgeons feature in the "Med Shed TV" section, giving young people insights into the people already working in these roles so they can envisage themselves in similar careers.

All schools across East Yorkshire will be invited to Med Shed events in 2023 and school leaders will also be able to book "Med Shed On Tour" where HUTH staff will visit individual year groups to talk about their work at Hull's hospitals.

ZERO30

Microplastics Discovered In Operating Theatres For The First Time
High levels of microplastics have been found in surgical environments in a landmark study. A team at the University of Hull analysed microplastic levels in both the operating theatre and anaesthetic room, in cardiothoracic surgeries.

The study is the latest in a series of ground-breaking microplastics research from the University of Hull, Hull York Medical School and Hull University Teaching Hospitals NHS Trust.

Researchers discovered an average of 5,000 microplastics per metre squared when the theatre was in use, almost three times the amount found in our homes.

In addition, the anaesthetic room showed average levels of microplastics to be 500 per metre squared when in use.

Both settings had no microplastics settling out from the air when not in use.

This study is the latest by the team in Hull which has already reported microplastics in abundance in outdoor and indoor environments and also in human lungs.

Other studies have also detected microplastics in the colon and blood, but until now, no studies have quantified microplastic levels in a hospital environment.

The study in surgical environments captured atmospheric microplastics for 12 hours per day in both operating theatres and anaesthetic rooms for seven days, on both working and non-working days; findings which will be replicated in surgical theatres throughout the country.

The microplastics in surgical environments study was published in the Journal Environment International.

RESEARCH DEVELOPMENT AND INNOVATION

Thousands Say 'Yes' To Clinical Research
Patients accessing health services across Hull and East Yorkshire are amongst the most willing to help when it comes to clinical research.

Data published by the Trust's Research, Development and Innovation (RDI) Team shows that 5,465 people agreed to take part in research studies over the last 9 months alone, that's an average of more than 600 people every month.

One of the Trust's most recent and perhaps memorable research programmes was the recruitment of participants to help trial to Oxford Astra-Zeneca vaccine against Covid-19.

As at the end of the year, HUTH ranks 4th out of 25 partner organisations in Yorkshire and the Humber for recruitment to the National Institute of Health Research portfolio, having found patients willing to take part in some 127 NIHR studies. We've also delivered feedback from over 300 participants as part of the annual NIHR Participant in Research Experience Survey (PRES), where Hull Hospitals continue to see a rise in patient satisfaction year-on-year, and this is testament to the quality of care and support those patients receive.

2. MEDIA/SOCIAL MEDIA ACTIVITY

In December 2022 there were 32 articles published about the Trust:

- 24 positive (75%)
- 2 neutral (6%)
- 5 negative (16%)
- 1 factual (3%)

Social media

Facebook
Total "reach" for Facebook posts on all Trust pages in October – 243,445

- Hull Women and Children's Hospital – 64,670
- Castle Hill Hospital – 63,770
- Hull Royal Infirmary – 104,487
- Hull University Teaching Hospitals NHS Trust – 10,518

Twitter @HullHospitals

- 59,100 impressions in December 2022
- 10,632 followers
- Tweets with highest number of impressions related to the Trust winning the "Sustainable Hospitals" award at the 2022 Healthcare Business Awards, and Dr Kristina Medlinskiene being named as one of the Pharmaceutical Journal's 'Women to Watch'.

In December 2022 there were 46 articles published about the Trust:

- 32 positive (70%)

- 3 neutral (6%)
- 10 negative (22%)
- 1 factual (2%)

Social media

Facebook

Total “reach” for Facebook posts on all Trust pages in January – 272,787

- Hull Women and Children’s Hospital – 82,578
- Castle Hill Hospital – 71,084
- Hull Royal Infirmary – 97,393
- Hull University Teaching Hospitals NHS Trust – 21,732

Twitter @HullHospitals

- 59,300 impressions in January 2023
- 10,707 followers
- Tweets with highest number of impressions related to the commemoration of the 3 year anniversary since HUTH staff treated the UK’s first Covid patients, and the arrival of our latest intake of international nurses.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	14 February 2023
Title	Care Quality Commission (CQC) Update Report				
Lead Director	Suzanne Rostron – Director of Quality Governance				
Author	Leah Coneyworth – Head of Quality Compliance and Patient Experience				
Report previously considered by (date)	A more detailed version of this report was presented at Quality Committee and is available on sharepoint and on the Teams channel for Board members.				

Purpose of the Report		**Reason for submission to the Trust Board private session**		**Link to CQC Domain**		**Link to Trust Strategic Objectives 2021/22**	
Trust Board Approval		Commercial Confidentiality		Safe	✓	Honest Caring and Accountable Future	✓
Committee Agreement		Patient Confidentiality		Effective	✓	Valued, Skilled and Sufficient Staff	
Assurance		Staff Confidentiality		Caring	✓	High Quality Care	✓
Information Only	✓	Other Exceptional Circumstance		Responsive	✓	Great Clinical Services	✓
				Well-led	✓	Partnerships and Integrated Services	✓
						Research and Innovation	
						Financial Sustainability	

Key Recommendations to be considered:

The Trust Board is recommended to:

- Receive the updates in this report and decide if any further information and/ or assurance are required at this stage in the inspection process

ULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
CARE QUALITY COMMISSION (CQC) UPDATE REPORT
Prepared for the Trust Board to be held in February 2023

1. PURPOSE

The purpose of this report is to provide the Trust Board with an update against the Trust's response to the letter of intent raising the urgent concerns relating to the Emergency Department from the CQC Inspection in November 2022.

2. ED ACTION PLAN

Following the unannounced inspection in November 2022, the CQC issued a letter of intent and highlighted urgent concerns against the Emergency Department; the identification and management of deteriorating patients, the inability to demonstrate that fundamental standards of care are being met, management of patients waiting within the department and assessment rooms within the department (ECA) were potentially unsafe for patients with mental health needs. In response to this, the Trust put an immediate action plan in place, which was shared with the CQC. The CQC confirmed they were satisfied with the Trust's actions to address the urgent concerns.

The ED action plan includes 43 actions and is reviewed at the Weekly Safety Oversight Group and was last updated at the meeting held 06 February 2023. A brief breakdown against the progress of the actions so far is provided in the table below.

Actions completed with evidence of completion provided	37
Implemented with ongoing monitoring	3
Open with further updates required	3

The full action plan is attached at Appendix A for information. However, the table below provides the committee with key highlights to note from the delivery of ED action plan since November 2022.

Overview	Actions completed in November 2022	Actions completed in December 2022 and January 2023	Variations to plan	Outcomes achieved	Further actions required
ED1: The identification and management of deteriorating patients					
15 out of 16 actions have been completed with evidence of completion provided. The focus for these actions will now be on sustainability and the impact on the outcomes. Should the outcomes not be achieved, practice will be reviewed. The 1 remaining open actions will continue to be monitored via the Weekly Safety Oversight Group.	• ED Sepsis task and finish group established. • Safety nurse role established • Additional nursing establishment created – registered and non-registered • Review of all cases identified in CQC letter of intent • RAT doctor in ECA commenced • Two hourly ward rounds commenced • NEWS scores visible on screens in department for all patients • Twice weekly bronze meetings including consultant review of improvement plan and exceptions	• Sepsis training and competency sign off is underway for Emergency Department staff • Digital sepsis bundle trialled and implemented • Patients on ambulances of a NEWS score higher than 5 to be moved into the department or have a plan within 30 minutes • SOP updated for escalation of NEWS score 5 or above or 3 in 1 parameter and communicated to the team • Clarification of B8a matron roles in the department and in the site team provided and evidence provided • Daily handover sheets analyses for feedback of where improvements are working well and	• Established reviews every 2 hours are not always a full Board Rounds depending on patient flow. However, assurance has been obtained that a review of patients is undertaken by the senior nurse and consultant/registrar as a minimum. The full Board rounds are of most use when there is good patient flow and the patients change whereas the patient safety conversations are of most benefit when patients remain in the department for a longer period of time. • The term 'Escalation doctor/nurse' was changed to 'Safety doctor/nurse' early on in the implementation of the action plan. • The safety nurse is not always available if	• Reduction in SIs and incidents causing harm • Reduction in complaints and PALS – more compliments received than complaints during 2022 • Flow improved from mid-January with reduction in NCTR patients, improved ambulance handover and OPEL 3 level • Starting to see improvements in 12 hours in department	• Confirm outstanding competency check requirements for ED staff • Review risk rating of risk 3439 at February EMC meeting • Continue assurance visits and Safety Oversight Group for February, considering any changes required for ensuring actions are sustained and outcomes achieved. • Audit reports from digital sepsis tool for screening in addition to compliance with sepsis bundle once sepsis is identified.

		where further work could be required	there is short notice sickness absence. However, the safety checks in place do now mitigate for this.		
ED2: The inability to demonstrate that fundamental standards of care are being met					
All 7 actions have been completed with evidence of completion provided. The focus for these actions will now be on sustainability and the impact on the outcomes. Should the outcomes not be achieved, practice will be reviewed.	• Met with all Band 6 and Band Senior Nurses and Band 5 Nurses to undertake briefing sessions around the expectations of fundamental standards of care • Released the Clinical Matrons from patient flow escalation to focus on training, assurance checks against the fundamental standards of care and escalation • Weekly review commenced against the quality and safety checks • Pressure relieving mattresses were ring-fenced for ED use only; no concerns accessing these beds to date	• ED Tissue Viability task and finish group established • Matron handbook reviewed to be ED specific and links in with the documentation on Nerve Centre e.g. completed assessments as part of the quality and safety checks – this was done in conjunction with the ED Senior Matron • Interim arrangements were implemented via the Deputy Chief Nurse to support the department during the absence of the ED Nurse Director	• Weekly quality and safety checks commenced as planned; however, these have been undertaken by the ED Senior Matron in the absence of the ED Nurse Director and shared with the Interim Chief Nurse	• Improved completion and the quality and safety checks • Improved compliance with the completed assessments and intervention of fundamental standards of care • Reduction in SIs and incidents causing harm	• Continue with the close monitoring of the delivery of the fundamentals of care in a timely response • Tissue Viability Nurses to review the impact of any delayed skin assessments on patient outcomes • Continue with the interim support arrangements from the Deputy Chief Nurse • Continue assurance visits and Safety Oversight Group for February, considering any changes required for ensuring actions are sustained and outcomes achieved
ED3: Management of patients waiting within the department					
9 out of 11 actions have been completed with evidence of completion provided. The focus for	• 2.5 WTE increase Registered and 2.5 WTE Non-registered	• Implementation of dedicated treatment area for ambulatory patients to have	• Development of a high observation acute assessment unit and an operational plan to	• Starting to see a reduction in the number of patients lodged in ECA	• Continually review the impact of the HOB opened on the 13th floor and agree the

these actions will now be on sustainability and the impact on the outcomes. Should the outcomes not be achieved, practice will be reviewed. The 2 remaining open actions will continue to be monitored via the Weekly Safety Oversight Group.	Nurses to support in Emergency Care • The weekend Roaming Team continued as planned • Implementation of the Bristol Model following a trail in October 2022 • Safety brief at shift handover (8am, 4pm, midnight) – introduced as planned and well embedded into practice	ongoing care in Emergency Care • Non-registered staff identified and in place to support the discharge lounge to ensure patients are safe whilst waiting for transport during out of hours • Complete the 12 days of Christmas as planned and use learning from the scheme to inform an improved command and control framework • Clarification of B8a matron roles in the department and in the site team provided and evidence provided • Introduced an assigned Director of the Day • The Executive Team agreed for the 90 day plan of the ground floor model to commence in January 2023	release capacity in Resus – a hob has been implemented on the 13th floor following the relocation of the Children Wards. • Following discussions regarding introducing an additional daily Gold Command meeting at 3.00pm with the Executive Team it was felt a an assigned Director of the day would have a better impact. Therefore, this was introduced in replace of an additional Gold Command	• Starting to see improvements in 12 hours in department • Flow improved from mid-January with reduction in NCTR patients, improved ambulance handover and OPEL 3 level	requirements for a HOB on the Acute Assessment Unit • Recruitment to the 1WTE additional to support the discharge lounge • Continue with the plans to introduce the 90 day plan of the ground floor model • Continue assurance visits and Safety Oversight Group for February, considering any changes required for ensuring actions are sustained and outcomes achieved
ED4: Assessment rooms within the department (ECA) were potentially unsafe for patients with mental health needs					
2 out of 4 actions have been completed with evidence of completion provided. The focus for these actions will now be	• Health and Safety undertook the ligature risk assessments in ED; Rooms 4 and 5 in Majors and dedicated	• Work continued to take place with Humber Foundation Trust to develop a designated mental health		• Small numbers of staff are starting to receive the MCA training	• Continue to raise awareness of and deliver the MCA training

on sustainability and the impact on the outcomes. Should the outcomes not be achieved, practice will be reviewed. The 2 remaining open actions will continue to be monitored via the Weekly Safety Oversight Group.	room ECA and identified the areas for improvement. These were also shared with Estate and Facilities to support their plans and building works • The Director of Estates, Facilities and Development undertook a walk round with the ED Nurse Director to identify any further actions regarding potential ligature risks • Any immediate ligature risks were removed and patients with mental health needs placed in the dedicated rooms were assessed and the rooms were cleared if required • Work continued to take place with Humber Foundation Trust to develop a designated mental health assessment area adjacent to ED	assessment area adjacent to ED with a deadline of April 2023 agreed • Work continues with Humber Foundation Trust to support the development of the required SOPs and governance arrangements for the dedicated mental health assessment area • Introduction of an mental health triage and assessment form for ED on Nerve Centre • Implementation of a MCA training module offered to all staff delivered by the MCA Lead Nurse and are offered twice per week until the end of March 2023		• Increased staff awareness of mental health in the department and starting to see an improvement in the appropriate triage and assessment of patients with mental health needs via the Nerve Centre Triage Form	• Work to continue with the development of the designated mental health assessment area adjacent to ED • Completion of the actions in response the ligature risks • Continue assurance visits and Safety Oversight Group for February, considering any changes required for ensuring actions are sustained and outcomes achieved
ED5: Other actions					
4 out of 5 actions have been completed with evidence of completion	• Implementation of the Weekly Safety Oversight Group and	• Continuation of the Weekly Safety Oversight Group and	• The System Meeting have been cancelled	• CQC update reports to the Quality Committee with progress against	• To include performance data against the outcome

provided. The focus for these actions will now be on sustainability and the impact on the outcomes. Should the outcomes not be achieved, practice will be reviewed. The 1 remaining open action will continue to be monitored via the Weekly Safety Oversight Group.	reporting / escalation to the Quality Committee • The first System Meeting took place with partners to accelerate and add to existing system wide plans	reporting / escalation to the Quality Committee and the CQC • ED Digital task and finish group established – continue to meet weekly. The majority of ED documentation has now been reviewed and updated on the digital records, tested and uploaded to LIVE. The latest form to be uploaded was the mental health triage and assessment form. There are another 2/3 forms to be completed. • A review of the cohorting arrangements were undertaken jointly by HUTH and YAS. A risk assessment was completed and a joint SOP was developed and agreed. The Trust also developed On-call guidance for YAS cohorting. • The YAS and HUTH risk assessment was reviewed as planned.	on a number of occasions • The YAS and HUTH risk assessment was reviewed as planned. It was agreed at Gold Command that cohorting will continue in the Atrium and 'frosting' will be applied to glass to improve privacy and dignity.	the ED action plan, feedback from the assurance reviews and escalation of potential risks – demonstrating good progress against the delivery of the plan • Implementation of the improved ED digital documentation	measures from January 2023 • Test staff feedback following the full completion of the ED digital work • 'Frosting' will be applied to glass to improve privacy and dignity. • Continue assurance visits and Safety Oversight Group for February, considering any changes required for ensuring actions are sustained and outcomes achieved

3. OVERSIGHT AND EVIDENCE

The Safety Oversight Group has been established since the 14 November 2022, led by the Director of Quality Governance and continues to meet weekly. The group receives weekly updates on the ED action plan and the assurance visit reports on compliance with the agreed actions and improvements. From the end of January 2023 the group also started to receive performance against the outcome measures highlighted on the ED action plan.

A CQC update paper is presented to the Quality Committee on a monthly basis which also provides updates on the ED action plan and any variations to plan, the assurance visit reports on compliance with the agreed actions and improvement, performance against outcome measures (from January 2023) and a summary from the Safety Oversight Group. This information is then subsequently be shared with the CQC as evidence following each meeting. A submission of evidence has been sent to the CQC in December 2022 and January 2023 to date. The documents are also shared with the Executive Team via our internal Board Team channel.

The ICB has set up a monthly HUTH Quality Improvement Group that includes all providers, NHSE and CQC to support with the delivery of actions across the system and within HUTH.

4. DRAFT REPORT

The Trust has received the draft report and the relevant services and key leads currently completing the factual accuracy. The Trust is required to provide a response to the CQC, no later than 16 February 2023.

The draft report highlights breaches in the regulations that the Trust is required to address as 'must' and 'should' do actions. Some of these concerns were those highlighted in the initial letter of intent regarding the Emergency Department and as part of our initial feedback from this CQC. A number of key improvement work streams are required to address the areas for improvement as follows:

- Assurance mechanisms – need to challenge ourselves on the assurances we receive,
- Training & appraisals
- Theatre work-stream – culture, WHO checklist, controlled drugs/medicines management
- Continuation of ED support & monitoring
- Continuation of Patient Flow & elective recovery work
- Digital health records & information
- Nutrition
- Continuation of complaints improvements
- Consent – particularly for those without capacity
- Mental capacity act/DoLS/Safeguarding
- Governance arrangement in Surgery Health Group – significant support required
- IPC – bare below the elbow, mask wearing, handwashing in ED
- Environmental risk assessments
- Never events learning & prevention
- Local induction arrangements
- Patient experience & engagement, particularly for ED
- Nursing & medical staffing levels
- Continue policy & procedure work for out of date documents

Working groups are being set up to commence the improvement work this month alongside core service improvement plans. The Trust will be asked to submit an action plan once the report is finalised.

5. RECOMMENDATIONS

The Trust Board is recommended to:

- Receive the updates in this report and decide if any further information and/ or assurance are required at this stage in the inspection process

Leah Coneyworth
Head of Quality Compliance and Patient Experience
February 2023

Hull University

ED1. The identi

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Teaching Hospitals - Urgent concerns improvement plan

fication and management of deteriorating patients

ection we found you did not manage, monitor and escalate deteriorating patients (PT) in line with national gui

Action
Implement an ED Sepsis Task and Finish Group. This will focus on the delivery of the Sepsis improvement work in the Emergency Department including education, pathways/bundles, audits, targets/KPIs and awareness
Sepsis Team to provide training within the department and sign off competencies
Development and implementation of the Digital Sepsis Bundle for ED - this will include reviewing how the NEWS scores are recorded and escalated in the digital record (currently using paper copies)
Implement a 'Safety ED Nurse' to support the recognition of the deteriorating patients and the management of Sepsis
Permanent recruitment into the 'Roaming escalation ED Nurse' role
Re-reinforcing the Trust escalation process which identifies the appropriate clinician to escalate deteriorating patient NEWS score - medical staff to have the systems up on screen and will be revisited on board rounds to review the management plan, EPIC Dr and the Charge Nurse will have an IPad with the live NEWs scores on to continuously monitor the patients
Implementation of the digital safety huddle board in ED

Review the patients identified in the CQC letter dated 04 November 2022, identify any learning and provide assurances of care and treatment
Taking learning from an existing QIP and from the clinical teams working in ED for the weekend of 5-6 November 2022, action is for an Escalation Doctor to be an allocated, specific role in the medical/practitioner numbers on each shift, accompanied by an Escalation Nurse where numbers enable. Role is to review any patient requiring escalation review per NEWS score, check correct interventions are in place, particularly sepsis, start interventions as necessary and hand patient back to responsible clinician
Rapid Assessment and Triage/Streaming doctor at front door to Emergency Care Area - one per day and evening shift
Two hourly Board Rounds in ECA.
Clarification and enhancement to describe the operational escalation process that was implemented immediately within all areas of the Emergency Department.
Assurance mechanisms introduced for a minimum of the duration of this plan and the Safety Oversight Group that include: Chief Nurse and Deputy Chief Nurse having nerve centre on their screens with live data on NEWs, escalation and actions taken in the Emergency Department. A minimum of 4 assurance visits per week to the Emergency Department from Executive Directors, Deputy Directors and Clinical Fellows to check the safety of patients via compliance with the SOP at 1.12, observation of Board rounds, confirmation of staff understanding and implementation of the ED elements of this plan. This will be reported to the Safety Oversight Group weekly. Any immediate concerns will be addressed with the EPIC or nurse in charge at the time of the visit.
SOP updated to include escalation NEWS score 5 or above or 3 in 1 parameter for patients waiting in ambulances and to ensure they are discussed as part of the bed meetings. The expectation is for these patients to be accommodated in majors or Resus depending on presentation within 30 minutes of escalation.

Clarification of the Matron B8a roles and responsibilities: Roles and responsibilities for the 8a Matrons:- 1.Work in conjunction with Nurse in Charge to provide senior quality/safety overview 2. Awareness of mental health patients in dept., ensuring safety and appropriate escalation, sited in correct room and 1:1's requested if required 3. Overview of department safety and link with operational rep regarding any specific support required 4. Review all patients and ensure safety maintained; • nursing assessments completed within required timeframes • observations completed • appropriate patients have fluid balance charts in place • appropriate patients have had sepsis screening undertaken • appropriate escalation of patients in accordance with Trust guidance and agreed management plans implemented. 5. Meet with Senior Matron and/or Deputy Chief Nurse weekly to discuss assurance and any further support required
Review daily handover sheets for feedback on what is working well and where improvements are required (particularly seeking to identify consistent application of key roles)

ity to demonstrate that fundamental standards of care are being met

ection we found you did not identify or manage patients' fundamental standards of care in accordance with the
excess of 24 hours in the department, lack of pressure relieving equipment, completion of fluid balance charts,

Action
Meet with all Senior Nurses (Band 6 and 7) to undertake briefing sessions to discuss expectations, delivery of fundamental care and responsiveness to patients and their requirements e.g. call bell by the end of 11 November 2022. The briefings for the remainder of the nursing team, Band 5 and unregistered nurses , to be completed by the end of November. Email circulated on the 4 November 2022. Briefings commenced on the 8 November 2022 and will continue until the end of November to ensure all nurses receive this information
Establishment of a Tissue Viability Task and Finish Group which will focus on improving the care and treatment for hospital acquired pressure ulcers in the department. This will include the management of beds and the relevant pressure relieving mattresses, chairs, training and an ED specific fundamental standard which will then be audited monthly
Release the Clinical Matrons from patient flow escalation rota (will be picked up by the Operational Managers) to allow them to provide education, complete assurance checks against quality and safety checks and all fundamentals for patients in department
Commence weekly review of the quality and safety checks by the Chief Nurse and Emergency Medicine Nurse Director

Review the matron handbook to ensure it is collecting the relevant data for ED and provides assurances and/or concerns for improvement and learning
New hospital beds stored at HRI to be available for ED as/when needed, including hospital mattress
Interim arrangements to provide support in absence of ED Nurse Director, including: Deputy Chief Nurse to undertake quality elements of ED Nurse Director role (daily check ins with matrons, escalation of any quality concerns, attendance at governance committees, support for safe staffing/workforce) Weekly meetings with Chief Nurse, Deputy Chief Nurse, Senior Matrons and Ops Director for ED to feedback back on the weekly review of the quality and safety checks to promote consistency of approach

ent of patients waiting within the department

n staff told us there was no formalised or documented plan on how to manage patients waiting within the dep

ior staff that unused minor injuries assessment rooms were used for the overnight boarding of patients experie
these patients and that staff in the minor injuries area would assume the additional responsibilities to their us

ll patients who were having treatment such as IV fluids and other treatments within the waiting room would be

d that staff were able to maintain oversight of all patients within the waiting areas due to layout and number o

Action
2.5 WTE increase Registered and 2.5 WTE Non-registered Nurses to support in Emergency Care - this will support quality and safety checks to be completed and ongoing care in accordance with the patients needs following the risk assessment and oversight of any patients lodged in ECA
Development of a high observation acute assessment unit and an operational plan to release capacity in Resus
The weekend Roaming Team to continue with continuous improvement evaluation
Implementation of dedicated treatment area for ambulatory patients to have ongoing care in Emergency Care. This will include seating, recliner chairs and pressure relieving aids

Identify non-registered staff to support the discharge lounge for patients to safely wait for transport home during out of hours
Trust-wide implementation of updated Full Capacity Protocol, taking lessons from North Bristol Hospitals NHS Trust. Model updated following trail in October 2022. Further adaptations to the model will be communicated by 09 November 2022 from the learning. This is to create a continuous flow model for the ground floor of Hull Royal Infirmary, including ED.
Safety brief at shift handover (8am, 4pm, midnight); includes key safety reminders - reviewed on 4 November 2022 to include escalation role and sepsis pathway prompts
Complete the 12 days of Christmas as planned and use learning from the scheme to inform an improved command and control framework
Clarity of Roles and Responsibilities Site team:- 1. Lead and chair patient placement meetings and ensure actions clear and have responsible leads within the HGs 2. Follow planned template for the patient placement meetings 3. Continued liaison with YAS with regards to demand and capacity, cohorting and new agreement that all patients with NEWs >3 with 1 parameter triggering or generally NEWs >5 must be transferred to the dept. immediately. ED team will ensure safety and clinical plan, Site team to liaise with appropriate HG and action a boarding plan to accommodate the patient within ED. To be recorded on the bed meeting template. 4. At the 7pm patient placement meeting, to confirm boarded patients have a plan for a bed and check physically on each ward that all boarded patients are in beds and out of the escalation beds on Lorenzo. To be recorded on the bed meeting template 5. Oversee the discharge lounge and ensure patients are transferred in a timely manner to free up the beds for patients from the assessment areas
Introduce an additional daily Gold Command meeting at 3pm to hold Health Group triumvirates to account on actions agreed at the daily 10am Gold meeting. Gold meetings will be chaired by the CNO, CMO or COO to ensure appropriate grip, challenge and assurance

90 day plan of ground floor model to commence January 2023 as approved by the Executive Team

nt rooms within the department (ECA) were potentially unsafe for patients with men

tal health room was not Psychiatric Liaison Accreditation Network (PLAN) compliant.

rvised access to rooms with ligature points including the designated toilets adjacent to the mental health room e to the size of the room.

ature points within the room including standard door handles, missing door furniture and other fixtures and fitt

ubicles four and five within the majors area were used as mental health observation cubicles. We saw that bot

Action
Undertake ligature risk assessments in ED with H&S; Rooms 4 and 5 in Majors and dedicated room ECA to identify areas for improvement and next steps
Estates plan to confirm when actions in response to the ligature risk assessments will be undertaken
Work to continue with Humber Foundation Trust to develop a designated mental health assessment area adjacent to ED
Undertake a walk around with the Director of Estates, Facilities and Development to review clinical oversight in ECA and identify areas for improvement and next steps (Linked to action 3.4)

ons.

Action
Set up the weekly Safety Oversight Group, Chaired by the Director of Quality Governance and other Executive Members leading all areas of improvement. The Weekly Safety Oversight Group will report directly to the Quality Committee.
Quality Committee to have dedicated agenda item to discuss the Trust's CQC action plan
System Meeting to take place with partners to accelerate and add to existing system wide plans

Establishment of a task and finish group to review the current digital records in ED. This will include review of the SOPS, simplified training for staff to have full visibility of patients records and effectively navigate through the records, trajectory for completion of training
Review of cohorting risk assessment, and associated actions, undertaken jointly with YAS

dance. Patient identifiers provided for 5 patients. Examples included NEWS scores 5-8 with no docume

Responsible Lead	Completion or Implementation date	Evidence of completion
Austin Smithies Emergency Department Consultant and Medical Quality Improvement Lead	First meeting to take place November 2022, to agree the proposed actions, frequency of meetings and timescales for actions to be completed	Action Tracker Revised pathway and bundle Audit arrangements KPI Performance Data Education package, training dates, records and % completed
Helen Hudson Emergency Medicine Nurse Director	Implementation from November 2022	Training records and competency checks
Steve Jessop Chief Nurse Information Officer	06-Jan-23	Electronic records available Automatic NEWS escalation and response to escalation and data collection
Helen Hudson Emergency Medicine Nurse Director	Transfer of April Montoya and Kath Oglesby with immediate affect (agreed 08.11.22 to be in place from W/C 14.11.22)	Rotas
Helen Hudson Emergency Medicine Nurse Director	Dec-22	Recruitment outcomes Rotas
Helen Hudson Emergency Medicine Nurse Director	09-Nov-22	Communications
Helen Hudson Emergency Medicine Nurse Director	25-Nov-22	Options review document and agreed actions

Helen Hudson Emergency Medicine Nurse Director	28-Nov-22	Case review report presented to the Quality Committee
Ben Rayner Clinical Director Emergency Medicine	Implementation began November 2022 to be fully embedded by December 2022	Role outline shared 4 November 2022; to be updated following debrief 7 November 2022. Shift feedback sheets confirm that role was allocated in the shift.
Ben Rayner Clinical Director Emergency Medicine	Implementation began November 2022 to be fully embedded by December 2022	Updated SOP shared 4 November 2022; shift feedback sheets confirm allocation of role or pull of role to meet higher clinical priority
Ben Rayner Clinical Director, Emergency Medicine	Re-launched November 2022	SOP to be updated and recirculated following debrief 7 November 2022; shift feedback sheets to capture when board rounds and catch up huddles took place.
Helen Hudson Emergency Medicine Nurse Director	09/11/2022	Escalation Process capturing the immediate enhancements
Jo Ledger Chief Nurse Dr Purva Chief Medical Officer Ellen Ryabov Chief Operating Officer	09/11/2022	Reports to Safety Oversight Group
Carla Ramsay Operations Director, Emergency Medicine Paul Walker, Deputy COO - Unplanned Care	12-Dec-22	Updated SOP. Included in Operational Support bed meeting record

Wendy Page Deputy Chief Nurse	13-Dec-22	Confirmation from Deputy Chief Nurse that meeting held with senior nursing team.
Carla Ramsay Operations Director, Emergency Medicine	15-Dec-22	Communications Handover sheets

e regulations. We saw an inconsistent approach to the completion of documentation regarding intenti

, excessive length of time for nurse call bells to be answered, observations not completed on time or on

Responsible Lead	**Completion or Implementation date**	**Evidence of completion**
Helen Hudson Emergency Medicine Nurse Director	08-Nov-22	Meeting dates Briefing Information Attendance records
Helen Ingleson Senior Matron Emergency Medicine	Implement from December 2022	Action Tracker Audit arrangements Performance Data Education package, training dates, records and % completed
Helen Hudson Emergency Medicine Nurse Director	Implement from November 2022	Increase in compliance with the quality and safety checks completed for patients
Helen Hudson Emergency Medicine Nurse Director	W/C 28 November 2022	Completed audit reviews Actions for improvement and learning

Helen Hudson Emergency Medicine Nurse Director Jo Ledger Interim Chief Nurse	Dec-22	Revised Matron Handbook
Jo Ledger, Chief Nurse	4 November 2022 - completed 4 November	Beds placed in storage area, accessible to porters and site team
Jo Ledger, Chief Nurse	12/12/2022	Meetings Quality and Safety Checks Actions and improvements

artment. In addition, there was no formalised or documented plan how to manage and provide clinica

ncing long waits. During our inspection there were between 4 and 6 patients boarded in minor assess
ual designated roles.

e within line of sight of the nursing station. During inspection we observed patients receiving treatmen

f patients. We saw no documentation regarding intentional rounding of patients who had not been se

Responsible Lead	**Completion or Implementation date**	**Evidence of completion**
Helen Hudson Emergency Medicine Nurse Director	Implementation from	Recruitment outcomes Rotas
Vicky Sharman Medicine Health Group Nurse Director		High observation area
Shoaib Faruqi Medicine Health Group Medical Director	Nov-22	Process / SOP Risk assessment
Duncan Taylor Director of Estates, Facilities and Development	Date to be confirmed following the review with Duncan Taylor of the clinical oversight in ECA - linked to action 4.4	New designated area Process / SOP

Wendy Page Deputy Chief Nurse	Dec-22	Rotas
Jo Ledger Chief Nurse Dr Purva Chief Medical Officer Ellen Ryabov Chief Operating Officer	Commenced from 07 November 2022	Bed template reports
Ben Rayner, Clinical Director, Emergency Medicine; operationally per shift responsibility is with ED EPIC to ensure safety brief delivered	Already in place; process and content updated 4 November 2022 - content to be updated weekly	Shift handover sheets confirming delivery
Ellen Ryabov Chief Operating Officer	Dec-22	12 days of Christmas overview Outcome
Wendy Page Deputy Chief Nurse	Dec-22	Email confirmation that meetings have been held with Site Team and Head of Patient Placement
Ellen Ryabov Chief Operating Officer	Dec-23	Outcome of review

Ellen Ryabov Chief Operating Officer	Jan-23	Exec Team Decision Log & paper

tal health needs.

. There were no observation facilities and the doors did not have usable viewing panels. The room wa

ings.

h rooms had multiple ligature points and other fixtures and equipment that could potentially cause har

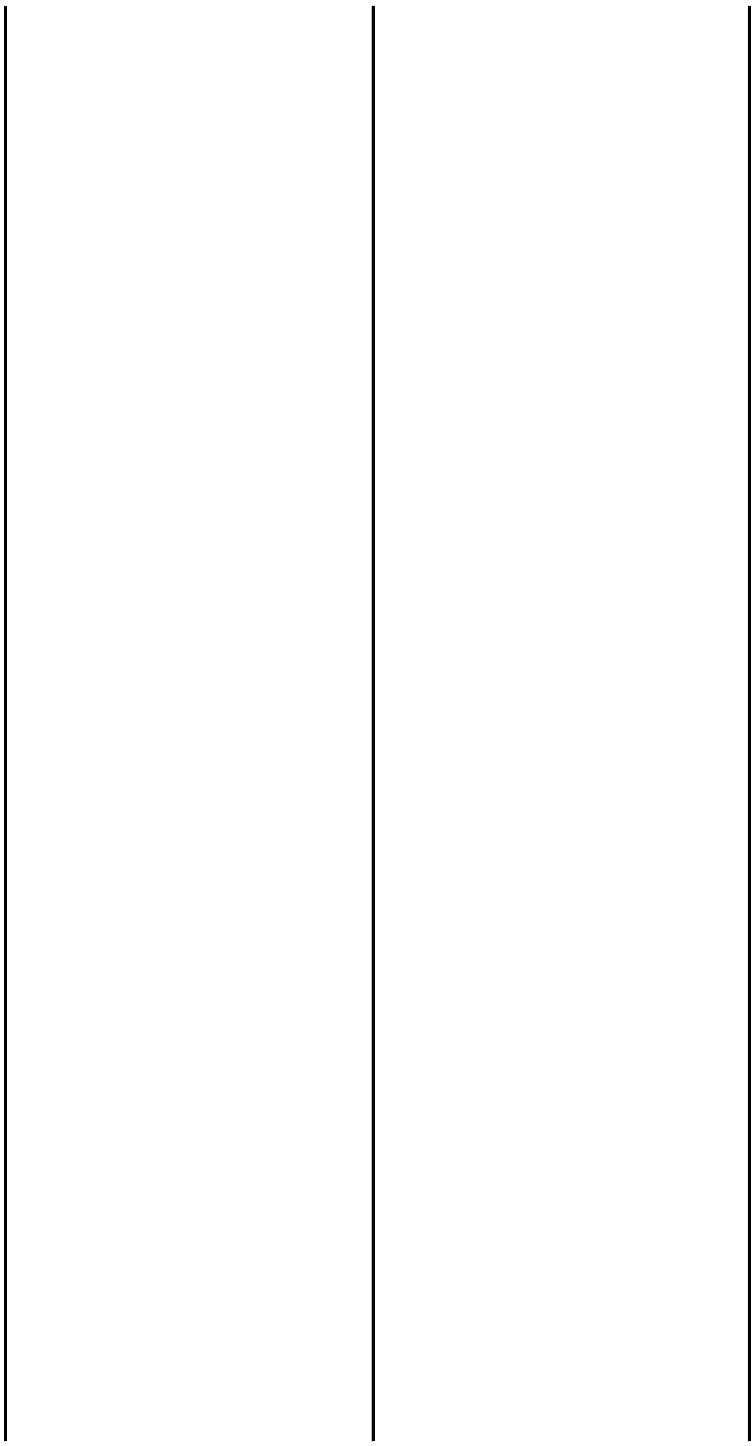
Responsible Lead	Completion or Implementation date	Evidence of completion
Ian Stanley, Deputy Safety Manager	07/11/2022	Risk Assessments with actions identified
Duncan Taylor, Director of Estates, Facilities and Development	Nov-22	Improvement plan with timeframes
Paul Walker Duncan Taylor	Apr-23	Dedicated mental health assessment areas
Helen Hudson Emergency Medicine Nurse Director Duncan Taylor Director of Estates, Facilities and Development	09-Nov-22	Estates plan with timeframes

Responsible Lead	Completion or Implementation date	Evidence of completion
Suzanne Rostron Director of Quality Governance	Meetings to commence w/c 14 November 2022	Meeting dates and attendance records Action tracker Reports to Quality Committee
Suzanne Rostron Director of Quality Governance	28 November 2022	Meeting agenda and minutes
Chris Long Chief Executive	08.11.22	Updated system plans

Steve Jessop Chief Nurse Information Officer	01-Dec-22	Development of SOPs, completion of training records
Paul Walker Deputy Chief Operating Officer	20-Jan-23	Refreshed Risk Assessment

ented escalation of 4 patients.

Monitoring arrangements	Measure of Success
Emergency Medicine Health Group Bronze Command meetings (every Monday and Friday) Emergency Health Group Specialty Governance Weekly Safety Oversight Group Quality Committee Site Meeting	Increase in staff trained in Sepsis Improved compliance with the delivery of the Sepsis pathway and bundle Reduction in the number of patients with sepsis deteriorating and escalating Increase escalation and response times for Deteriorating Patient Improvement in Doctor First Seen times in ECA compared with current times (reduce variation above KPI) Improvement in four-hour performance in ECA



onal rounding. Examples provided include vulnerable/compror
nitted, risk assessment completion, pressure care overall, nutri

Monitoring arrangements	**Measure of Success**
Emergency Health Group Specialty Governance Weekly Safety Oversight Group Quality Committee	Improved completion of fundamental standards of care in ED to all patients Improvement in completion of nursing assessments and timeliness of interventions Reduction in Serious Incidents for patients deteriorating in the department Reduction in incidents reported for pressure ulcers and falls

Datix for any exceptions that state bed not available	Zero Datix reports that bed and mattress not available
Emergency Health Group Specialty Governance Weekly Safety Oversight Group Quality Committee	Improved completion of fundamental standards of care in ED to all patients Improvement in completion of nursing assessments and timeliness of interventions

l oversight of patients who were left waiting.

ment rooms overnight. We were told that these patients were

t not in line of sight of the nurses station. Due to the current la

en within the waiting rooms.

Monitoring arrangements	**Measure of Success**
Emergency Health Group Specialty Governance Weekly Safety Oversight Group Quality Committee	Reduction in the number of patients lodged in ECA Reduction in the 12 hours waits Releasing capacity in Resus

Trust Gold Command meetings (daily, Monday - Friday)	Reduction in 12-hour trolley breaches; improvement in ambulance handover times and reduction in crew hours lost; improvement in movement of lodged patients from ECA to specialty bed, assessment bed or majors within 60 minutes of DTA
EMHG Bronze Command twice weekly	Implementation of changes/improvement in practice - this month, will monitor for improvement in sepsis pathway compliance
Trust Gold Command meetings Site Team Meeting	Improved flow from ED
Trust Gold Command meetings	
Trust Gold Command meetings Site Team Meeting	

Exec Team Meeting

s well lit but the lights were not adjustable. The room was too

m. We observed an acutely unwell mental health patient in cu

Monitoring arrangements	Measure of Success
Emergency Health Group Specialty Governance Weekly Safety Oversight Group Quality Committee	Maintaining no harm to this group of patients

Monitoring arrangements	Measure of Success
Quality Committee	Oversight and assurance received by Trust Board
Trust Board	
ICB Board/ICB Quality Improvement Board	Reduction in NCTR patients (aiming for no more than 100)

Safety Oversight Group	Feedback from staff (survey monkey) - post implementation
Safety Oversight Group	

Status update (to be discussed at the weekly safety oversight group)	Status
Sepsis Task and Finish Group established as planned. Meetings are underway, evidence been collated.	Completed
Training in the department has commenced. Rosemary Flanagan is collating the training data and competency checks	Implemented - ongoing monitoring
Digital Sepsis Tool piloted and live in the department. Met to discuss the automatic escalation of NEWS scores from nerve centre across the organisation - approx. 6 - 8 weeks to be in place - met with AP and Nerve Centre training will be provided JD in February, scoping out new devices and Hospital at Night training will be fully set up by the end of February 2023 23.01.23 - SJ is looking at establishing a performance dashboard to monitor compliance with the Sepsis Tool.	Completed
Nurses were in place as planned	Completed
Recruited to additional staff to improve overall staffing but not to a role with that title	Completed
Completed as planned	Completed
Completed and in use. Monitored via the assurance reviews that are reported to Weekly Safety Oversight Group.	Completed

Completed as planned, a summary was included in the presentation to the November 2022 Quality Committee.	Completed
Completed as planned and is being assessed as part of the assurance reviews that are reported to the Weekly Safety Oversight Group as per the associated actions in this plan.	Completed
Underway as planned and is being assessed as part of the assurance reviews that are reported to the Weekly Safety Oversight Group	Completed
is being assessed as part of the assurance reviews that are reported to the Weekly Safety Oversight Group	Completed
Completed as planned	Completed
Underway as planned and is being reported to the Weekly Safety Oversight Group	Completed
Completed as planned - embedded and discussed and recording actions	Completed

Roles and responsibilities clarified with senior nursing team in ED. Regular meetings scheduled. Existing assurance visits to include these elements. Reviewing how the shift evaluation can capture staff feedback.	Completed
Completed as planned. The feedback is reported and discussed at Emergency Medicine Health Group Bronze Command	Completed

nised skin integrity without a treatment plan or records of pressure area care tion and hydration and failure to monitor a patient's blood sugar and dietary

Status update	**Status**
Briefings completed as planned, presentation shared with the CQC.	Completed
TV Task and Finish Group established as planned. Meetings are underway, evidence continues to be collated.	Completed
Underway as planned and is being assessed as part of the assurance reviews that are reported to the Weekly Safety Oversight Group	Completed
Underway as planned; however, in the absence of HH the Senior Matron has been completing the checks and sharing them with the Interim Chief Nurse	Completed

The ED Matron Assurance Handbook has been reviewed an updated with the Senior Matron. Changes have been made to ensure it now reviews specific documentation in Nerve centre such as timing of completed assessments and aspects of fundamental care from the Quality and Safety Checks. Staff questions have also been removed as they are now captured as part of the monthly insight peer review audits.	Completed
Action complete, 0 incidents reported.	Completed
In place as planned.	Completed

not risk assessed prior to boarding and that no additional staff were

ıyout this would not be possible.

Status update	**Status**
Completed as planned	Completed
Weekly meetings to review the model and plans have been held. SOP to be presented to the Weekly Safety Oversight Group for assurance and evidence.	Open - requires update
Continues to be in place	Completed
Now up and running, need to ensure we deliver the SOPs that have been implemented - SOP to be presented at Weekly Safety Oversight Group for assurance and evidence.	Implemented - ongoing monitoring

Action completed, staff identified and in recruitment process - 1WTE short, but advert is out for this. Staff in place have started overnight and will be covering 7 days a week	Completed
Commenced as planned on 7 November 2022. Impact variable depending on operational pressures and system responses.	Completed
Continues as standard practice and is being assessed as part of the assurance reviews that are reported to the Weekly Safety Oversight Group	Completed
Programme completed with system partners from the 12/12/22	Completed
Completed as planned	Completed
Following further discussion regarding this it was agreed that an additional Gold Command Meeting would be held as required, it was agreed to have an assigned Director of the Day as a more robust measure. This is now in place.	Completed

Execs signed off 13/12/23 for it to start by the end of January 2023 - Jo and Purva to pick this up with Medicine	Open - requires update

small to be able to safely manage a disturbed patient. One set of seating

bicle five but with the lights off were not observable.

Status update	Status
Completed as planned	Completed
Commenced as planned, buildings works are underway and ligature free sinks, doors etc. have been ordered and awaiting delivery.	Implemented - ongoing monitoring
Work continues. Humber Mental Health Foundation Trust have begun developing the required SOPs and governance arrangements.	Open - requires update
Completed as planned.	Completed

Status update	Status
Completed as planned, SOG meets weekly and reports monthly to the Quality Committee.	Completed
Completed as planned. A monthly report of evidence is being shared with the CQC.	Completed
Took place as planned	Completed

SJ Task & Finished group meeting weekly. Initial review of all ED documentation completed with revisions required for all nursing assessments. Revision with developers and expected to be completed, tested and uploaded into LIVE. Continue to meet every Tuesday, work ongoing. Staff satisfaction survey to be completed once delivered final product. Have another 2/3 forms to be delivered before end and staff experience will be assessed.	Implemented - ongoing monitoring
risk assessment has been reviewed and plans made for the glass to be frosted. review again before the end of February	Completed

Hull University Teaching Hospitals NHS Trust

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	14.02.23
Title	Standing Orders				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Rebecca Thompson, Head of Corporate Affairs				
Report previously considered by (date)	The report was previously considered at the November 2022 Trust Board				

Purpose of the Report		**Reason for submission to the Trust Board private session**		**Link to CQC Domain**		**Link to Trust Strategic Objectives 2021/22**	
Trust Board Approval	✓	Commercial Confidentiality		Safe		Honest Caring and Accountable Future	
Committee Agreement		Patient Confidentiality		Effective		Valued, Skilled and Sufficient Staff	
Assurance		Staff Confidentiality		Caring		High Quality Care	
Information Only		Other Exceptional Circumstance		Responsive		Great Clinical Services	✓
				Well-led	✓	Partnerships and Integrated Services	
						Research and Innovation	
						Financial Sustainability	✓

Key Recommendations to be considered:

The Trust Board is requested to:

- Authorise the use of the Trust's seal
- Approve the amendment to the Scheme of Delegation to allow the Director of Procurement to sign off waivers and contract recommendation reports up to a total contract value of £100,000.

Hull University Teaching Hospitals NHS Trust

Trust Board

Standing Orders February 2023

1 Purpose of the Report

To approve those matters reserved to the Trust Board in accordance with the Trust's Standing Orders and Standing Financial Instructions.

2 Approval of signing and sealing of documents

The Trust Board is requested to authorise the use of the Trust seal as follows: This paper summarises all use of the Trust seal since November 2022.

SEAL	DESCRIPTION OF DOCUMENTS SEALED	DATE	DIRECTORS
2022/32	Hull University Teaching Hospitals NHS Trust and Compass Contract Services (UK) Ltd – Lease relating to ground floor premises known as units 2 and 3, HRI Anlaby Road, Hull	01/12/22	Signed and sealed by: Chris Long – CEO Lee Bond - CFO
2022/33	Hull University Teaching Hospitals NHS Trust and Compass Contract Services (UK) Ltd – Licence for alterations (Minor Works) relating to ground floor premises known as units 2 and 3 HRI, Anlaby Road, Hull	01/12/22	Signed and sealed by: Chris Long – CEO Lee Bond - CFO
2022/34	Hull University Teaching Hospitals NHS Trust and Sanne Group (UK) Ltd – Libor transition: Provision of Oncology and Haematology facilities at Castle Hill Hospital – Project Agreement Variation Agreement	20/12/22	Signed and sealed by: Chris Long – CEO Lee Bond - CFO
2023/01	Hull University Teaching Hospitals NHS Trust and Alliance Medical Ltd – Reversionary Lease and Deed of Variation relating to part of the PET scanning, medical research and clinical facility at Castle Hill	16/01/23	Signed and sealed by: Chris Long – CEO Lee Bond - CFO

3 Changes to Scheme of Delegation

The Board is asked to approve an amendment to the Scheme of Delegation to allow the Director of Procurement to sign off waivers and contract recommendation reports up to a total contract value of £100,000. Attached to this report is the amended Scheme of Delegation for approval.

4 Recommendation

The Trust Board is requested to:

- Authorise the use of the Trust's seal
- Approve the amendment to the Scheme of Delegation to allow the Director of Procurement to sign off waivers and contract recommendation reports up to a total contract value of £100,000.

Rebecca Thompson
Head of Corporate Affairs
February 2023

Hull University Teaching Hospitals NHS Trust
Financial Scheme of Delegation (made under CP105 Standing Orders)

The attached financial scheme of delegation and authorisation procedure for revenue expenditure, capital expenditure and tenders has been approved by the Chief Executive and the Chairman.

…….. ……...

Christopher Long
Chief Executive

Sean Lyons
Chairman

Date signed

Version control
The current version of this Financial Scheme of Delegation will be the version published on Pattie and available to all staff. This Financial Scheme of Delegation is a sub-set of the Trust's Standing Orders and Standing Financial Instructions and is delegated by the Trust Board. As such, updates and amendments require signature by the Chief Executive and Chairman and will be received at the next meeting of the Audit Committee for good governance. The Head of Corporate Affairs will work with the Chief Executive to enact the publication of the Financial Scheme of Delegation and receipt by the Audit Committee.

Version control table

Version	Date	Change/amendment
1.0	April 2016	New Financial Scheme of Delegation under Standing Orders and Standing Financial Instructions
1.1	March 2018	Delegation to Chief Executive £1m for code 129999 Statement of Financial Position Weekly Liaison/Tempre invoices delegated up to £25,000 and up to £200,000 and clarity on Director-level responsibilities for monthly Liaison /Tempre invoices
1.2	April 2018	Director of Operations Medicine Health Group – Fresenius expenditure up to £200,000
1.3	April 2019	Chief Financial Officer, PFI & NHS Supply Chain invoices up to £1.1m
1.4	July 2019	Changes to EU tender threshold and programmes of work amounts
1.5	January 2020	Changes to EU tender threshold and programmes of work amounts
1.6	October 2020	To amend the Scheme of Delegation to allow the Chief Executive to sign orders for NHS Blood and Transplant up to the value of £2,500,000
1.7	September 2022	To amend the Scheme of Delegation to allow the Chief Finance Officer to

		sign off invoices from NHS Resolution for the Clinical Negligence Scheme for Trusts up to the value of £2,500,000
1.8	February 2023	To amend the Scheme of Delegation to allow the Director of Procurement to sign off waivers and contract recommendation reports up to a total contract value of £100,000

Scheme of Delegation

The Trust's scheme of delegation makes the following provisions:

- The Chief Executive and the Chief Financial Officer are accountable for financial control but will, as far as appropriate, delegate their detailed responsibilities.
- The Chief Executive will delegate budget to budget holders
- The Chief Financial Officer will devise and maintain systems of budgetary control
- The Chief Executive and the Chairman will sign amendments to this Financial Scheme of Delegation, as the document forms a schedule to Trust Standing Orders and Standing Financial Instructions

Revenue Expenditure

For orders, invoices, cheque requests petty cash and contract amendments:-

Updated Scheme of Delegation		*Typical Grade*	*Authorisation Limit*
Chief Executive		VSM	over £500k
Corporate Directorates			
	Chief Finance Officer	VSM	Up to £500k
	Director of Procurement	Band 9	Up to £100k
	Other Corporate Directors	VSM	Up to £150k for own budgets
	Assistant Directors	Band 8d	Up to £25k own budgets
	Other Managers	Band 8a+	Up to £10k own budgets
		Band 7	Up to £5k own budgets
		band 6	Up to £500 own budgets
Health Groups			
	All Directors (ie Operations, Nursing and Medical Directors)	Band 9/VSM	Up to £100k own budgets
	Divisional Triumvirates	Band 8b	Up to £25k own budgets
	Business Managers /Heads of Departments/Matron (or equivalent role)	Band 8a	Up to £10k own budgets
	Ward Managers, Dept Managers, Deputies to the above	Band 7	Up to £5k own budgets
	Senior Nurse, Deputy Department Managers	Band 6	Up to £500 own budgets

Exceptions (record of agreement at Chairman and Chief Executive Level) :-

High non pay clinical expenditure only - for practical reasons
Cardiology/Radiology/Vascular labs - lead technicians/AHP/sister (at least B7) £25k (Clinical Lab/ECG supplies only)
Chief Pharmacist/Deputy Chief Pharmacist £100k (drugs only)
Clinical Manager Orthotics/Prosthetics £25k
Departmental Manager Prosthetics £10k
Chief Executive over £500k for code 129999, Capital Expenditure
Director of Operations Medicine Health Group Fresenius up to £200k
Chief Financial Officer, PFI & NHS Supply Chain invoices up to £1m
Chief Executive to sign orders for NHS Blood and Transplant up to the value of £2,500,000

Agency
Monthly Liaison/Tempre invoices, one of the following up to £500,000:

- Chief Executive
- Chief Financial Officer
- Chief Nurse

Weekly Liaison/Tempre invoices up to £25,000 requires 1 Deputy Director (Finance) approval
Weekly Liaison/Tempre invoices up to £200,000 require 2 Deputy Director (Finance) approval

These agency exceptions are as at 8.3.18 and are subject to review and amendment only with evidence of Director level agreement

Clinical Negligence Scheme for Trusts (CNST)

Chief Financial Officer up to £2,500,000 for NHS Resolution for CNST.

Capital Expenditure

The approval process for the agreement of capital expenditure is summarised below:-

Capital Cost	Approval Required
£5m to £15m	Trust Board
£2m to £5m	Performance and Finance Committee (PAF)
£0.5m to £2m	Executive Management Committee (EMC)
£5k to £0.5m	Capital Resource Allocation Committee CRAC)

Note: any business case deemed to be a high financial risk will also require approval at the next level of authority.

The authorisation for orders and invoices etc, following the approvals process above, is as follows and is regardless of whether or not the VAT is reclaimable:-

Capital Expenditure	Orders/Invoices
Chief Executive	All commitments/invoices > £500k
Chief Finance Officer	Up to £500k including VAT
Other Corporate Directors	Up to £100k including VAT
Heads of Service (I&D)	Up to £50k including VAT
Senior Project Manager/Estates Operations Manager	Up to £10k including VAT
Project Officer/Manager	Up to £5k including VAT

Tenders

The full details of the formal tendering requirements are included in the SFIs, but the table below summarises the general requirements:

Value	Requirement
Less than £10k	In line with procurement procedures approved by the Chief Financial Officer and using NHS Supply Chain, where applicable.
£10 - £50k	Quotations
£50k- to £118,133	Local Tenders
£118,133*	EU Tenders

*Programmes of "works" have an EU tender threshold of £4,551,413 – further defined in SFIs

Formal authorisation and the award of a contract may be decided by the following, to the value of the contract as follows:

Budget Holder	Up to £50k
Director of Procurement	Up to £100k
Chief Executive or Chief Financial Officer	Up to £500k
Chief Executive or Chief Financial Officer or Chairman/vice Chairman (2 signatures of the 3 required)	£500k to £1m
Performance and Finance Committee	£1m - £3m
Trust Board	Over £3m
All lease tenders must be authorised by the Chief Executive only	**All**

Report to the Board in Public
Audit Committee November 2022

Item: NHS EI HFMA Self Certification	Level of assurance gained: Partial
The Trust's self-certification checklist was presented and had been scored fairly low in some areas due to Covid and not being confident that all processes were in place. Internal Audit commended this cautious approach and advised that the scores could be higher once assessed, The report to be presented to the Board once the action plan was in place.	
Item: Internal Audit – Data Security Toolkit Review	Level of assurance gained: Partial
The internal audit had been given a moderate rating. There was more work to do regarding back up servers and IG Training compliance. The actions would be	
Item: Internal Audit – Safeguarding Review	Level of assurance gained: Partial
The Audit had been undertaken and the assurance rating given was partial. A strong framework and policies were in place but there was an issue around Datix reporting and safeguarding issues. The report is to be discussed at the Quality Committee in December 2022.	
Item: Counter Fraud Progress/Annual Report	Level of assurance gained: Good
A summary of the work carried out was reported and this included a number of bitesize Fraud sessions, working whilst off sick issues and nhs.net emails potentially being hacked. The Conflict of Interest Audit was also commencing.	
Item: External Auditors Report	Level of assurance gained: Good
An annual review of the accounts was presented and a clean statement had been received other than the Trust's opening stock balance. No significant weaknesses had been identified, but a recommendation relating to efficiency savings had been made.	
Item: Half year update from Quality and Remuneration Committee	Level of assurance gained: Good
There were no issues raised relating to gaps in controls. Both committees are functioning as they should be.	
Item: Review of Credit Card Spending	Level of assurance gained: Good
IT purchases and International Levies were the main areas of expenditure. NLAG purchase their IT consumables on the normal ordering system and not on credit cards. It was the intention that HUTH and NLAG would standardise the purchasing process.	
Item: Review of Losses, Special Payments and Write-Offs	Level of assurance gained: Good
There was a total of £2600 in losses and compensations. The majority of the items were patient's clothing, slippers and false teeth. The report did not include Pharmacy losses and this would be reviewed.	
Item: Clinical Audit and Effectiveness Annual Report	Level of assurance gained: Good
The annual report was presented and the Trust had achieved a high compliance for National Audits at 92%. PDSA cycles were being used as well as audits to encourage quick improvements which helped with busy workloads.	
Item: Claims Annual Report	Level of assurance gained: Good
The Claims Annual Report was presented and highlighted the following work streams: Court of Protection cases and costs, the team was clearing 11 claims per month, ELPL claims were averaging 2 per month and Inquests were at 14 per month. Future plans included a GIRFT litigation pack which would focus	
Item: External Agency Report	Level of assurance gained: Good
External Agency Report 2021/22 which listed the visits from external agencies and whether actions had been completed or were still outstanding. There had been 28 visits during 2021/22 and there were only 2 that were still open. The 2 that were open had action plans in place.	

Hull University Teaching Hospitals NHS Trust
Trust Board and Committee Front Sheet

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	14.02.23
Title	HNY CAP Joint Working Agreement				
Lead Director	Chris Long, CEO				
Author	Rebecca Thompson, Head of Corporate Affairs				
Report previously considered by (date)					

Purpose of the Report		**Reason for submission to the Trust Board private session**		**Link to CQC Domain**		**Link to Trust Strategic Objectives 2021/22**	
Trust Board Approval	✓	Commercial Confidentiality		Safe		Honest Caring and Accountable Future	✓
Committee Agreement		Patient Confidentiality		Effective		Valued, Skilled and Sufficient Staff	
Assurance		Staff Confidentiality		Caring		High Quality Care	
Information Only		Other Exceptional Circumstance		Responsive		Great Clinical Services	✓
				Well-led	✓	Partnerships and Integrated Services	
						Research and Innovation	
						Financial Sustainability	✓

Key Recommendations to be considered:

The Board is asked to review the Joint Working Agreement and Terms of Reference and approve the approach.

The documents attached are not finalised and could be subject to change.

HILL DICKINSON

Draft No: 1 - 2
Date of Draft: 04/02/23

Dated 2023

HUMBER AND NORTH YORKSHIRE COLLABORATIVE OF ACUTE PROVIDERS (CAP) JOINT WORKING AGREEMENT

Between

(1) HARROGATE AND DISTRICT NHS FOUNDATION TRUST

(2) HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

(3) NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST

(4) YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRUST

CONTENTS

CLAUSE **PAGE**

1 **Introduction**

1.1 In this Agreement, the following words bear the following meanings:

Agreement	this agreement signed by each of the Trusts in relation to their joint working and the operation of the HNY CAP CiCs;
Confidential Information	all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Agreement;
Competition Sensitive Information	means Confidential Information which is owned, produced and marked as Competition Sensitive Information including information on costs by one of the Trusts and which that Trust properly considers is of such a nature that it cannot be exchanged with the other Trusts without a breach or potential breach of competition law;
Dispute	any dispute arising between two or more of the Trusts in connection with this Agreement or their respective rights and obligations under it;
HNY CAP CiCs	the committees established by each of the Trusts to work alongside the committees established by the other Trusts and "HNY CAP CiC" shall be interpreted accordingly.
HNY CAP Board	the HNY CAP CiC's meeting in common.
Meeting Lead	the HNY CAP CiC Member nominated (from time to time) in accordance with paragraph 7.6 of the Terms of Reference, to preside over and run the HNY CAP CiC meetings when they meet in common;
Member	a person nominated as a member of an HNY CAP CiC in accordance with their Trust's Terms of Reference and "Members" shall be interpreted accordingly;
Terms of Reference	the terms of reference adopted by each Trust (in substantially the same form) more particularly set out in the Appendices to this Agreement;
Trusts	the Harrogate and District NHS Foundation Trust, Hull University Teaching Hospitals NHS Trust, Northern Lincolnshire and Goole NHS Foundation Trust and York And Scarborough Teaching Hospitals NHS Foundation Trust and "Trust" shall be interpreted accordingly.

1.2 Each Trust is putting in place a governance structure which will enable it to work together with the other Trusts to implement change and develop HNY CAP as a provider collaborative.

1.3 Each Trust has agreed to establish a committee which shall work in common with the other HNY CAP CiCs, but which will each take its decisions independently on behalf of its own Trust.

1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each HNY CAP CiC will be different.

1.5 The HNY CAP Trusts agree that, notwithstanding the good faith consideration that each Trust has afforded the terms set out in this agreement, this agreement shall not be legally binding. The HNY CAP Trusts enter into this agreement with the approval of their boards and intending to honour all their obligations to each other.

Commented [A1]: Clarification on the status of the agreement and enforceability.

2 Background

Vision

2.1 The proposed vision statement articulates the ambitions of HNY CAP:

"[xxs]"

Commented [A2]: To follow from the CAP group

Key functions

2.2 It is intended that HNY CAP will take responsibility for current Hull and North Yorkshire system wide strategic transformation programmes of work which specifically focus on the National, Regional and ICB priorities, namely:

2.2.1 HNY CAP will operate across four strategic objectives:

2.2.2 Clinical Programmes

- Development of strategic approach to clinical services focusing on vulnerable services and a strategic response to clinical networks and associated cross system working arrangements
- Delivery of elective recovery (covering inpatient, diagnostics and cancer) to meet or exceed national benchmarks, standards and targets
- Delivery urgent care standards and requirements across providers and local systems to reduce variation and improve consistency of response

2.2.3 Clinical Support Programmes

- Building capacity and capability in clinical support services to achieve appropriate infrastructure in place to delivery strategic clinical aims

2.2.4 Corporate Programmes

- Establish and deliver appropriate corporate strategies to enhance integration and tackle variation (thereby ensuring enhanced efficiency) including approaches to collective planning, rationalised and aligned estates/capital process and development of underpinning approaches in workforce.

2.2.5 Provider Collaborative Development

- To continue to build capacity and capability within and across CAP to meet ongoing requirements.

2.2.6 Planning, delivering and transforming services together, consolidating these where it makes sense to do so enabling the Hull and North Yorkshire population to access latest technologically informed care;

2.2.7 Investing in workforce, giving staff the training and support to deliver the standards of care we want for the Hull and North Yorkshire population; and

2.2.8 Put in place a shared financial sustainability plan and identify opportunities for reducing waste, duplication, delivering corporate efficiency.

Commented [A3]: Taken from Board Papers - CAP to confirm

2.3 More specifically the HNY CAP CiCs and the HNY CAP Board will facilitate the ICS Priorities and the Trusts' work in the following key work programmes at this initial stage of HNY CAP development*:*

2.3.1 Elective recovery - reduce the maximum waiting times and the overall number of patients waiting for elective care, with the longest waiting times to reduce most;

2.3.2 Cancer - enhance the provider and clinical input into the Cancer Alliance and develop a work programme that drives the delivery of improved outcomes and equality of outcomes;

2.3.3 Diagnostics - develop the diagnostic capability and capacity across the Humber and North Yorkshire ICS;

2.3.4 Urgent and Emergency Care - improve the experience and outcomes of urgent and emergency care for patients; and

2.3.5 Responding to and coordinating HNY CAP action in response to any national, regional or HNY ICB initiated priorities.

2.4 The Trusts have identified that a preferred model for their closer collaboration and joint working is to establish a governance structure that, so far as possible within the legislation, enables "group" and common decision making structures; the HNY CAP CiCs acting through the HNY CAP Board.

2.5 The HNY CAP Trusts are part of the ICS. Regional and inter regional relationships should first and foremost be guided by the ICB. To support this HNY CAP will provide both intelligence to the ICB and respond to ICB calls for action. Where necessary and appropriate HNY CAP may seek to develop relationships with peers or for trusts, across other ICS's and ICB's (for example, related to specialised commissioning). This will be notified and communicated between the HNY CAP Trusts in accordance with the principle outlined in clause 4.8.

Commented [A4]: Inserted to emphasise the importance of the links to other ICS/Systems and working with the ICB.

The areas within scope of this Agreement may be amended though variation, by Trust Board resolutions or agreement of an annual HNY CAP workplan.

2.6 The Trusts will remain as separate legal entities with their own accountabilities and responsibilities. The priorities for HNY CAP will be complementary to (and do not revise or replace) the existing statutory duties of the Trusts (such as the delivery of NHS Constitutional Standards or equivalent). For avoidance of doubt there is no intention that the governance structure outlined in this Agreement will lead to a statutory merger or acquisition under section 56 or section 56A of the National Health Service Act 2006 (as amended).

3 Rules of working

3.1 The Trusts have agreed to adopt this Agreement and agree to operate the HNY CAP CiCs as the **HNY CAP Board** in line with the terms of this Agreement, including the following rules (the "**Rules of Working**"):

3.1.1 Working together in good faith;

3.1.2 Putting patients interests first;

3.1.3 Having regard to staff and considering workforce in all that we do;

3.1.4 Consider the wider system impact and perspective and discuss proposals before any unilateral Trust action which may impact other Trusts;

3.1.5 Airing challenges to collective approach / direction within HNY CAP openly and proactively seeking solutions;

3.1.6 Support each other to deliver shared and system objectives;

3.1.7 Empower and expect our professional (executive) groups to think from a system perspective and to develop proposals with this in mind;

3.1.8 Recognising and respecting the collective view and keeping to any agreements made between the HNY CAP CiC's;

3.1.9 Maintain HNY CAP collective agreed position on shared decisions in all relevant communications;

3.1.10 Be accountable. Take on, manage and account to each other for performance of our respective roles and responsibilities; and

3.1.11 Appropriately engage with the ICB and with other partners on any material service change.

4 Process of working together

4.1 The HNY CAP CiCs shall meet together as the HNY CAP Board in accordance with and discuss the matters delegated to them in accordance with their Terms of References (attached here as Appendices).

4.2 The HNY CAP CiCs shall work collaboratively with each other as the HNY CAP Board in relation to the committees in common model.

4.3 Each HNY CAP CiC is a separate committee, with functions delegated to it from its respective Trust in accordance with its Terms of Reference and is responsible and accountable to its Trust. Acknowledging this and without fettering the decision-making power of any HNY CAP CiC or its duty to act in the best interests of its Trust, each HNY CAP CiC shall seek to reach agreement with the other HNY CAP CiCs in the HNY CAP Board and take decisions in consensus, in light of its aims and Rules of Working set out in clauses 2 and 3 above.

4.4 The HNY CAP CiC meeting structure will be as follows:

H&NY CAP Board **(Monthly)**	Members will be the Chief Executives from each of the four HNY CAP Trust members having delegated authority from their Boards to take decisions together in accordance with the Terms of Reference. Purpose to set the strategic direction for HNY CAP, to agree and set the annual plan and to take decisions through delegated authority (acting under the HNY CAP CiC).
H&NY CAP Board meeting with Chairs **(Quarterly)**	Chief Executives and Chairs from each of the four HNY CAP Trust members for a wider discussion on a quarterly basis.

H&NY CAP Programme Executive	The purpose of this separate executive group is to deliver the identified priority programmes of work in the annual plan successfully, bringing together key teams and leads from HNY CAP organisations to drive delivery.

4.5 The HNY CAP Board will work in partnership to determine service priorities and to develop a HNY CAP programme of work into an [annual] plan which will be approved through the HNY CAP Board. The HNY CAP [annual] plan and any updates or revisions will be annexed to this Agreement.

The HNY CAP Board will also contribute and respond to any setting of objectives/outcomes by the ICB and then agree the HNY CAP response to this (including through updating the programme of work (annual plan)). Any changes to the annual plan will be submitted to the HNY CAP Board for approval.

4.6 When the HNY CAP CiCs meet in common, as the HNY CAP Board, the Meeting Lead shall preside over and run the meeting. The intention is that the current lead arrangements for the Meeting Lead with the Chief Executive of Hull University Teaching Hospitals NHS Trust will continue for eighteen (18) months before being reviewed by the CAP Board.

4.7 The HNY CAP CiCs will run a process to appoint a *HNY CAP Medical Director* through nominations and the development of a proposal for the process, role and engagement of the Medical Director through the HNY CAP Trusts to ensure robust clinical leadership and engagement in all areas of HNY CAP work.

4.8 The Trusts agree that they will adopt a tiered approach to bringing decisions which come within the Terms of Reference to the HNY CAP Board which will reflect the principle of subsidiarity (that issues should be dealt with at the most immediate level that is consistent with their resolution) in the following approach:

Commented [A5]: Tiered approach for discussion.

Scale of involvement/impact	**Approach to decision**
Matter under discussion has no involvement or impact on other HNY CAP Trusts (e.g. local issue related to place)	Matter for the Trust involved and notified to the HNY CAP Board if appropriate.
Matter only involves or impacts a smaller group of HNY CAP Trusts and not all (e.g. issue for Hull and NLAG under their CiC but not York and Harrogate)	If the HNY CAP CiC's for the Trusts involved consider that the required decision is outside their delegation as set out in the Terms of Reference then this would be notified to the HNY CAP Board.
Matter involves or impacts all HNY CAP Trusts and comes within the delegation under the HNY CAP CiCs (e.g. collaborative approach to non-clinical services or workforce)	Matter to be dealt with through the HNY CAP CiCs at the HNY CAP Board in accordance with this Agreement and the Terms of Reference.

4.9 Each HNY CAP CiC will report back to its own Board and the HNY CAP Board will be responsible for transparent information sharing in the form of common briefings and updates to each of the HNY CAP Trust Board meetings. [The HNY CAP Trust chairs will meet regularly as a group to share information and for general discussions on HNY CAP on an informal basis.]

Commented [A6]: Note: involvement of Non-executives is subject to further discussion and will be put to Trust Boards.

4.10 When HNY CAP CiC meetings are intended to take decisions under the delegations made to those committees then the meeting of HNY CAP (or if relevant, section of the meeting), will be

held in public except where a resolution is agreed by the HNY CAP Board to exclude the public on the grounds that it is believed to not be in the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time. Papers and minutes of HNY CAP meetings held in public will be published.

5 Future Involvement and Addition of Parties

5.1 Subject to complying with all applicable law, and the Trusts' unanimous agreement, third parties may become parties to this Agreement on such terms as the Trusts shall unanimously agree.

5.2 Any Trust may propose to the other Trusts that a third party be added as a Party to this Agreement.

6 Exit Plan

6.1 Within three (3) months of the date of this Agreement the Trusts shall develop and agree an exit plan which shall deal with, for example, the impact on resourcing or financial consequences of:

6.1.1 termination of this Agreement;

6.1.2 a Trust exercising its rights under clause 7.1 below; or

6.1.3 the Meeting Lead and the HNY CAP CiC Chairs varying the Agreement under clause 10.6.2.

6.2 Once agreed by all of the Trusts, the exit plan shall be inserted into this Agreement as an Appendix and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this Agreement.

7 Termination

7.1 If any Trust wishes to revoke the delegation of functions to the relevant HNY CAP CiC committee and exit this Agreement ("**Exiting Trust**"), then the Exiting Trust shall, prior to such revocation and exit:

7.1.1 send a written notice from the Chair of the Exiting Trust to the other Trusts' Chairs and the HNY CAP Board of their intention to do so; and

7.1.2 if required by any of the other Trusts (by sending a written notice within ten (10) business days of receipt of such notice) meet with the other Trusts' Chairs within ten (10) business days of the notice given under clause 7.1.1 to discuss the consequences of such revocation and exit.

7.2 If:

7.2.1 no other Trust sends a notice to the Exiting Trust within the time limit referred to in clause 7.1.2; or

7.2.2 following the meeting held under clause 7.1.2 the Exiting Trust still intends to exit the Agreement,

then the Exiting Trust may (subject to the terms of the exit plan at Appendix 15) exit this Agreement.

7.3 If following the steps and meeting (if any) pursuant to clause 7.1.2 above the Exiting Trust revokes its delegation to its HNY CAP CiC and exits this Agreement then the remaining Trusts shall meet and consider whether to:

7.3.1 Revoke their delegations and terminate this Agreement; or

7.3.2 Amend and replace this Agreement with a revised Agreement to be executed by the remaining Trusts and to make such revisions as may be appropriate in the circumstance.

8 **Information Sharing and Competition Law**

8.1 For the purposes of any applicable data protection legislation the Trusts shall be the data controller of any Personal Data (as defined in the UK General Data Protection Regulation (UK GDPR)) created in connection with the conduct or performance of the principles of this Agreement.

8.2 Where appropriate the HNY CAP Trusts agree to use all reasonable efforts to assist each other to comply with their respective responsibilities under any applicable data protection legislation. For the avoidance of doubt, this may include providing other Trusts with reasonable assistance in complying with subject access requests and consulting with other Trusts, as appropriate, prior to the disclosure of any Personal Data (as defined in the UK GDPR) created in connection with the conduct or performance of this Agreement in relation to such requests.

8.3 All Trusts will adhere to all applicable statutory requirements regarding data protection and confidentiality. The HNY CAP Trusts agree to co-operate with one another with respective statutory obligations under the Freedom of Information Act 2000 and Environmental Information Regulations 2004.

8.4 Subject to compliance with all applicable law (including without limitation competition law and obligations of confidentiality (contractual or otherwise)) the Trusts agree to share all information relevant to the operation of this Agreement in an honest, open and timely manner. The Trusts, shall not, (save as permitted by this Clause 8) either during or after the period of this Agreement divulge or permit to divulge to any person (including the other Trusts) any information acquired form other Trusts in connection with this Agreement which concerns:

8.4.1 any matter of commercial interest contained or referred to in this Agreement;

8.4.2 Trusts' manner of operations, staff or procedures;

8.4.3 the identity or address or medical condition or treatment of services received by any client or patient of any of the Trusts;

unless previously authorised by the Trusts concerned in writing, provided that these obligations will not extend to any information which is or shall become public information otherwise than by reason of a breach by a Trust of the provisions of this Agreement.

HNY CAP is committed to clear, consistent and transparent communication across the HNY CAP Trusts and with system partners' where appropriate. It is specifically recognised that HNY CAP Trusts are part of the ICS and members of Place Based Partnerships and will be working with their local partners and other collaboratives. Communication to and from Place Based Partnerships will be key for HNY CAP and the HNY CAP Trusts may be asked to represent both their own organisations and HNY CAP in such local place-based discussions.

Commented [A7]: Reflecting the commitment of the Trusts to communication and working with other partners (and specifically with place). Also acknowledging the multiple roles of Trusts which include Place.

8.5 For the avoidance of doubt, nothing in this Agreement shall be construed as preventing any rights or obligations that the Trusts may have under the Public Interest Disclosure Act (1998) and / or any obligations to raise concerns about any malpractice with regulatory or other appropriate statutory bodies pursuant to professional and ethical obligations including those

obligations set out in the guidance issued by regulatory or other appropriate statutory bodies from time to time.

8.6 The Trusts acknowledge and agree that each may be required to disclose Confidential Information to others. For the purpose of this Agreement "Confidential Information" means all information provided in connection with this Agreement which is secret or otherwise not publicly available (in both cases in its entirely or in part) including commercial, financial, marketing or technical information, know-know or trade secrets, in all cases whether disclosed orally or in writing before or after the date of this Agreement.

8.7 The Trusts undertake for themselves and their respective Boards and employees that:

8.7.1 the disclosing Trust shall confirm whether information is to be regarded as confidential prior to its disclosure by clearly marking all such documents with 'Confidential';

8.7.2 they will use no lesser security measures and degree of care in relation to any Confidential Information received from the other Trusts than they apply to their own Confidential Information;

8.7.3 they will not disclose any Confidential Information of the other Trusts to any third party without the prior written consent of the disclosing Trust; and

8.7.4 on the termination of this Agreement, they will return any documents or other material in their possession that contains Confidential Information of the other Trusts.

8.8 The Trusts agree to provide in a timely manner and without restriction all information requested and required by the relevant designated HNY CAP Programme Support team (either internal team or external contractor where agreed) to carry out work including but not limited to relevant detailed financial, activity, workforce and estates related information pertaining to HNY CAP activities.

8.9 The Trusts will ensure they share information, and in particular Competition Sensitive Information, in such a way that is compliant with competition law to the extent applicable.

8.10 The Trusts will seek to agree a protocol to manage the sharing of information to facilitate the operation of HNY CAP across the Trusts as envisaged under this Agreement in accordance with competition law requirements, within three (3) months of the date of this Agreement. Once agreed by the Trusts (and their relevant information officers) , this protocol shall be inserted into this Agreement at Appendix 16 and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this Agreement.

9 Conflicts of Interest

9.1 Members of each of the HNY CAP CiCs shall make arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the HNY CAP Board will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of HNY CAP's decision-making processes.

9.2 The HNY CAP Board will agree policies and procedures for the identification and management of conflicts of interest which will be published on the HNY CAP webpages. It is proposed that such policies will either be HNY CAP developed or HNY CAP will support the adoption and application of the policy of a host organisation of HNY CAP.

9.3 All HNY CAP Board, committee and sub-committee members, and employees acting on behalf of HNY CAP, will comply with the HNY CAP policy on conflicts of interest in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests on a register that will be maintained by HNY CAP. Reuse / resubmission of host employer or home trust data, where applicable, will be supported

9.4 All delegation arrangements made by the Trusts will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures agreed by the HNY CAP Board.

9.5 Where an individual, including any individual directly involved with the business or decision-making of the HNY CAP Board and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the HNY CAP Board considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Agreement and any agreed HNY CAP Conflicts of interest Policy and Standards of Business Conduct Policy.

10 Dispute Resolution

10.1 The Trusts agree to adopt a systematic approach to problem resolution which recognises the Rules of Working set out in clause 3 above.

10.2 If a problem, issue, concern, or complaint comes to the attention of a Trust in relation to any matter in this Agreement, that Trust shall notify the other Trusts in writing and the Trusts each acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.

10.3 If any Trust considers an issue identified in accordance with clause 10.2 to amount to a Dispute requiring resolution and such issue has not been resolved under clause 10.2 within a reasonable period of time, the matter shall be escalated to the Meeting Lead who shall decide in conjunction with the HNY CAP CiCs at the HNY CAP Board the appropriate course of action to take. If the Meeting Lead is involved in the dispute directly then their role in the process will be allocated by the HNY CAP Board to an alternate lead person for the purposes of the determination of the issues which the Meeting Lead is involved in and any references to the Meeting Lead in this clause 10 in such a process shall be to the alternate appointed by the HNY CAP Board.

10.4 If the Meeting Lead and the HNY CAP Board reach a decision that resolves, or otherwise concludes a Dispute, the Meeting Lead will advise the Trusts of the decision by written notice. Any decision of the Meeting Lead and the HNY CAP Board will be final and binding on the Trusts once it has been ratified by the Trusts' Boards (if applicable).

10.5 If the matter referred to in clause 10.3 above cannot be resolved by the Meeting Lead and the HNY CAP Board, within fifteen (15) Working Days, the Trusts agree that the Meeting Lead and the HNY CAP Board, may determine whatever action they believe necessary to resolve the Dispute which may include:

10.5.1 appointment of a panel of HNY CAP Board members who are not involved in the dispute to consider the issues and propose a resolution to the Dispute;

10.5.2 mediation arranged by HNY ICB for consideration and to propose a resolution to the Dispute; or

10.5.3 if considered appropriate selecting an independent facilitator and utilising the Centre for Effective Dispute Resolution (CEDR) Model Mediation Procedure. Unless otherwise agreed between the HNY CAP Trusts, the facilitator will be nominated by CEDR to assist with resolving the Dispute;

and who shall:

- be provided with any information they request about the Dispute;
- assist the Meeting Lead and HNY CAP Board to work towards a consensus decision in respect of the Dispute;

- regulate their procedure and, subject to the terms of this Agreement, the procedure of the Meeting Lead and HNY CAP Board at such discussions;

- determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Working Days of their appointment; and

- where appropriate have their costs and disbursements met by the Trusts in dispute equally.

10.6 If the independent facilitator proposed under clause 10.5 cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this clause 10 and only if after such further consideration the Trusts again fail to resolve the Dispute, the Meeting Lead and HNY CAP Board may decide to recommend their Trust's Board of Directors to:

10.6.1 terminate the Agreement;

10.6.2 vary the Agreement (which may include re-drawing the member Trusts); or

10.6.3 agree that the Dispute need not be resolved.

11 **Variation**

No variation of this Agreement shall be effective unless it is in writing and signed by the Trusts (or their authorised representatives).

12 **Counterparts**

12.1 This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Agreement, but all the counterparts shall together constitute the same agreement.

12.2 The expression "counterpart" shall include any executed copy of this Agreement transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

12.3 No counterpart shall be effective until each Trust has executed at least one counterpart.

13 **Governing law and jurisdiction**

This Agreement shall be governed by and construed in accordance with English law.

This Agreement is executed on the date stated above by

……
For and on behalf of **Harrogate and District NHS Foundation Trust**

This Agreement is executed on the date stated above by

……
For and on behalf of **Hull University Teaching Hospitals NHS Trust**

This Agreement is executed on the date stated above by

……
For and on behalf of **Northern Lincolnshire and Goole NHS Foundation Trust**

This Agreement is executed on the date stated above by

……
For and on behalf of **York and Scarborough Teaching Hospitals NHS Foundation Trust**

APPENDIX 1– TERMS OF REFERENCE FOR THE HARROGATE AND DISTRICT NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Trust CiC]

APPENDIX 2 – TERMS OF REFERENCE FOR THE HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST CIC

[Insert Terms of Reference for the Trust CiC]

APPENDIX 3 – TERMS OF REFERENCE FOR THE NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Trust CiC]

APPENDIX 4 – TERMS OF REFERENCE FOR THE YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Trust CiC]

APPENDIX 5 - EXIT PLAN

1 In the event of termination of this Agreement by all parties, the Trusts agree that:

1.1 each Trust will be responsible for its own costs and expenses incurred because of the termination of the Agreement up to the date of termination UNLESS it is agreed between the Trusts that the costs and expenses are to be borne equally between the Trusts;

1.2 upon reasonable written notice, each Trust will be liable for one quarter of any professional advisers' fees incurred by and on behalf of HNY CAP in relation to the termination of this Agreement (if any) up to and including the date of termination of this Agreement;

1.3 each Trust will revoke its delegation to its HNY CAP Committee in Common (CiC) on termination of this Agreement;

1.4 termination of this Agreement shall not affect any rights, obligations or liabilities that the Trusts have accrued under this Agreement prior to the termination of this Agreement; and

1.5 there are no join assets and resources but should these be identified in the future, Trusts will need to confirm agreement at termination of this Agreement how any joint assets or resources will need to be dealt with on termination of the Agreement.

2 In the event of an Exiting Trust leaving this Agreement in accordance with clause 7, the Trusts agree that:

2.1 a minimum of six months' notice will be given by the Exiting Trust and they shall pay to the other Trusts all reasonable costs and expenses incurred by the other Trusts as a consequence of the Exiting Trust's exit from HNY CAP and this Agreement up to and including the Exiting Trust's date of exit from this Agreement. Notwithstanding this, the Exiting Trust's total aggregate liability, in respect of such reasonable costs and the expenses, shall be capped at the value of their annual contribution of resources that are agreed to remain for the financial year or term of any agreement being overseen by the HNY CAP CiC;

2.2 upon reasonable written notice from the other Trusts, the Exiting Trust shall be liable to pay [one fifth of] any professional advisers' fees incurrent by and on behalf of HNY CAP as a consequence of the Exiting Trust's exit from the collaborative and this Agreement up to and including the date of exit of the Exiting Trust from this Agreement;

2.3 the Exiting Trusts will revoke its delegation to its HNY CAP CiC on its exit from this Agreement;

2.4 the remaining Trusts shall use reasonable endeavours to procure that the Agreement is amended or replaced as appropriate in accordance with clause 7.3.2;

2.5 subject to any variation to or replacement of this Agreement in accordance with paragraph 2.4 above, and clause 7.3.2, this Agreement shall remain in full force and effect following the exit of the Exiting Trust from this Agreement

APPENDIX 6 - INFORMATION SHARING PROTOCOL

[to be inserted once agreed]

V 1-2 February 2023

HUMBER AND NORTH YORKSHIRE
COLLABORATIVE OF ACUTE PROVIDERS (HNY CAP)

TERMS OF REFERENCE FOR A COMMITTEE OF THE BOARD TO MEET IN COMMON WITH COMMITTEES OF OTHER HNY CAP TRUSTS

TERMS OF REFERENCE

1 Introduction

1.1 In these terms of reference, the following words bear the following meanings:

XXX NHS Foundation Trust	XXX NHS Foundation Trust of XXX;
XXX NHS Foundation Trust CiC	the committee established by XXX NHS Foundation Trust, pursuant to these Terms of Reference, to work alongside the other HNY CAP CiCs in accordance with these Terms of Reference;
Humber and North Yorkshire Collaborative of Acute Providers or HNY CAP	the partnership formed by the Trusts to work together to improve quality, safety and the patient experience; deliver safe and sustainable new models of care; and make collective efficiencies. This mainly operates within the NHS Humber and North Yorkshire Integrated Care System.
HNY CAP Agreement	the joint working agreement signed by each of the Trusts in relation to their provider collaborative working and the operation of the XXX NHS Foundation Trust CiC together with the other HNY CAP CiCs;
HNY CAP CiCs	the committees established by each of the Trusts to work alongside the committees established by the other Trusts and "**HNY CAP CiC**" shall be interpreted accordingly;
HNY CAP Programme Steering Group	the Group, to provide programme support and oversight of the delivery of agreed collaborative activities;
HNY CAP Managing Director	The Named Lead Officer or any of subsequent person holding such title in relation to HNY CAP;
HNY CAP Office	Administrative infrastructure supporting HNY CAP;
Meeting Lead	the CiC Member nominated (from time to time) in accordance with paragraph 7.6 of these Terms of Reference, to preside over and run the HNY CAP CiC meetings when they meet in common;
Member	a person nominated as a member of an HNY CAP CiC in accordance with their Trust's Terms of Reference, and Members shall be interpreted accordingly;

NHS Humber and North Yorkshire Integrated Care System or "HNY ICS"	the Integrated Care System (ICS) for Humber and North Yorkshire bringing together NHS organisations, councils, and wider partners in a defined geographical area to deliver more joined up care for the population.
Trusts	The (i) Harrogate and District NHS Foundation Trust, (ii) Hull University Teaching Hospitals NHS Trust, (iii) Northern Lincolnshire and Goole NHS Foundation Trust and (iv) York and Scarborough Teaching Hospitals NHS Foundation Trust and "Trust" shall be interpreted accordingly. and
Working Day	a day other than a Saturday, Sunday or public holiday in England.

1.2 The XXX NHS Foundation Trust is putting in place a governance structure, which will enable it to work together with the other Trusts in HNY CAP to implement change.

1.3 Each Trust has agreed to establish a committee which shall work in common with the other HNY CAP CiCs, but which will each take its decisions independently on behalf of its own Trust.

1.4 Under paragraph 15(2) and (3) of Schedule 7 of the National Health Service Act 2006, the constitution of a Foundation Trust may provide for any of the powers exercisable by the Board of Directors on behalf of the Foundation Trust to be delegated to a committee of its directors. Section 32 - Appointment of Committees and Sub Committees, of the Standing Orders of the Trust Board provides that: "Subject to SO 33.0, the board may make arrangements for the exercise, on behalf of the trust, of any of its functions by a committee or sub-committee."

Commented [RM1]: Note that the Hull version will reflect NHS trust powers

1.5 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each HNY CAP CiC will be different.

1.6 Each Trust has entered into the HNY CAP Agreement on **[DATE]** and agrees to operate its HNY CAP CiC in accordance with the HNY CAP Agreement.

2 Aims and Objectives of the XXX NHS Foundation Trust CiC

2.1 The aims and objectives of the XXX NHS Foundation Trust CiC are to work with the other HNY CAP CiCs on system work or matters of significance as delegated to the XXX NHS Foundation Trust CiC under Appendix A to these Terms of Reference to:

2.1.1 provide strategic leadership, oversight and delivery of new models of care through the development of HNY CAP and its workstreams;

2.1.2 set the strategic goals for HNY CAP and approving work programmes and the annual plan, defining its ongoing role and scope ensuring recommendations are provided to Trusts' Boards for any changes which have a material impact on the Trusts. Potential HNY CAP work programmes have been identified as

covering urgent and emergency care, cancer and elective recovery, and these will be refined further by the HNY CAP Board.

2.1.3 review the key deliverables and hold the Trusts to account for progress against agreed decisions;

2.1.4 review the HNY CAP Agreement and Terms of Reference for HNY CAP CiCs on an annual basis;

Commented [RM2]: For comment and development by the CAP trusts

Commented [RM3R2]: Further clarification required

3 Establishment

3.1 The XXX NHS Foundation Trust's board of directors has agreed to establish and constitute a committee with these terms of reference, to be known as the XXX NHS Foundation Trust CiC. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the XXX NHS Foundation Trust CiC.

3.2 The XXX NHS Foundation Trust CiC shall work cooperatively with the other HNY CAP CiCs and in accordance with the terms of the HNY CAP Agreement.

3.3 The XXX NHS Foundation Trust CiC is a committee of **XXX** NHS Foundation Trust's board of directors and therefore can only make decisions binding XXX NHS Foundation Trust. None of the Trusts other than XXX NHS Foundation Trust can be bound by a decision taken by XXX NHS Foundation Trust CiC.

3.4 The XXX NHS Foundation Trust CiC will form part of a governance structure to support collaborative leadership and relationships with system partners and follow good governance in decision making (as set out in the updated Code of Governance for NHS Provider Trusts). The XXX NHS Foundation Trust CiC will have regard in their decision-making to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources.

4 Functions of the Committee

4.1 Paragraph 15(2) and (3) of Schedule 7 of the National Health Service Act 2006 allows for any of the functions of a Foundation Trust to be delegated to a committee of directors of the Foundation Trust. This power is enshrined in [Paragraph 8.8.3 [9.6.14 YORK]] of XXX NHS Foundation Trust's Constitution.

Commented [RM4]: Note that the Hull ToR will reference the relevant NHS Trust provisions.

4.2 XXX NHS Foundation Trust CiC shall have the following function: decision making in accordance with Appendix A to these Terms of Reference.

5 Functions reserved to the Board of the Foundation Trust

Any functions not delegated to the XXX NHS Foundation Trust CiC in paragraph 4 of these Terms of Reference shall be retained by XXX NHS Foundation Trust's Board or Council of Governors, as applicable in line with its Scheme of Delegation and Schedule of Matters Reserved to the Board of Directors. For the avoidance of doubt, nothing in this paragraph 5 shall fetter the ability of XXX NHS Foundation Trust to delegate functions to another committee or person.

6 Reporting requirements

6.1 On receipt of the papers detailed in paragraph 13.1.2, the XXX NHS Foundation Trust CiC Members shall consider if it is necessary (and feasible) to forward any of the agenda items or papers to XXX NHS Foundation Trust's Board for inclusion on the private agenda of XXX NHS Foundation Trust's next Board meeting in order that XXX NHS Foundation Trust's Board may consider any additional delegations necessary in accordance with Appendix A.

6.2 The XXX NHS Foundation Trust CiC shall send the minutes of XXX NHS Foundation Trust CiC meetings to XXX NHS Foundation Trust's Board, on a monthly basis, for inclusion on the agenda of XXX NHS Foundation Trust's Board meeting.

6.3 XXX NHS Foundation Trust CiC shall provide such reports and communications briefings as requested by XXX NHS Foundation Trust's Board for inclusion on the agenda of XXX NHS Foundation Trust's Board meeting.

7 Membership

7.1 The XXX NHS Foundation Trust CiC shall be constituted of directors of XXX NHS Foundation Trust. Namely:

7.1.1 The XXX NHS Foundation Trust's Chief Executive; and

7.1.2 The XXX NHS Foundation Trust's Chair (who will attend the quarterly meeting designated for Chief Executives and Chairs)

who shall each be referred to as a "Member".

Commented [RM5]: Consider the inclusion of the Chair as discussed

7.2 The XXX NHS Foundation Trust's Chair shall be invited to meetings of the HNY CAP CiC on a quarterly basis (or where appropriate) as set out in the HNY CAP Agreement under clause 4.

Commented [RM6]: To be confirmed

7.3 Each XXX NHS Foundation Trust CiC Member shall nominate a deputy to attend XXX NHS Foundation Trust CiC meetings on their behalf when necessary ("**Nominated Deputy"**).

7.4 The Nominated Deputy for XXX NHS Foundation Trust's Chief Executive shall be an Executive Director of XXX NHS Foundation Trust and the Nominated Deputy for XXX NHS Foundation Trust's Chair shall be a Non-Executive Director of XXX NHS Foundation Trust.

7.5 In the absence of the XXX NHS Foundation Trust CiC Chief Executive Member and/or the Chair Member, his or her Nominated Deputy shall be entitled to:

7.5.1 attend XXX NHS Foundation Trust CiC's meetings which the Member would be entitled to attend;

7.5.2 be counted towards the quorum of a meeting of XXX NHS Foundation Trust CiC's; and

7.5.3 exercise Member voting rights,

and when a Nominated Deputy is attending a XXX NHS Foundation Trust CiC meeting, for the purposes of these Terms of Reference, the Nominated Deputy shall be included in the references to "Members".

7.6 When the HNY CAP CiCs meet in common, one person nominated from the Members of the HNY CAP CiCs shall be designated the Meeting Lead and preside over and run the meetings on a rotational basis for an agreed period.

8 Non-voting attendees

8.1 The Members of the other HNY CAP CiCs shall have the right to attend the meetings of XXX NHS Foundation Trust CiC.

8.2 The Meeting Lead's Trust Corporate Secretary shall have the right to attend the meetings of XXX NHS Foundation Trust CiC to support the provision of governance advice and ensure that the working arrangements comply with the accountability and reporting arrangements of the HNY CAP CiCs.

8.3 The HNY CAP Managing Director shall have the right to attend the meetings of XXX NHS Foundation Trust CiC.

8.4 Without prejudice to paragraphs 8.1 to 8.3 inclusive, the Meeting Lead may at his or her discretion invite and permit other persons relevant to any agenda item to attend any of the HNY CAP CiCs' meetings, but for the avoidance of doubt, any such persons in attendance at any meeting of the HNY CAP CiCs shall not count towards the quorum or have the right to vote at such meetings.

8.5 The attendees detailed in paragraphs 8.1 to 8.4 (inclusive) above, may make contributions, through the Meeting Lead, but shall not have any voting rights, nor shall they be counted towards the quorum for the meetings of XXX NHS Foundation Trust CiC.

9 Meetings

9.1 Subject to paragraph 9.2 below, XXX NHS Foundation Trust CiC meetings shall take place monthly and dates for meetings both with Chief Executives and the quarterly meeting with the Chair in attendance will be set before the start of each financial year.

9.2 The XXX NHS Foundation Trust CiC shall meet with the other HNY CAP CiCs as the HNY CAP Leadership Board in accordance with the HNY CAP Agreement (as set out in clause 4 of the HNY CAP Agreement) and discuss the matters delegated to them in accordance with their respective Terms of References.

9.3 Any Trust CiC Member may request an extraordinary meeting of the HNY CAP CiCs (working in common) on the basis of urgency etc. by informing the Meeting Lead. In the event it is identified that an extraordinary meeting is required the HNY CAP Managing Director shall give five (5) Working Days' notice to the Trusts.

9.4 The agenda and supporting papers for a meeting shall be forwarded to each XXX NHS Foundation Trust CiC Member and planned attendees not less than three clear days before the date of the meeting. In exceptional or urgent circumstances, a shorter period may be acceptable, at the discretion of the Meeting Lead.

9.5 Meetings of the XXX NHS Foundation Trust CiC shall generally be held in public save where items are agreed to be private and confidential and otherwise in accordance with clause 4.10 of the HNY CAP Agreement.

9.6 Matters not discussed in public in accordance with paragraph 9.5 above and dealt with at the meetings of the XXX NHS Foundation Trust CiC shall be confidential to the XXX NHS Foundation Trust CiC Members and their Nominated Deputies, others in attendance at the meeting and the members of XXX NHS Foundation Trust's Board.

10 Responsibility of Members and Attendees

10.1 Members of the XXX NHS Foundation Trust CiC have a responsibility to:

- be guided by and act consistently with the Seven Principles of Public Life;
- act as 'champions' and lead by example (reflecting the Trusts' values), disseminating information, agreements and good practice as appropriate;
- adhere to the principles of collective decision making. *[Note: Where concerns regarding decisions may exist, members have a responsibility to ensure these concerns are aired at the time of the decision so that they can be discussed and resolved and/or recorded.];*
- ensure that when matters are discussed in confidence at the meeting, such confidences are maintained;
- declare any conflicts of interest / potential conflicts of interest in any of the agenda items in accordance with XXX NHS Foundation Trust's policies and procedures; and
- attend at least 80% of XXX NHS Foundation Trust CiC meetings, having read any papers in advance.

11 Quorum and Voting

11.1 Members of the XXX NHS Foundation Trust CiC have a responsibility for the operation of the XXX NHS Foundation Trust CiC. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

11.2 Each Member of the XXX NHS Foundation Trust CiC shall have one vote. The XXX NHS Foundation Trust CiC shall reach decisions by consensus of the Members present.

11.3 The quorum shall be [one Member for meetings of the Chief Executives and two (2) Members for the quarterly meeting with the Chief Executive and Chair].

11.4 If any Member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.

12 Conflicts of Interest

12.1 Members of the XXX NHS Foundation Trust CiC shall comply with the provisions on conflicts of interest contained in XXX NHS Foundation Trust Constitution/Standing Orders, the HNY CAP Agreement and NHS Conflicts of Interest guidance. For the avoidance of doubt, reference to conflicts of interest in XXX NHS Foundation Trust Constitution/Standing Orders also apply to conflicts which may arise in their position as a Member of the XXX NHS Foundation Trust CiC.

12.2 All Members of the XXX NHS Foundation Trust CiC shall declare any new interest at the beginning of any XXX NHS Foundation Trust CiC meeting and at any point during a XXX NHS Foundation Trust CiC meeting if relevant.

13 Attendance at meetings

13.1 XXX NHS Foundation Trust shall ensure that, except for urgent or unavoidable reasons, XXX NHS Foundation Trust CiC Members (or their Nominated Deputy) shall attend all relevant XXX NHS Foundation Trust CiC meetings (in person) and fully participate in all XXX NHS Foundation Trust CiC meetings.

13.2 Subject to paragraph 13.1 above, meetings of the XXX NHS Foundation Trust CiC may consist of a conference between Members who are not all in one place, but each of whom is able directly or by secure telephonic or video communication (the Members having due regard to considerations of confidentiality) to speak to the other or others, and be heard by the other or others simultaneously.

14 Administrative

14.1 Administrative support for the XXX NHS Foundation Trust CiC will be provided by HNY CAP Office (or such other route as XXX NHS Foundation Trust may agree in writing). The HNY CAP Office will:

14.1.1 draw up an annual schedule of HNY CAP CiC meeting dates and circulate it to XXX NHS Foundation Trust CiC;

14.1.2 circulate the agenda and papers three (3) Working Days prior to HNY CAP CiC meetings; and

14.1.3 take minutes of each XXX NHS Foundation Trust CiC meeting and, following approval by the Meeting Lead, circulate them to the HNY CAP Trusts and action notes to all Members within ten (10) Working Days of the relevant XXX NHS Foundation Trust CiC meeting.

14.2 The agenda for the XXX NHS Foundation Trust CiC meetings shall be determined by the HNY CAP Managing Director and agreed by the Meeting Lead prior to circulation.

14.3 The Meeting Lead shall be responsible for approval of the first draft set of minutes for circulation to Members and shall work with the HNY CAP Office to agree such within five (5) Working Days of receipt.

15 Equality Act (2010)

15.1 XXX NHS Foundation Trust is committed to promoting a pro-active and inclusive approach to equality which supports and encourages an inclusive culture which values diversity.

15.2 XXX NHS Foundation Trust is committed to building a workforce which is valued and whose diversity reflects the community it serves, allowing the Trust to deliver the best possible healthcare service to the community. In doing so, the Trust will enable all staff to achieve their full potential in an environment characterised by dignity and mutual respect.

15.3 XXX NHS Foundation Trust aims to design and provide services, implement policies and make decisions that meet the diverse needs of our patients and their carers the general population we serve and our workforce, ensuring that none are placed at a disadvantage.

15.4 XXX NHS Foundation Trust therefore strives to ensure that in both employment and service provision no individual is discriminated against or treated less favourably by reason of age, disability, gender, pregnancy or maternity, marital status or civil partnership, race, religion or belief, sexual orientation or transgender (Equality Act 2010).

APPENDIX A – DECISIONS OF THE XXX NHS FOUNDATION TRUST CIC

The Board of each Trust within HNY CAP remains a sovereign entity and will be sighted on any proposals for service change and all proposals with strategic impact.

Subject to XXX NHS Foundation Trust's Scheme of Delegation, the matters or type of matters that are fully delegated to the XXX NHS Foundation Trust CiC to decide are set out in the table below.

If it is intended that the HNY CAP CiCs are to discuss a proposal or matter which is outside the decisions delegated to the XXX NHS Foundation Trust CiC, where at all practical, each proposal will be discussed by the Board of each Trust prior to the XXX NHS Foundation Trust CiC meeting with a view to XXX NHS Foundation Trust CiC requesting individual delegated authority to take action and make decisions (within a set of parameters agreed by XXX NHS Foundation Trust's Board). Any proposals discussed at the XXX NHS Foundation Trust CiC meeting outside of these parameters would come back before XXX NHS Foundation Trust's Board.

References in the table below to the "Services" refer to the services that form part of the HNY CAP Agreement for joint working between the Trusts (as set out in [NOTE: we need to specify the areas of working/delegation for the Agreement] of the HNY CAP Agreement and which may be supplemented or further defined by an annual HNY CAP Work Programme) and may include both back office and clinical services.

	Decisions delegated to XXX NHS Foundation Trust CiC
1.	Providing overall strategic oversight and direction to the development of the HNY CAP programme ensuring alignment of all Trusts to the vision and strategy;
2.	Promoting and encouraging commitment to the key Rules of Working;
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Commented [RM7]: Scope of delegation to be agreed

	Decisions delegated to XXX NHS Foundation Trust CiC
11.	
12.	Reviewing the Terms of Reference and HNY CAP Joint Working Agreement on an annual basis.

APPROVED BY THE BOARD OF DIRECTORS: [DATE] 2022

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	14.02.23
Title	Quality Report				
Lead Director	Suzanne Rostron, Director of Quality Governance, Jo Ledger, Chief Nurse and Dr Makani Purva, Chief Medical Officer				
Author	Michela Littlewood - Associate Director of Quality Donna Pickering – Head of Patient Safety and Improvement, Leah Coneyworth – Head of Quality Compliance and Improvement and Andy Lockwood – Head of Patient Experience and Engagement, Nathaniel Steadman – Head of Continuous Quality Improvement				
Report previously considered by (date)	This report has previously been considered at the Quality Committee (Jan 2023)				

Purpose of the Report		**Reason for submission to the Trust Board private session**		**Link to CQC Domain**		**Link to Trust Strategic Objectives 2021/22**	
Trust Board Approval		Commercial Confidentiality		Safe	✓	Honest Caring and Accountable Future	✓
Committee Agreement		Patient Confidentiality		Effective	✓	Valued, Skilled and Sufficient Staff	✓
Assurance	✓	Staff Confidentiality		Caring	✓	High Quality Care	✓
Information Only		Other Exceptional Circumstance		Responsive	✓	Great Clinical Services	✓
				Well-led	✓	Partnerships and Integrated Services	✓
						Research and Innovation	
						Financial Sustainability	✓

Key Recommendations:

The Quality Committee is recommended to review the executive summary of the key indicators and decide if assurance has been received with the actions been taken to address the concern areas and confirm if any further action is required.

Quality Report

December 2022 Performance Data

Produced for the January 2023 Quality Committee

TABLE OF CONTENTS

1. EXECUTIVE SUMMARY

1.1 ESCALATION OF KEY INDICATORS

The following table provides an executive summary of the key indicators that require escalation from the performance in December 2022.

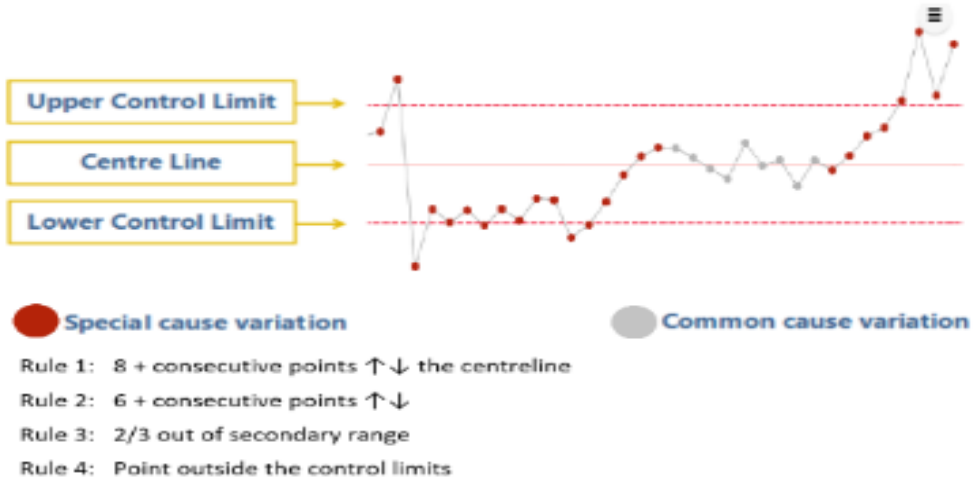
	Indicator	Success	Risks / Challenges	Actions / Future Plans
Safe Domain	Patient Safety Incident Reporting	The Trust has a positive patient safety reporting culture (high volume, low harm)	There has been a slight increase in the incidents that are being reported. Incidents causing moderate harm or above have increased but remain within control limits	The learning from incidents is shared through various avenues in the Trust to communicate key information and key learning and to share and celebrate success. Key quality improvement programmes linked to the Quality Strategy are informed by incident data. A Quality Improvement project is currently underway to further increase incident reporting across the organisation.
	Serious Incidents	The trajectory to be in a sustainable position of ~35 SI open at any time has been met and is still demonstrating a downward trend.	There are still a number of SIs that have been open for more than 100 days. The Trust will continue to declare SIs in line with the Serious Incident Framework (2015) until April 2023	All open SI investigations are reviewed weekly and additional focus and support is given to the oldest open investigations, this has resulted in a downward trend of SI's open over 100 days. All incidents meeting SI criteria are discussed at the Weekly Patient Safety Summit (WPSS). Where there is no new learning, differing approaches other that SI investigations are considered e.g.

	Indicator	Success	Risks / Challenges	Actions / Future Plans
				AAR, Safety Huddles, and Thematic Reviews to identify if there are improvement opportunities. Transition to PSIRF planned from April 2023. PSIRF training has started and a draft PSIRP is in circulation for consultation.
Effectiveness Domain	HSMR	The rolling HSMR is steady showing a consistent mortality rate during 2022 compared with the spikes demonstrated in 2021	The Trust continues demonstrate 'higher than expected deaths' and is an outlier against its HSMR	The Mortality and Morbidity Task and Finish Group continue to meet monthly to closely monitor the mortality data and to work on improving the areas that are highlighting as a potential risk Our HSMR is fairly stable around the 120 mark. This is higher than our peer group overall value and higher than most of the trusts in our peer group for the most recent 12 month period available, as well as higher than the notional national value of 100. Using the HSMR methodology as implemented by CHKS, we have more deaths than expected. We don't get the control limits like those calculated by NHS Digital for the SHMI to determine if we are truly a statistical outlier in the same way. Therefore we would like to correct the error in the report which states that we are an outlier.
	SHMI	The overall Trust SHMI has reduced further and is now within the 'expected levels of deaths' with a SHMI of 1.11 The Trust is no longer highlighted at one of the top 12 Trusts with an outlier status by NHS Digital Pneumonia SHMI has reduced further and is now within the 'expected levels of deaths' with a SHMI of 1.03 in August 2022	The top 3 common clinical conditions remain Sepsis, Pneumonia and Stroke	UTI mortality is increasing and therefore, the Mortality Task and Finish Group are undertaking some further analysis to understand if there is a cause of concern.

	Indicator	Success	Risks / Challenges	Actions / Future Plans
		compared with a SMHI of 1.19 at its highest point in 2020.		
	Stroke	Stroke SHMI has also improved further with a SHMI of 1.10 in August 2022 compared with a SHMI of 1.46 at its highest point in 2020. 73% of the stroke admissions were cared for on a Stroke Ward The Stroke Service now undertake an SJR review on all deaths	HUTH is one of middle performing Trusts against its peers for Stroke	Continue to deliver the Stroke improvement plan, improving the services and outcomes for patients being cared for on or off a Stroke ward at HUTH Continue to review all Stroke deaths, present the findings and learning to the Stroke M&M Meeting Provide regular updates to the Mortality and Morbidity Committee
Responsive Domain	Complaints	CSHG & EMHG complaints within acceptable limits.	Capacity of Patient Experience Team to log new complaints in a timely manner. To reduce complaints >40 days Implementation of the PHSO complaints framework, using learning from pilot areas	Trajectories given to each HG to support backlog of open complaints. Targeted work with Surgical and Medicine HGs to clear complaints. Band 6 Patient Experience & Engagement Manager appointed and recruitment for a Band 7 Senior Patient Experience & Engagement Manager has commenced.
Well-led Domain	Continuous Quality Improvement	Continued development of the Trusts staff led improvement initiatives via the Think Tank platform. Development of the 2023/2024 QSIR delivery programme	None	Development of the second Celebration Event planned for February 2023 Health Groups supported to develop their 2023/24 Continuous Quality Improvement and Quality Strategy priorities Development of the CQI public facing website Development of the Human Factors Hub in partnership with the Patient Safety Team to meet an April 2023 launch date Launch of QSIR Practitioner cohort 4 February 2023

1.2 EXECUTIVE SUMMARY SCORECARD

The following provides a high level executive summary of the number of Quality Indicators which are achieving, those which are displaying variance between achieving and failing and those that are consistently failing as detailed on the Integrated Performance Report for January 2023.



Statistical Process Control (SPC) is an established analytical technique that plots data over a period of time to help us understand variation and assurance and as a result directing us to the correct area of improvement for the appropriate action to be taken to make a difference. The charts also allow us to monitor the relevant KPIs and determine if they are improving.

A minimum of 15 data points are required for an SPC to be meaningful and inform decision making, improvements and change. This is completed in line with NHS Improvement 'Making Data Count'

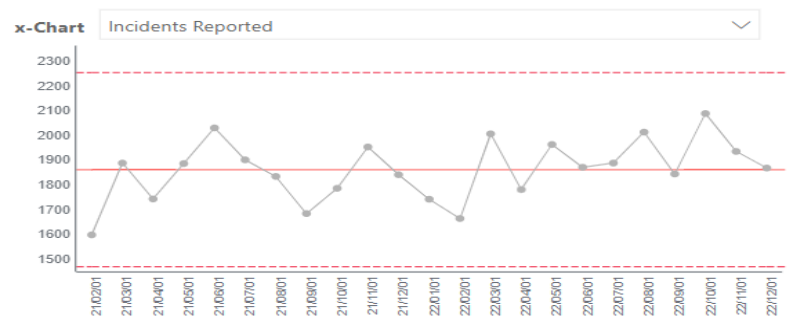
2. SAFE DOMAIN

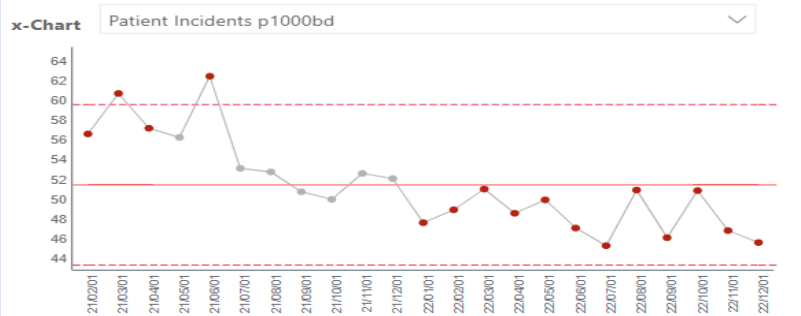
2.1 PATIENT SAFETY INCIDENT REPORT AND INCIDENTS CAUSING HARM

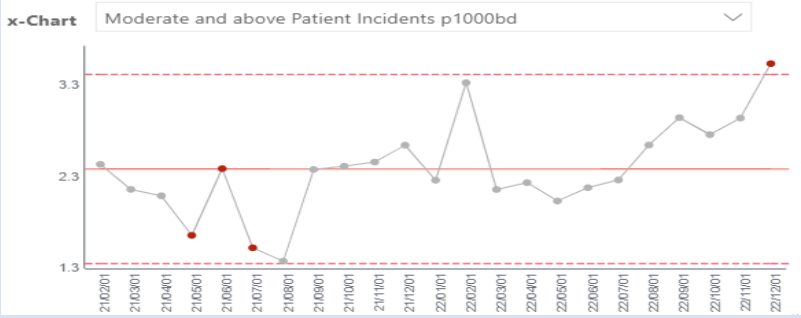
Patient Safety Incidents reported per 1000 bed days
Patient Safety Incidents causing harm per 1000 bed days

Aim: To promote a safe learning culture by reporting patient safety incidents

Target: To see a reduction in the number of incidents resulting in harm







What is the chart telling us:

- There were 46 patient safety incidents per 1000 bed days recorded in December 2022 (n=1510); 3.5 (per 1000 bed days) incidents resulted in moderate, severe or catastrophic harm to the patient.
- The number of incidents of all severities is within control limits and shows a reduction over the last 12 months by per 1000 bed days compared to the previous 12 months. This can be accounted for by a return of increased activity within the Trust with the absolute number of incidents remaining around the mean
- The number of incidents causing harm to patients (per 1000 bed days) is showing an upward trend over the last 7 months; in December the data shows above the upper control limit

Successes:

- The Trust has a positive patient safety reporting culture (high volume, low harm)
- The Trust continues to sustain incident-reporting levels above the national average of 45 per 1000 bed days.

Key Risks and Challenges:

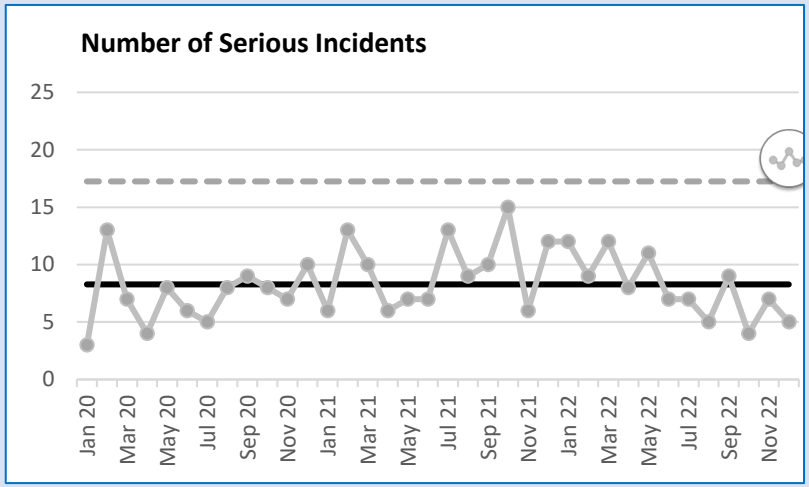
- The highest reported harms were inpatient falls and hospital acquired pressure ulcers with an increase in device related harms
- There was an increase in hospital acquired pressure ulcers reported in the Clinical Support Health Group with a total of 6 reported in the month; 29 in Medicine Health Group and 27 in Surgery Health Group
- There were 8 deaths of patients in the month with 5 relating to treatment and care; 3 deaths in cardiology and 2 in radiology; one incident was declared as a SI. There was 1 maternal death in the ICU that has been referred to HSIB

	Actions / Future Plans for Improvement: • Quality Improvement Project is underway to increase the number of patient safety events being reported and will incorporate work to integrate the transition from the NRLS to Learn from Patient Safety Events service (LFPSE) from April 2023. • QI work streams aligned to Quality Strategy strategic ambitions for harm free care • Incidents resulting in death to continue to be reviewed at Weekly Patient Safety Summit (WPSS) for immediate learning • All pressure ulcer incidents are validated to establish the harm and discussed at the Safer Skin Committee to identify learning and improvements • November/December saw an increase in DTIs on Ward 50; a focused piece of work was undertaken with the Ward Sister and Senior Matron which is being monitored through a task and finish group • Membership of the WPSS has been expanded to include more colleagues from the Radiology specialty to provide expert advice on incidents that include a radiological aspect to the patient's care. This will provide earlier challenge and discussion for incidents that are potential SIs where the accepted error rates in radiology reporting conclude that there were no failings in care or new learning.

2.2 SERIOUS INCIDENTS

Number of Serious Incidents reported
Serious Incidents per 1000 bed days

Aim: To reduce the number of serious incidents being declared
Target: Zero serious incidents in the month



What is the chart telling us:

- The Trust declared 5 serious incidents in December 2022 equating to 0.11 serious incidents per 1000 bed days.
- The graphs show common cause variation with no cause for concern with a downward trend since January 2022.

Successes:

- The WPSS reviews patient harms and allows for discussion on emerging themes and immediate learning, improvement opportunities and differing approaches to investigation methods e.g. AAR, Safety Huddles, and Thematic Reviews required.
- The WPSS allows for timely identification of serious incidents and sharing information across the HGs.
- There has been improvements to patient safety in the Emergency Department following the cluster of patient deaths reported at the beginning of October; there have been no repeat incidents and only one SI declared in relation to a delayed diagnosis

Key Risks and Challenges:

- The trust will continue to declare SIs in line with the serious incident framework (2015) until April 2023 (subject to approval of PSIRP).
- 1 serious incident resulted in the death of the patient in clinical support health group following a treatment delay.
- 3 serious incidents occurred in the family & women's health group but there were no commonalities. 1 of which was declared as a never event for wrong site surgery in the ophthalmology service (investigation completed), a drug administration error in neonatal and a treatment delay in ophthalmology which will be investigated as part of the next ophthalmology thematic review.
- 1 serious incident occurred in surgery health group for an unwitnessed fall.
- No themes have been identified amongst the incidents which have been declared for SI investigation.

Actions / Future Plans for Improvement:

- Transition to PSIRF from April 2023 will transform the approach to patient safety incident investigations (PSII) with a move away from the traditional root cause analysis training that most are familiar with to a proportionate systems based approach. This is grounded in human factors, engaging families and staff affected by the incident and a focus on continuous improvement.
- The draft PSIRP has been shared with the Trust Board and is being circulated for circulation for consultation in the Health Group with engagement sessions being held in January and February.
- The ICB are sending a representative to the February PSIRF steering group to provide feedback on the draft PSIRP as part of the approval process.

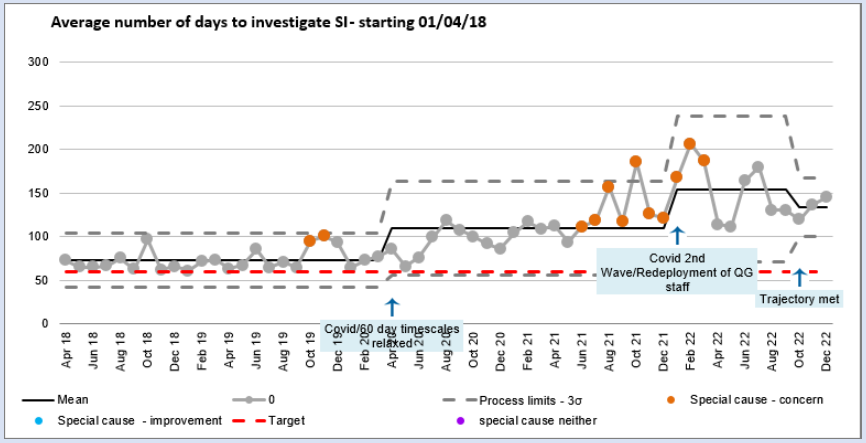
2.3 SERIOUS INCIDENTS COMPLETED WITHIN TIMESCALES

Average number of days to investigate serious incidents

Trajectory for reducing investigation backlog

Aim: To reduce the number of serious incident investigations open more than 100 days

Target: For serious incidents to be investigated within 60 working days



What is the chart telling us:

- The number of days taken to close serious incident investigations has increased slightly during December, this is due to the investigations being some of the oldest open (i.e. 201 and 160 days).
- The number of open investigations has reduced and is still demonstrating a downward trajectory. The trajectory that was set has now been achieved.

Successes:

- In April 2022 a trajectory was set with an aim be in a stable position, within agreed tolerance limits, by October 2022 with a sustainable case load of ~35 open SIs at any time and for no serious incident investigation to take more than 100 days to investigate.
- The trajectory has been met for the number of investigations open at any one time with 32 open at the end of December demonstrating a further downward trend.
- 7 investigations were closed in November and 4 investigations were closed in December.
- 1 investigation was closed within 100-day timescales.

Key Risks and Challenges:

- The average number of days to close an investigation continues to be above 100 days.
- The range of days taken to investigate on those closed in November was 75 to 201 days.
- 9 investigations remained open over 100 days at the end of December which is again showing a downward trajectory on the previous month.

Actions / Future Plans for Improvement:

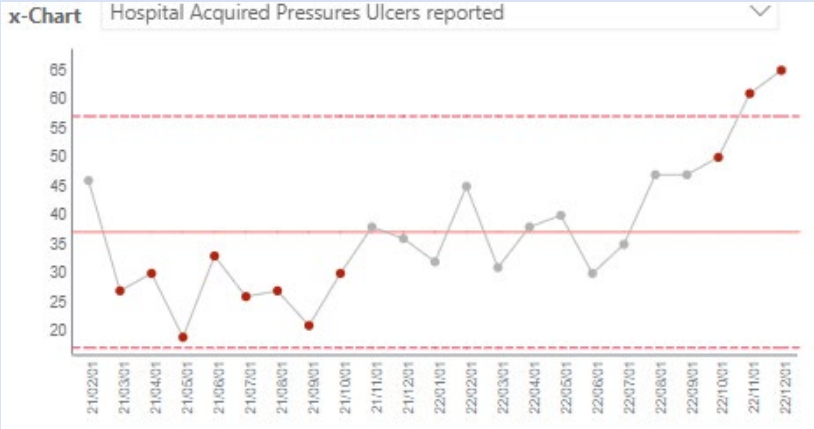
- Work continues to close SIs over 100 days and to ensure families are kept updated.
- The reduction in the number of serious incident investigations being open has resulted in a smaller more manageable caseload that will allow for timelier completion of investigations.
- Sharing the learning from serious incidents in line with a Trust Lessons Learned framework will ensure learning from serious incidents is communicated to all areas within the Trust and actions are embedded.
- Patient Safety Incident Investigation (PSII) Training commenced in November 2022 to drive a systems approach to investigations and improvement.
- Engagement/briefing sessions with individual specialties throughout the Trust has begun to talk about what PSIRF means and the different learning responses to incidents e.g. PSIIs and thematic reviews.
- One session was delivered to over 100 clinicians at the joint obstetric and anaesthetic audit meeting at the beginning of January

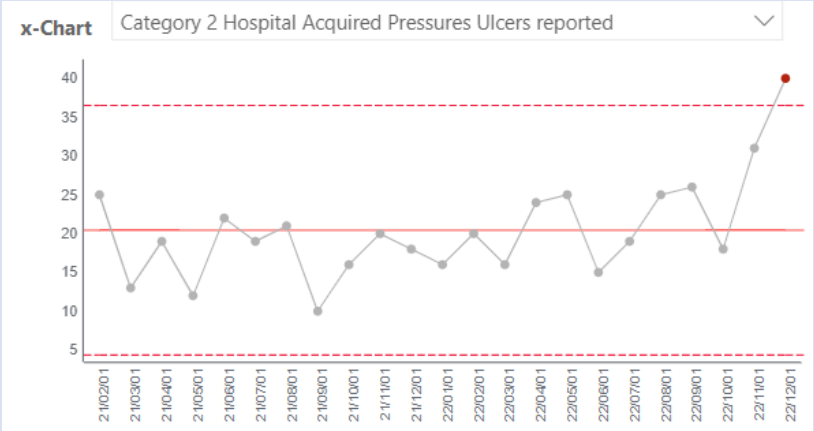
2.4 HOSPITAL ACQUIRED PRESSURE ULCERS CAUSING HARM

Hospital acquired pressure ulcers
Deep Tissue Injury pressure ulcers
Category 2 pressure ulcers

Aim: To have a zero tolerance approach to hospital acquired pressure ulcers

Target: To reduce the number of hospital acquired pressure ulcers to below the mean





What is the chart telling us:

- There were 1.49 pressure ulcers per 1,000 bed days resulting in moderate and above harm in December (n=66)
- The number of pressure ulcers reported has increased and is above the upper control limit for the second month
- Category 2 pressure ulcers have increased above the upper control limit
- DTIs have decreased for the second month
  NB the CPS charts do not include device related pressure damage

Successes:

- Core training around fundamentals of care completed with clinical nurse educator teams – they will now cascade to clinical areas
- Work has started with the digital team on digitalising the wound chart

Key Risks and Challenges:

- There were 36 Category 2 (plus 10 device related) pressure ulcers reported; 17 Deep Tissue Injuries (DTI) (plus 5 device related) and 3 Unstageable pressure injuries (plus 1 device related) and 2 device related unclassified
- Training cancelled due to clinical demand across the organisation
- High five ward rounds not arranged due to staffing challenges

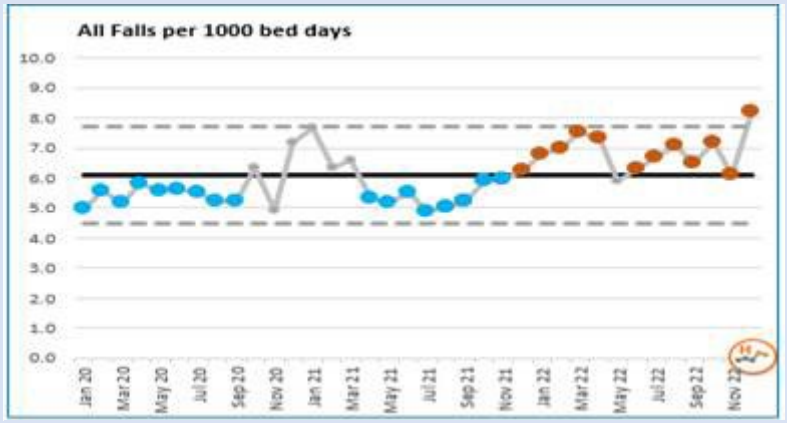
Actions / Future Plans for Improvement:

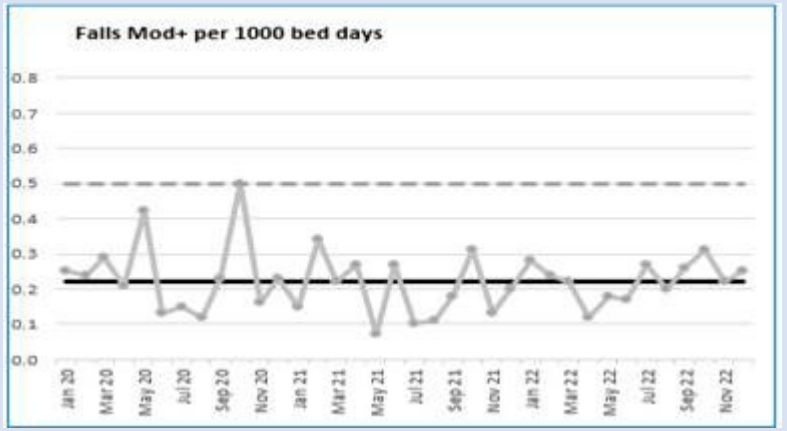
- Re-instate training and high five ward rounds
- Tissue viability link dates in the diary starting in February 2023 – planned for the year
- Link nurse roles and responsibilities being reviewed and will be discussed at task and finish group
- Draft template has been developed for each directorate to report to the Safer Skin Committee – this has gone out and is being trialled

	• Patient information leaflets are being reviewed – comments received and leaflet being updated • Training being arranged with AH on use of bed frames and troubleshooting – going ahead in February.

2.5 INPATIENT FALLS CAUSING HARM

Inpatient falls per 1000 bed days **Inpatient falls resulting in harm per 1000 bed days**	**Aim:** To reduce the number of inpatient falls resulting in moderate and above harm **Target:** To reduce the number of inpatient falls to below the mean





What is the chart telling us:

- There were 8.2 inpatient falls per 1000 bed days in December 2022 (n= 363)
- 0.3 (per1000 bed days) inpatient falls resulted in moderate, severe or catastrophic harm to the patient
- The number of falls being reported over the last month, is above the control limits
- The falls committee are aware of the significant increase of falls in December this may be due the increased numbers of patients with a longer length of stay, this can often increase the numbers of patients having multiple falls. In December 2022, 63 (out of 363 falls) patients fell more than once, with a range of between 2-15 falls. Also through training we are stressing the importance of datix reporting and the need to complete one datix for each fall, this may impacting in the number of reported falls. We also know that the number of falls will rise due to the increasing prevalence of multimorbidity, polypharmacy and frailty.
- We have also recognised that the majority of falls happen between midnight and 03:00 the reasons for this could be multifaceted, less visible staff (ie at breaks), disturbed sleep through purpose T compliance and the impact on patients with a cognitive impairment and dementia.

Successes:

- Staff Training continues across the Trust, both online and face to face training (796 staff have received face to face), moving toward the Trust target of 85% of staff having completed training in line with their role. Attendance has also included staff from Radiology and Ophthalmology

Falls Training 2022 from the end of Feb 2022 to Dec 2022

Row Labels	Training Completed	Training Outstanding	Grand Total	%
Falls Prevention	195	1044	1239	15.7%
Preventing Falls in Hospital: Carefall	37	34	71	52.1%
Preventing Falls in Hospital: Fallsafe	1476	1413	2889	51.1%
Grand Total	**1708**	**2491**	**4199**	**40.7%**

- Flojac (Device for moving patients) education to date, has been delivered to 142 members of staff face to face

Key Risks and Challenges:

- With the ongoing face to face training continuing to be successful, it has become apparent that there will be no suitable training rooms available at HRI after March 2023, options are being considered. This could affect the Strategic goal of 85% of staff receiving falls training
- A business case to obtain sufficient flat lifting equipment is in progress to ensure patient comfort and staff safety when patients are moved from the floor

Actions / Future Plans for Improvement:

- Development of a Falls Champions network, to share lessons learned, best practice and quality improvement initiatives. The aim is to have 1 registered and 2 non registered Champions on each ward
- Implementation of improvement programme to see a reduction in patients coming to harm from falls against strategic ambition ‘harm free care’ in the Quality Strategy 2022/2025
- A meeting was held on the 10 January 2023 in order to decide Falls Committee aims/ objectives during 2023. This information will be added to the Trust falls strategic plan
- A long term falls QIP is being discussed, this aims to identify improvement projects to reduce the number of inpatient falls in 2023- 2025

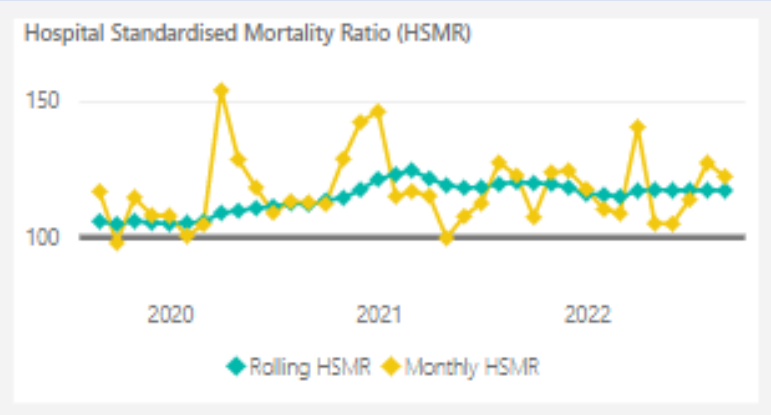
3. EFFECTIVENESS DOMAIN

3.1 MORTALITY

Hospital Standardised Mortality Ratio (HSMR)

Aim: To reduce the HSMR to below the national average of 100 and improve patient outcomes

Target: Below 100



What is the chart telling us:

- HSMR reporting period to September 2022 (latest period available on the BI Mortality Dashboard)
- HSMR continues to demonstrate 'higher than expected deaths' and is above the national average and target of 100
- The rolling HSMR is 117.21 and the monthly (September 2022) HSMR is 122.32

Successes:

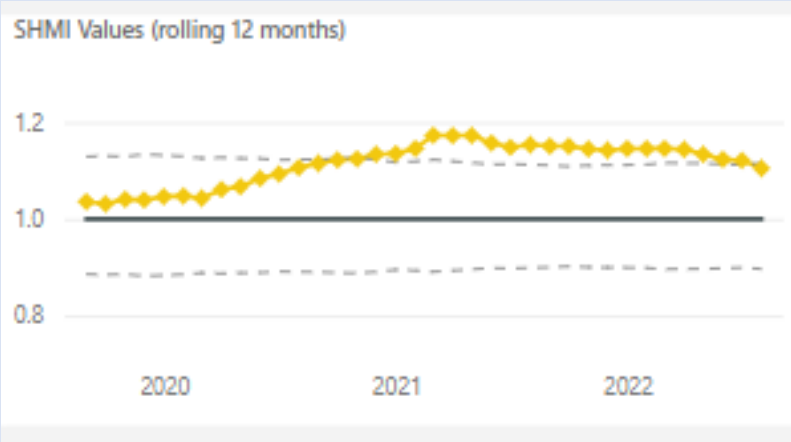
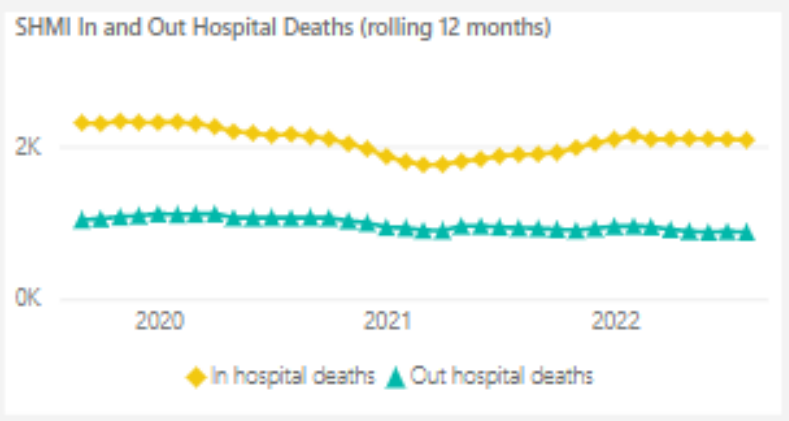
- The rolling HSMR is steady showing a consistent mortality rate during 2022 compared with the spikes demonstrated in 2021

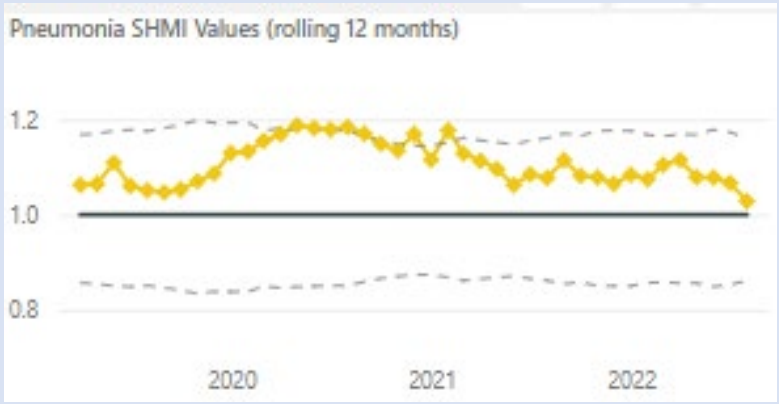
Key Risks and Challenges:

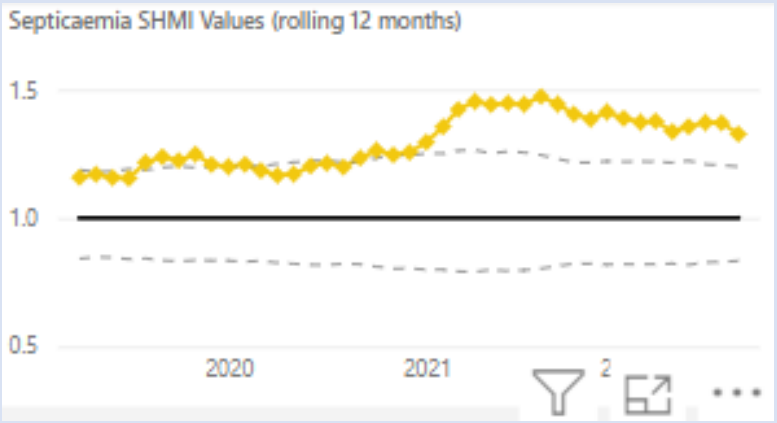
- The Trust continues demonstrate 'higher than expected deaths' and is an outlier against its HSMR

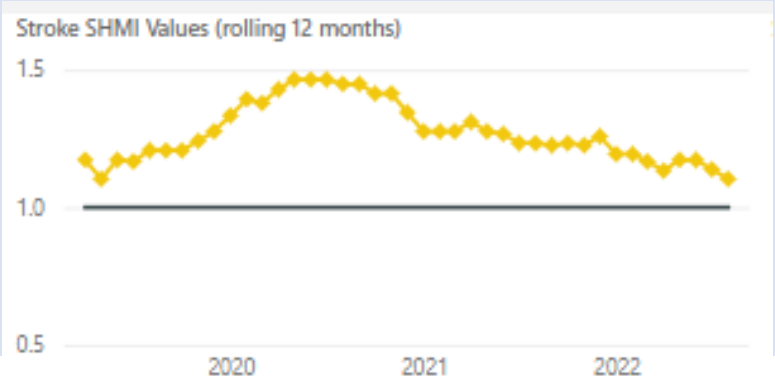
Actions / Future Plans for Improvement:

- The Mortality and Morbidity Task and Finish Group continue to meet monthly to closely monitor the mortality data and to work on improving the areas that are highlighting as a potential risk
- The Mortality and Morbidity Task and Finish Group will run alongside the Sepsis and Pneumonia Steering Groups. The M&M Task and Finish Group will continue to closely monitor the mortality data, undertake benchmarking and comparison work and highlight areas for further investigation and seek assurance from the other established steering groups

Summary Hospital-level Mortality Indicator (SHMI)	**Aim:** To reduce the SHMI to below the national average of 1.0 and improve patient outcomes **Target:** Below 1.0
 	**What is the chart telling us:** • Charts are displaying performance for a rolling 12 month period. Latest data is August 2022 • Trust SHMI has continued on a downwards trend since the end of 2021 and in August 2022 it dropped further to 1.11 and moved from 'higher than expected deaths' to 'expected level of deaths' • The out of hospital deaths remain consistent against the SHMI • Pneumonia SHMI continues to demonstrate a downward trend and in August 2022 it moved from 'higher than expected deaths' to 'expected level of deaths' with a SHMI of 1.03 compared with its highest point of 1.19 in May 2020 • Sepsis SHMI continues to demonstrate 'higher than expected deaths' with an excess of 55 deaths. Although it remains 'higher than expected' performance is demonstrating an improving journey from its highest point of 1.47 in August 2021 to 1.33 in August 2022 • Stroke SHMI continues to an improving journey also. It has improved from 1.46 in 2020 to 1.10 in August 2022. **Successes:** • The overall Trust SHMI has reduced further and is now within the 'expected levels of deaths' with a SHMI of 1.11 • The Trust is no longer highlighted at one of the top 12 Trusts with an outlier status by NHS Digital • Pneumonia SHMI has reduced further and is now within the 'expected levels of deaths' with a SHMI of 1.03 in August 2022 compared with a SMHI of 1.19 at its highest point in 2020. • Stroke SHMI has also improved further with a SHMI of 1.10 in August 2022 compared with a SHMI of 1.46 at its highest point in 2020.







Key Risks and Challenges:

- The top 3 common clinical conditions remain Sepsis, Pneumonia and Stroke

Actions / Future Plans for Improvement:

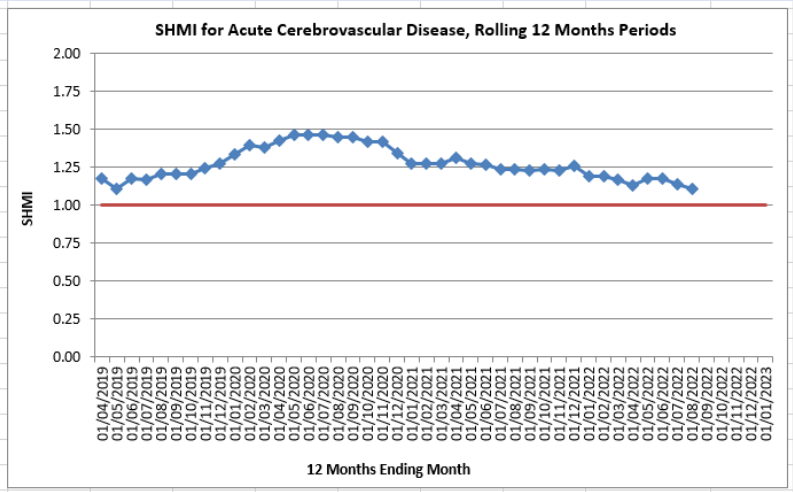
- The Mortality and Morbidity Task and Finish Group continue to meet monthly to closely monitor the mortality data and to work on improving the areas that are highlighting as a potential risk
- The Mortality and Morbidity Task and Finish Group will run alongside the Sepsis and Pneumonia Steering Groups. The M&M Task and Finish Group will continue to closely monitor the mortality data, undertake benchmarking and comparison work and highlight areas for further investigation and seek assurance from the other established steering groups
- UTI mortality is increasing and therefore, the Mortality Task and Finish Group are undertaking some further analysis to understand if there is a cause of concern.

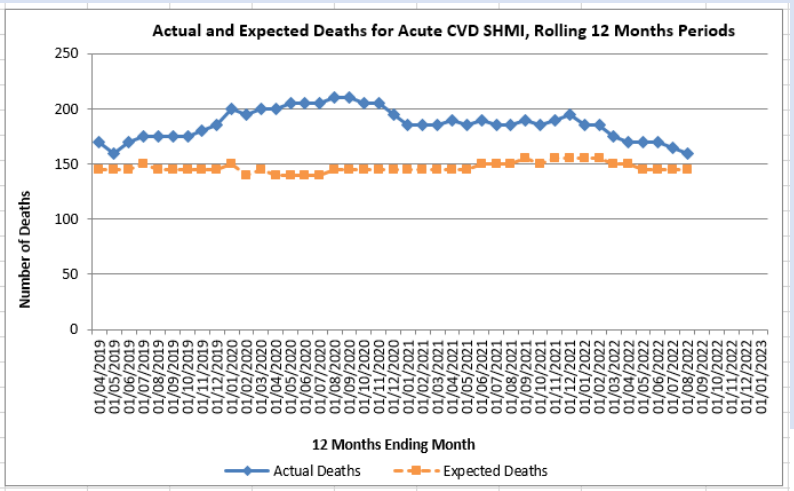
3.2 STROKE

Summary of Stroke 30-day mortality

Aim: To reduce the HSMR to below the national average of 100 and improve patient outcomes

Target: Below 100





What is the chart telling us:

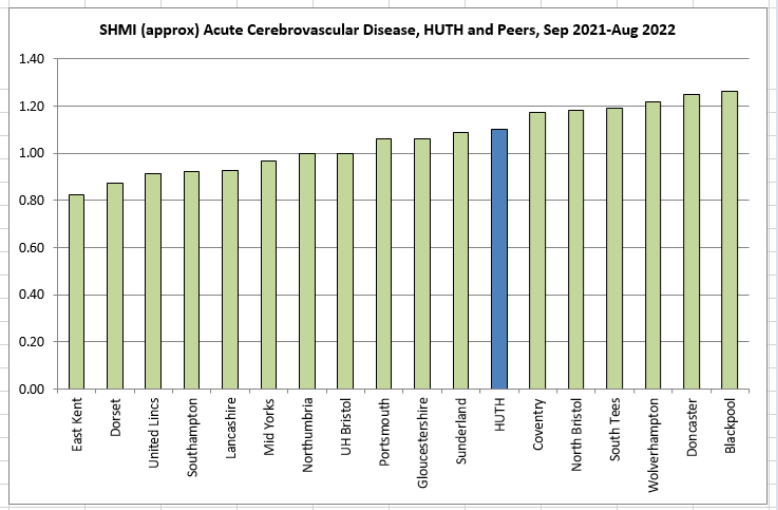
- The SHMI for Stroke is continually reducing. It has improved from 1.46 in 2020 to 1.10 in August 2022.
- The gap between expected deaths and actual deaths is getting closer
- HUTH continues to be one of middle performing Trusts against its peers for Stroke SHMI
- 73% of the stroke admissions were cared for on a Stroke Ward

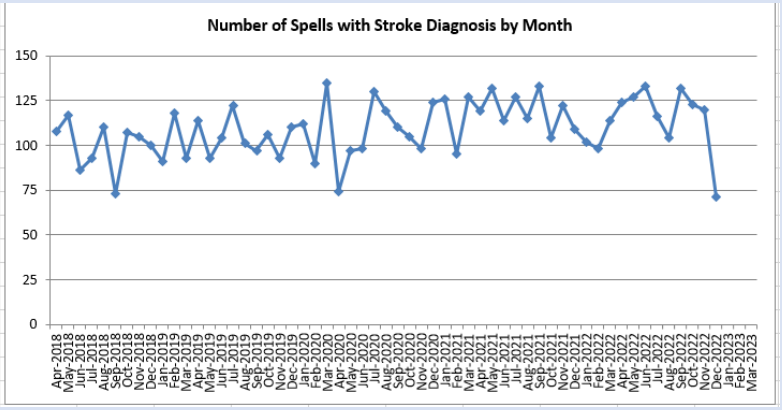
Successes:

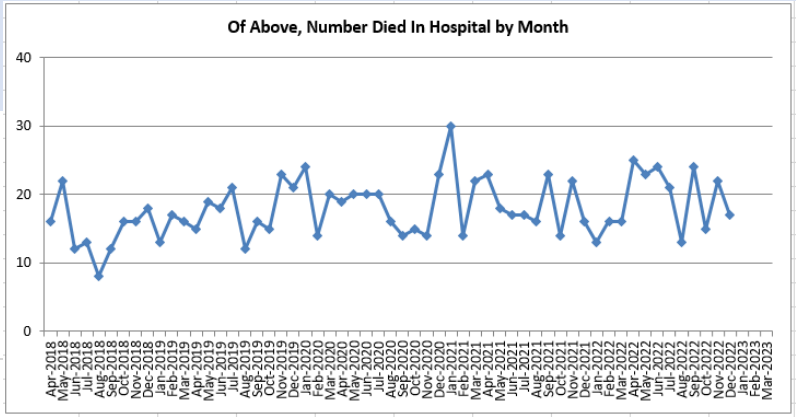
- Stroke SHMI has also improved further with a SHMI of 1.10 in August 2022 compared with a SHMI of 1.46 at its highest point in 2020.
- 73% of the stroke admissions were cared for on a Stroke Ward
- The Stroke Service now undertake an SJR review on all deaths

Key Risks and Challenges:

- Stroke SHMI continues to be higher than expected







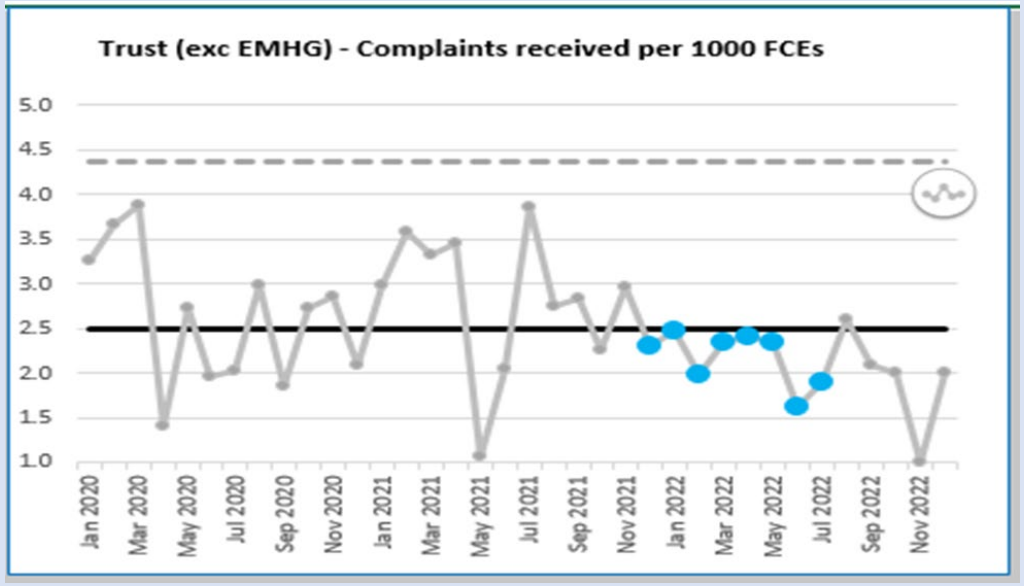
Actions / Future Plans for Improvement:

- Continue to deliver the Stroke improvement plan, improving the services and outcomes for patients being cared for on or off a Stroke ward at HUTH
- Continue to review all Stroke deaths, present the findings and learning to the Stroke M&M Meeting
- Provide regular updates to the Mortality and Morbidity Committee

4. RESPONSIVE DOMAIN

4.1 COMPLAINTS RECEIVED

Trust (exc EMHG) - Complaints received per 1000 FCEs



Aim: Minimise formal complaints & increase PALs/Early resolution

Target: 2.5

What is the chart telling us:

- 12/13 data points below average
- 19 formal complaints (treatment is the largest theme)
- 23 Early Resolution complaints

.	CSHCG	FWHCG	MHCG	SHCG	Total
Attitude	2	1	0	1	4
Care and comfort including privacy and	0	0	4	0	4
Communication/Record Keeping	0	1	1	1	3
Delays, waiting times and cancellations	3	2	2	2	9
Discharge	0	0	1	1	2
Environment	0	0	0	1	1
Treatment	1	8	5	5	19
Totals:	6	12	13	11	42

Successes:

- Early Resolution (responding within 10 working days) successfully reducing complaints that move to the full formal process)
- Dementia activity volunteers established (25 in total)

Key Risks and Challenges:

- Logging complaints within timeframe (backlog reducing)

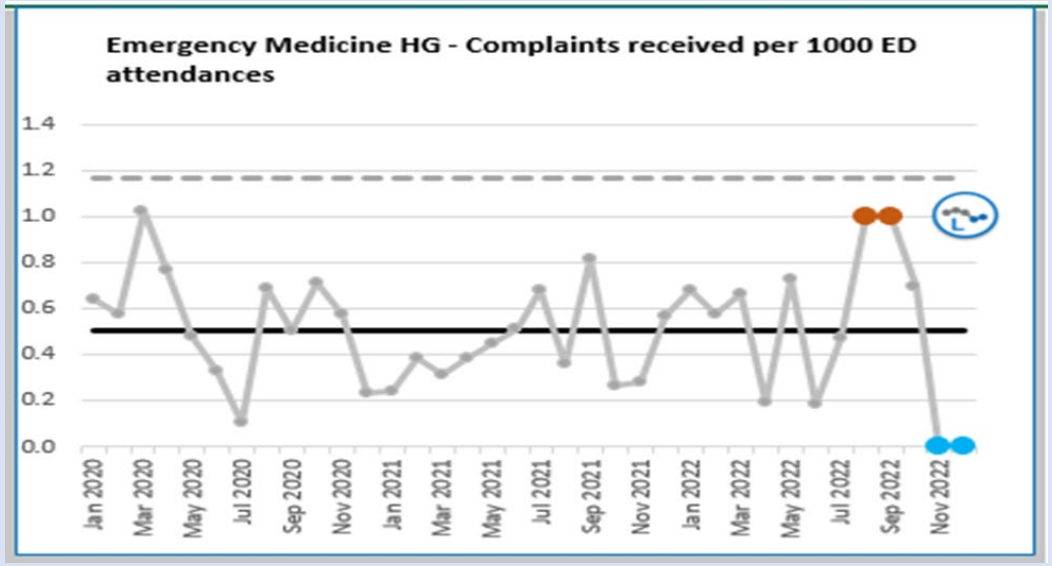
Actions / Future Plans for Improvement:

- Central team need to clear the inbox of new cases to log by end of each working day

Emergency Medicine HG - Complaints received per 1000 ED attendances

Aim: Minimise formal complaints & increase PALs/Early resolution

Target: 0.5



What is the chart telling us:

- 2 data points below average
- 2 Formal complaints (delays & treatment are the largest themes)
- 3 Early Resolution complaints

.	EAMHG	Total
Attitude	1	1
Delays, waiting times and cancellations	2	2
Treatment	2	2
Totals:	5	5

Successes:

- Early Resolution working well for ED (3 complaints closed within 10 working days and less onerous than full formal complaint process)
- EMHG are responsive to actions following complaints
- Patient Story from ECA in process of recording for Trust Board

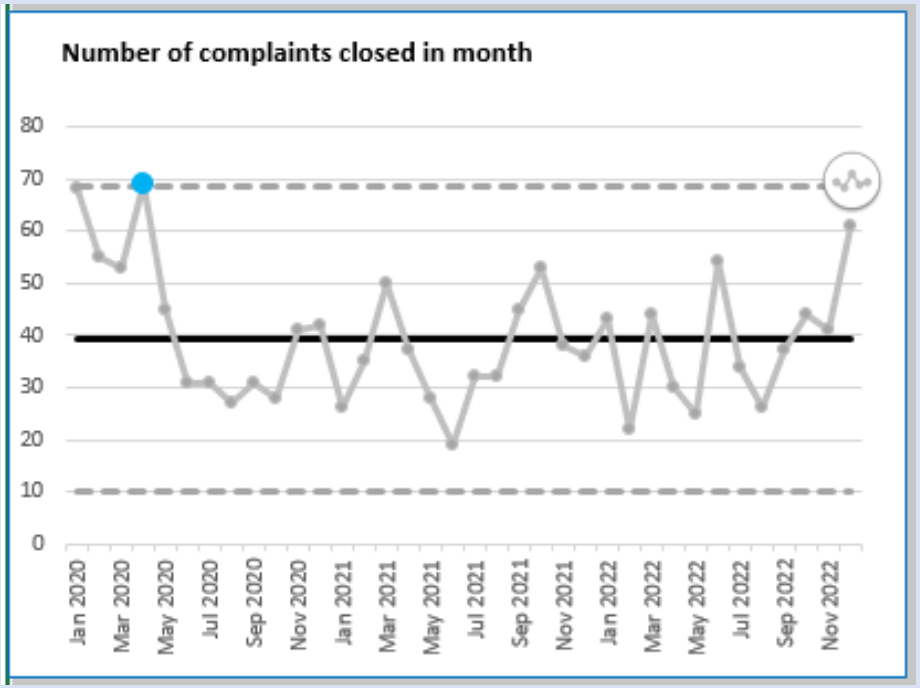
Key Risks and Challenges:

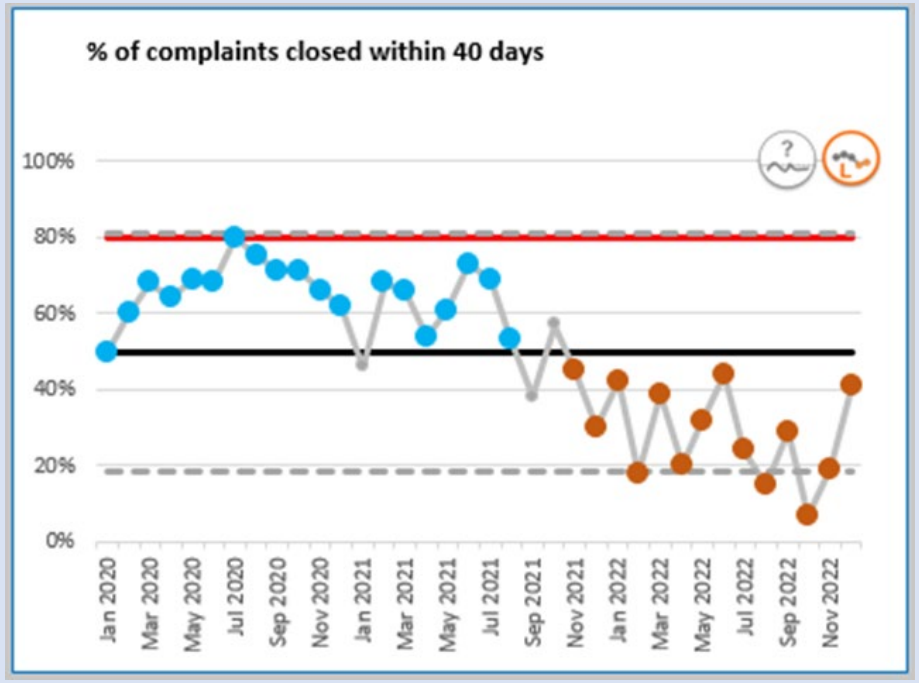
- Continue to maintain the very good performance of response times

Actions / Future Plans for Improvement:

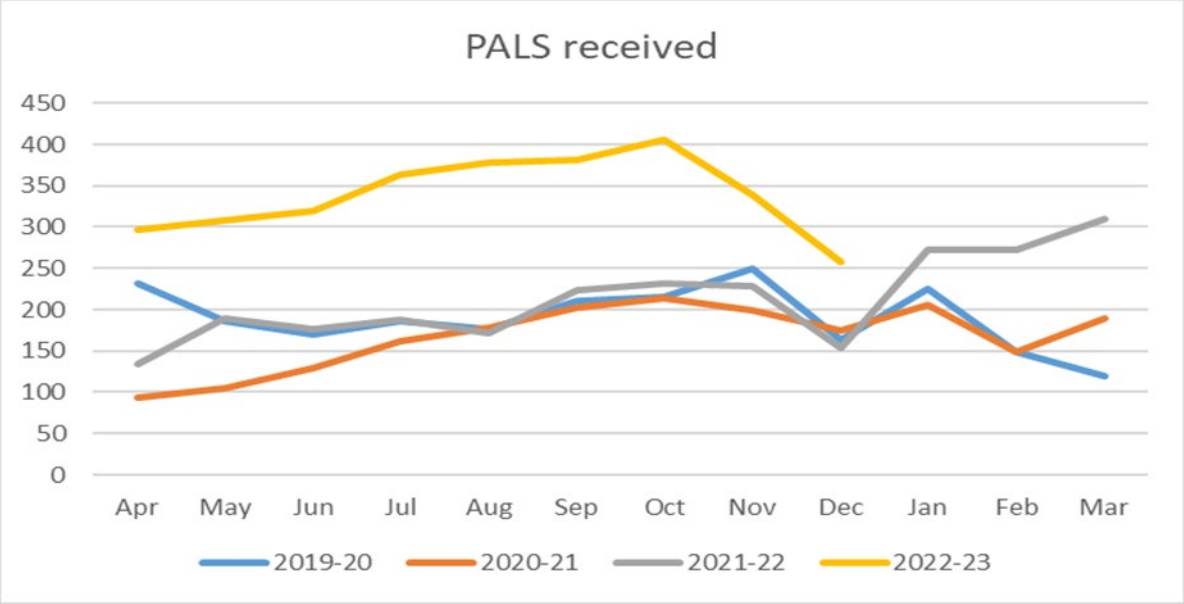
- Consolidate Early Resolution process.

4.2 COMPLAINTS CLOSED

Number of complaints closed in month	Aim: To close more each month than opened Target: 40 (minimum) closed per month
	**What is the chart telling us:** • Improving performance **Successes:** • Weekly challenge meetings and engagement from SHG & MHG positive **Key Risks and Challenges:** • F&WHG challenge meetings need consolidation and embedding into BAU **Actions / Future Plans for Improvement:** • Learning from complaints and patients experience to be reflected in action plans. • Action plans to be closed within timeframe.

% of complaints closed within 40 days	Aim: Increase % of complaints closed within 40 day target Target: 80%
	**What is the chart telling us:** • Performance remains below target but improving (Early Resolution cases helping performance) **Successes:** • Improved performance since November when the weekly HG challenge meetings were introduced **Key Risks and Challenges:** • Historical backlog remains a challenge. • HG engagement with weekly challenge meetings **Actions / Future Plans for Improvement:** • Weekly challenge meetings to be embedded into BAU • Recruitment April start date band 6 Patient Experience Manager • Advert out for a Band 7 Patient Experience Lead • Promote Early Resolution cases (closed within 10 working days) • Deliver patient experience plan that was presented to the Patient Experience Sub-Committee (Jan 23)

4.3 PALS RECEIVED

Number of PALS received by month	Aim: Prevent PALS becoming formal complaints Target: monitor
	**What is the chart telling us:** • 3048 cases logged April –December 2022 compared with 1696 the previous year (79% increase in activity) **Successes:** • Early resolution response (10 working day) process introduced **Key Risks and Challenges:** • Substantial increased activity continues throughout 2022 compared with previous years. The main themes are delays, waiting times and cancellations **Actions / Future Plans for Improvement:** • PET are working with the continuous quality improvement team (CQI) to look at possible quick wins to reduce some of the PALS calls • Other members of the wider Governance team will be provided with training to handle PALS calls to provide increased resilience within the team • Early Resolution process consolidation as per PHSO complaints handling framework

5. WELL-LED DOMAIN

5.1 CONTINUOUS QUALITY IMPROVEMENT

Training

A number of ongoing Quality Improvement QI courses continue to be available for staff developing their tools & techniques to support improvement initiatives. In addition to the Quality Service Improvement and Redesign (QSIR) Fundamentals one-day and the QSIR Practitioner 5 day course additional bespoke training sessions utilising QSIR course content is available to teams across the Trust. A number of ad-hoc sessions have been provided by the CQI team including the Medical Physics team, the Plastics team and to Junior Doctors via the Blackboard learning platform. Promotion of bespoke training sessions will continue throughout the Trusts and will include availability of training based on individualised scenarios for example, a team would like to improve patient waiting times but unsure where to start or how to sustain improvements – the training incorporates key QI tools and methods in order to support teams to develop and progress with their own improvement projects.

Quality Improvement Projects

A repository has been created to capture information on the number of improvement projects currently being undertaken across the organisation. To date, 40 have been shared.

The CQI website is currently under development and will act as a hub for staff to access information, utilise learning, network with staff across the trust in order to support and further embed a culture of continuous quality improvement. The CQI website will also host the digital repository of QI projects.

Junior Doctors QIPS

Support continues to be provided to the Leadership Fellow for Patient Safety and Quality Improvement; and the development of the Junior Doctors (JD) QIP bank where a number of projects around, sepsis, pneumonia, deteriorating patient, UTI, antimicrobial stewardship and tobacco dependency treatment had been agreed where Junior Doctors could support with including collection of baseline data.

A majority of the projects are now underway with QI teams established for each of the projects. Moving forward, a number of smaller QIPs are required which will feed into the overall aim for each of the projects.

Discussions have been held with the current Leadership Fellow around succession planning, following appointment of the new Leadership Fellow later in the year enabling the bank of Junior Doctors QIPs to continue.

Large Scale Improvements

A large scale improvement programme is currently being developed for perinatal services. An initial scoping session for the Perinatal Improvement Programme (PIP) Friday 24 March 2023. A range of stakeholders including patients have been invited to take part in order to identify improvements required in maternity and antenatal services.

5.2 THINKTANK

As of January 2023, the ownership, administration and monitoring of Think Tank was fully transitioned to the CQI team. Monthly Think Tank Group meetings also commenced in January 2023 with the Head of CQI chairing the meeting.

To date, **168** Think Tank ideas have been submitted via the Think Tank platform of which:

- **25** have been marked as 'in progress'
- **122** have been marked as 'to be started'
- **21** have been marked as 'completed'

Of the **122** marked as to be started, the Think Tank Group are assured that a majority of the submissions received were in progress ,however the Think Tank website required updating to reflect this. In order to support staff with providing updates, a step by step guide for updating Think Tank will be circulated.

Think Tank has generated a number of ideas for improvements across the Trust, and the following are examples of some of successes made:

- Submission regarding providing a space for staff and patients for spiritual reflection and prayer. The member of staff was connected with Rev. Tony Brookes who was able to meet with the staff member to advise that a shared spiritual space was being made available in the very near future. Rev. Tony Brooks was able to meet with the staff member to show them the space and also discuss additional ideas around how the space could be used.
- A submission was received highlighting requirements to simplify the patient referral pathway for Cardiac Rehab Services at CHH. Following submission of the idea, a process mapping session was held with Cardiac Rehab Services and during the session, a solution was identified that could potentially remove 20 plus steps from the current process which could potentially benefit staff with reduced administrative process and improve patient experience. Further meetings have been organised with H:Digital to discuss potential utilisation of alternative systems to improve the referral pathway.

- A number of submission shared with Estates team in support of the Zero-30 strategy were marked as complete as they were identified as long term improvement plans which would take a number of years and capital in order to complete.

Moving forward, the focus will involve promotion and fostering conversations regarding Think Tank to generate interest, engagement and more ideas along with ways to continually develop the Think Tank platform and ways to capture and theme data following submissions received.

5.3 CELEBRATION AND LEARNING

Celebration Event

The next celebration event showcasing improvement work undertaken across the Trust is scheduled to take place on Friday 24 February from 09:30am-12:00pm as in person event. staff have agreed to present their improvement projects at the event:

- Matt Smith and Amy Stuart, 'Improvements in Staff Health and Wellbeing'
- Dr Austin Smithies, 'Improvements in Emergency Department'
- Mr Ramdas Sensasi and team, 'Improvements to Paediatric Radiology'
- Miss Noemi Kelemen, 'Medical QI led improvements'

Tickets are available via Eventbrite.

CQI Website

A CQI website is currently under development which will promote continual quality improvement, provide tools and templates for staff to download and support with their improvement projects, create and support an improvement network where ideas and learning can be shared, video tutorials, details of QSIR training available, news and updates in relation to QI, links to other QI tools and so forth. The website will be available from April 2023.

Hull University Teaching Hospitals NHS Trust
Trust Board and Committee Front Sheet

Agenda Item	8.4	**Meeting**	Trust Board	**Meeting Date**	14th February 2023
Title	Infection Prevention & Control Board Assurance Framework (IPC BAF)				
Lead Director	Director of Infection Prevention & Control				
Author	Greta Johnson				
Report previously considered by (date)	Strategic Infection Reduction Committee (21st December 2022)				

Purpose of the Report		**Reason for submission to the Trust Board private session**		**Link to CQC Domain**		**Link to Trust Strategic Objectives 2021/22**	
Trust Board Approval		Commercial Confidentiality		Safe	√	Honest Caring and Accountable Future	
Committee Agreement		Patient Confidentiality		Effective	√	Valued, Skilled and Sufficient Staff	
Assurance	√	Staff Confidentiality		Caring	√	High Quality Care	√
Information Only		Other Exceptional Circumstance		Responsive	√	Great Clinical Services	√
				Well-led	√	Partnerships and Integrated Services	
						Research and Innovation	
						Financial Sustainability	

Key Recommendations to be considered:

The report provides a progress update on the IPC BAF. Significant progress and traction has been achieved since the last update to the Trust Board with a number of work streams developed and delivered to meet the requirements of the BAF, inclusive of antimicrobial stewardship, management of carbapenemase-producing Enterobacterales (CPE), development of an IPC work programme, including improved completion & compliance with IPC Fundamental Standards and additional work streams scheduled to come online as a result of the IPC BAF including Ventilation Safety Committee and a 'Back to Basics' IPC campaign.
Nationally, the IPC BAF is being reviewed and an updated version aligned to the Health and Social Care Act 2008: code of practice on the prevention and control of infections (commonly referred to as the Hygiene Code) is likely to be published from April 2023 onwards. The progress made to date and the Trust's focus on developing a robust IPC BAF will provide a solid foundation with which build upon once the new IPC BAF is published.

Infection Prevention & Control (IPC) Board Assurance Framework (BAF)

Progress update February 2023

Background

During the COVID19 pandemic NHS England (NHSEI) produced a series of IPC BAF templates in line with current national IPC guidance. National feedback of the Trust's IPC BAF and visits from NHSEI resulted in the Trust convening an IPC Task & Finish Group with a focus on the BAF and its associated content. Focus groups and sub groups, not exclusively infection prevention & control service driven was convened so that groups would have ownership of the elements of the BAF.

The Quality Governance Directorate and IPC Service continue alongside the Senior Corporate Nursing team to ensure the BAF remains a 'live' document and that monitoring of the BAF is facilitated via the existing IPC meeting structure.

The national approach to the ongoing pandemic is in line with reduced prevalence and incidence of COVID19 circulating in the community and as such is encouraging healthcare settings to return to pre-COVID19 pandemic systems and processes. This is underpinned with the application and adoption of the National Infection Prevention & Control Manual (NIPCM) and will form the basis alongside the existing Health and Social Care Act 2008: code of practice on the prevention and control of infections as a measure of compliance and assurance.

Update

On the 28th September 2022, in preparation for winter, NHSE published an updated Infection Prevention & Control Board Assurance Framework (IPC BAF). To date no further versions have been published therefore Version 1.11 remains the 'live' IPC BAF.

A convened developmental Strategic Infection Reduction Committee (SIRC) on the 21st December 2022 provided an opportunity to discuss and scope the IPC BAF, provide assurance against the key lines of enquiry (KLOE) underpinned with evidence and identify gaps and mitigating actions. Where risks are identified these would be incorporated within the appropriate risk register.

Progress to date includes fortnightly convened meetings to discuss each of the elements of the IPC BAF with other individuals/ teams co-opted to inform discussions and provide the relevant evidence. Core members of this group include the CNO, DIPC, Consultant Microbiologist/ICD, Associate Director of Quality and IPC Matrons. However, priorities are captured via SIRC, tabled every other month with focus groups to lead, influence, and action / embed change and improvement. Priorities have included antimicrobial stewardship, Estates & Facilities in particular water & ventilation safety, and compliance against the National Standards of Healthcare Cleanliness and the identification/ management of resistant infections e.g. carbapenemase-producing Enterobacterales (CPE). In addition, presentations and updates have been provided via Quality Committee and Board Development sessions.

Priorities from the previous IPC BAF task and finish group included IPC service delivery and development of an IPC work programme, were also identified via NHSE and the external auditors (RSM) and these actions have been incorporated into an IPC Work Plan which is being tabled at OIRC on the 14th February 2023. The IPC BAF remains a 'live' document

and continues to be monitored via OIRC and SIRC. Outputs and areas requiring additional focus are captured via the SIRC development meetings and the stand alone fortnightly IPC BAF development meetings.

During 2022, NHS England convened a working group with regional representation tasked with updating the current national IPC BAF which is mainly respiratory focused. The updated IPC BAF will be aligned to the Health and Social Care Act 2008: code of practice on the prevention and control of infections (commonly referred to as the Hygiene Code). The Code was refreshed in December 2022 taking account of changes to the IPC landscape and nomenclature that have occurred since the COVID-19 pandemic. The IPC BAF is likely to be aligned to the ten compliance Criterion:

Criterion 1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
Criterion 2	The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
Criterion 3	Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.
Criterion 4	The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.
Criterion 5	That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.
Criterion 6	Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
Criterion 7	The provision or ability to secure adequate isolation facilities.
Criterion 8	The ability to secure adequate access to laboratory support as appropriate.
Criterion 9	That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.
Criterion 10	That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.

In preparation for a national updated version the IPC BAF development group are being cognisant of the above criterion when populating and updating the Trust IPC BAF, enabling the Trust IPC service to be primed once this updated version is published.

Report drafted by:

Greta Johnson

Director of Infection Prevention & Control (DIPC)

NHS
Hull University Teaching Hospitals
NHS Trust

Mental Health, Learning Disabilities and Autism

Presentation to the Trust Board

Tuesday 14th February 2023

Kate Rudston - Assistant Chief Nurse and Safeguarding Lead

NHS
Hull University Teaching Hospitals NHS Trust

Mental Health, Learning Disability and Autism Strategy 2022-2027

Our vision for Mental Health, Learning Disability and Autism services over the next 5 years is:

The needs of people with mental health, learning disability or autism have their needs met when receiving services from Hull University Teaching Hospitals NHS Trust.

1. Patients and Service Users will have a positive experience of care

Develop and support local and national initiatives to reduce the impact of mental ill health and associated physical health issues. ICB collaborative, pathway redesign with partners, public health

Support the delivery of reasonable adjustments for patients and carers within the acute service environment, both individually identified and environmentally. ED environment, paediatric areas, promoting care givers, ECT, raising awareness, LD Liaison etc.

Support delivery of patient engagement and experience initiatives.

Create communications systems that actively seek to gain patient and essential care givers feedback.

Embed digital systems that provides ongoing quality data to guide targeted quality improvement projects.

Ensure the trust provides safe therapeutic environments for mental health, learning disabilities and patients with autism which conform to national standards. This is particularly pertinent in the Emergency Department. Commenced, delivered in Paediatrics and ED before end of March 2023.

Ensure barriers for patients who are in crisis, or who have been identified as having the need for care in a more appropriate care environment, other than the acute trust, are removed to enable timely and safe relocation depending on need. Escalation pathways, incident management, good progress made and reported back

Ensure the trust has robust information systems that can identify patients with learning disabilities and autism to enable scrutiny around waiting times, incidents and outcomes of care episodes. Virtual wards, vulnerabilities fields on datix, referral to LD liaison nurse and SG, feedback. Weekly high level reports.

Continue to develop and promote the perinatal mental health service, in conjunction with the mental health experts within the maternity services. Presenting to MH, LD and Autism Committee – positive position – work required to take vulnerabilities oversight forward with BI and outcomes.

2. We will ensure high quality care, access to and integration of services

Develop leadership roles to promote the services and provide expert advice and support to the staff in the Trust which, in turn will enable high quality care to be delivered to patients (leadership and named roles specific to Mental Health and Learning Disabilities). Working with CMO on Named Medical Roles for each – progressing LD.

The Trust Board to work with local authorities, commissioning groups and integrated care providers to improve cross-sector planning and commissioning, to ensure that all patients have access to the physical, mental and social care they need. ICB collaborative.

The Trust to work to improve the system-wide pathways of mental health care by aligned coding and sharing of data. ICB MH collaborative and Suicide Prevention – work commenced on coding in ED on self harm.

The Board to continue to work with commissioners ensuring that people experiencing a mental health crisis are able to access meaningful alternatives to the emergency department. ICB collaborative.

Demonstrate that mental health, learning disabilities and autism is considered frequently at board level. Presentation in December to Trust Board Development, updates to Quality Committee, patient stories.

Expert patients and carers for mental health, learning disabilities and autism must be consulted when new physical and service developments are being planned and implemented. Requires work and progress.

Ensure collaboration with mental health services for children and young people. Huge amount of work internally and externally – risk register and mitigation. Inspire collaboration and ACP from Humber supporting paediatrics with very positive results on education, supervision, liaison and transfer of care.

Continue to develop a vision to ensure that all who need support from acute mental health inpatient unit accommodation are able to access it when it is needed. Requires work and as part of the ICB MH collaborative work and pathway redesign.

3. We will work in partnership with other organisations to share information, promote safeguarding and promote suicide prevention measures

Strengthen governance structures and IT infrastructure to assist sharing of information. Partnership meetings, escalation of concerns, task and finish groups, ICB collaborative and suicide prevention. Digital documentation and assessment/triage tools, flagging systems in place but need further cleansing and promotion in primary care.

Continue to support shared objectives and improvement projects. ED QIP, Humber and HUTH working together task and finish group focussing on paediatrics – eating disorders and Mental Health.

Following Covid 19 restrictions, re-establish relationships and networks with regional and national mental health and learning disability lead professionals. Completed and ongoing as part of the ICB structures.

Develop networks with experts regionally and nationally in the Autism arena. Commenced as part of the ICB collaborative.

Join, support and lead research proposals and projects. Nothing to update on.

4. We will have a workforce that is knowledgeable and skilled in delivering care to people with Mental Health conditions, Learning Disability and/or Autism

Supporting Trust staff, regardless of role, to complete a programme of learning, based on Oliver McGowan training (National training piloted in 2021/22 which will be recommended as mandatory, Health Education England) for Learning Disabilities and Autism. Commenced scoping as per HEE.

Provide a range of training opportunities that gives staff the necessary knowledge, skills and confidence for meeting children, young people and adult's mental health needs. Working with ACP Humber FT, HEY 24/7, MCA/MH training sessions, DMI training.

Identify and develop innovative roles for supporting staff with the care of children, young people and adult patients with mental health, learning disabilities and autism diagnosis. ACP Humber FT, LD Liaison, scoping medical lead roles, Inspire and joint working on eating disorders. Working with Specialist Doctor for LD in Humber FT to look at medical training and learning from cases.

Offer individual support to staff members who may be carers for relatives living with mental health issues, learning disabilities and or autism. Needs scoping but we already offer flexible working and a range of policies to support staff.

The trust will offer mental health care for patients alongside support for staff wellbeing. Staff support initiatives and well being, supervision, OH support, counselling, chaplaincy, psychologists etc.

Support staff in the safe and appropriate use of deprivation of liberty, restraint and capacity to consent decisions. MCA matron, training, virtual wards, LD Liaison, SG, ED visits, Paediatric ward rounds, Security liaison, DMI training, further work ongoing.

Partnership working is key to success!

We work closely with our Partners:

Safeguarding Adults and Children's Boards – Hull and East Riding
Prisons, Probation and Community Safety Partnership
Learning Disability Partnership Boards
HNY ICB Suicide Prevention
HNY ICB Mental Health Crisis Care Concordat
LEDER Steering Group and Panel
Changing Futures – Hull City Council
Right Care Right Person
Homeless Team
Humberside Police
Public Health

Internal governance

- Trust Board
- Quality Committee
- Patient Experience Sub Committee
- MH, LD and Autism Steering Group (covers; Children and Young People, Perinatal MH, Crisis and Liaison Team)
- ED QIP working group – looking at MH and the RCEM standards
- Maternity Steering Group (SG and Vulnerabilities pathway)
- MH working together (Humber and HUTH – paediatrics)
- Frequent Attenders MDT - ED
- Fundamental Standards
- Policies
- MH, LD and Autism Strategy
- LD and MH activity data
- SLA – Humber FT Legislation Department
- Flagging
- PATTIE
- Training – Oliver McGowan 2023
- Complaints, Incidents, SG, discharge liaison, Community LD Team, community profiling etc.

How do we know we are getting it right?

- Positive outcomes and patient journeys – seeing less complaints than a few years ago – working with regular service users and direct admissions etc.
- High level reports – children and adults – weekly for all patients detained, risk to others, LD, MH and complex SG issues.
- Complaints/PALs
- Incidents
- LEDER
- Safeguarding Reviews
- Respect Forms
- Fundamental Audits and Business Intelligence
- Feedback from service users, staff, partners etc.
- Medical Examiners – SJR – vulnerabilities list from March 2023
- Regulation 28/Coroners
- Commissioners/ICB
- CQC
- Improvements in MH detainment compliance (from 7 out of 11 in Q2 illegal to 5 out of 13 in Q3 – small progress but definitely better with continued work and awareness)
- Draft CQC report has some very positive references to staff understanding of safeguarding and what to do etc – must remember the positive!

What we are doing well?

- Skilled, knowledgeable and easily accessible Safeguarding Teams – this is unusual!
- Proactive and changing service which responds to the needs of our stakeholders.
- We have excellent links and representation with our Safeguarding Partners – Our voice is loud and clear.
- Last SI for patient with LD was 2020. Last SI for patient with MH was 2021.
- We work proactively with specific areas when we see trends that may cause concern.
- We receive many informal compliments and positive feedback.
- Our ICB colleagues have confidence in us and the services we deliver and what we are working towards.
- We have high visibility and good relationships with all wards and clinicians.
- We are actively involved with supporting services across the Trust.
- Despite COVID we have maintained relatively good training compliance with SG training and have looked at differently ways of educating staff.
- Aligned to many different internal stakeholders so we are able to respond early for any potential issues for patients – the team are well known, visible and experienced.
- Identifying Court of Protection Cases and liaison with Trust appointed solicitors.
- Self Harm risk assessments – children and adults . Implementation of restraint training – we are ahead of many other acute Trusts on this – we have a training plan.
- Environment – ligature points, safe rooms etc. – paediatric areas and ED.
- SG Annual reports, governance, staff information on PATTIE.
- SEND – review of Designated Doctor Roles.
- Managing the risks, escalation to system partners and working collaboratively.
- Leadership – ward to board.
- We have strong leadership and direction of travel for further improvements.

Staff want to come and work with us……

Hull University Teaching Hospitals NHS Trust

- The demands on the service are increasing year on year. We are seeing an increase in people who require much more support and who are very vulnerable.
- The cost of living crisis is and will continue to have an effect on our most vulnerable population and inequalities in health will be a significant consideration.
- We need to review the workforce and in particular 7 day LD Liaison Nurse service as well as an adult MH Specialist SG Nurse. We also need to review the Court of Protection workload and set out a post to manage this either in SG or Legal.
- We need to review medical champions for LD and MH and job plan this role. We are making progress on this!
- The dual purpose of our service, and demands for our time, often lead to us having to prioritise workload to the detriment of Trust requirements.
- We want to do more work around implementation of actions and learning in the clinical areas – this is a weakness in staff knowledge and confidence.
- Incomplete MH documentation which makes us non-compliant in legally detaining patients. This is improving as evidenced in latest January 2023 audit.
- Patient feedback and engagement in co-production of services.
- Environmental considerations for patients with complex needs and Mental Health problems.

……**There is so much more we could do!!**

NHS
Hull University Teaching Hospitals
NHS Trust

Remarkable people.
Extraordinary place.

Report to the Board in Public
Quality Committee
February 2023

Item: Quality Indicator Report	Level of assurance gained: Good

Pressure Ulcer training video is now available for staff. Due to increased pressure there is an expectation that falls and pressure ulcers will increase, a focus on the DME wards to accelerate improvement work has commenced.

Executive review of complaints in surgery (weekly focus and challenge) is underway and a similar process will take place for Family and Women's. The Complaint's Team have mapped out the blocks in the backlog and are working on an action plan to present to the Patient Experience Sub-Committee.

QSIR is now being offered virtually for practitioner candidates.

The first Celebration event was well received with 50 attendees.

The Committee discussed SSNAP data being positive, SHMI being on an upward trajectory, the spikes in secondary malignancy and the review of pneumonia patient coding.

Ambulance handovers remain a challenge as well as how the Trust cohorts patients. Capacity in resus is also challenging, although the HUTH version of the Bristol model is working well. There has been no change regarding the no criteria to reside patients with little support from the wider Healthcare system. The CEO was escalating the situation to the ICB and was reviewing stepping down elective procedures due to the pressures in the hospital.

Item: Patient Safety Quarterly Update	Level of assurance gained: Good

PSIRF implementation was on track for launch in April and a number of training courses were underway. The Trust was using a Just Culture indicator to obtain a baseline assessment in all services as part of the transition to PSIRF.

The number of serious incidents being declared remain within control limits, 24 serious incidents were declared in the reporting period September, October, November 2022 and 2 maternity incidents are being investigated by HSIB.

There were no Never Events declared in the period.

The Trust has a positive incident reporting culture of high reporting and low harm. The Trust is introducing After Action Reviews which is a facilitated discussion following an event to enable outcome discussions and improvement work.

The Trust held its second Patient Safety Conference in November 2022 with the theme of Medication Safety. This included a patient who shared her PTSD recovery story.

Duty of Candour arrangements are being reviewed as there are errors in the way it is displayed in BI.

Item: Safeguarding Internal Audit Report	Level of assurance gained: Reasonable
Partial Assurance was received from Internal Audit and the Safeguarding Steering Group were working through the actions. Work was ongoing with the digital team to resolve NerveCentre and Lorenzo alerts relating to detained patients. The action plan would be received at the April Quality Committee for review.	
Item: CNST Maternity Report	Level of assurance gained: Good
The report presented highlighted the open HSIB investigations, 5 moderate incidents and 1 major incident. An after action review had been undertaken for the major incident. Culture training had commenced and this was now being made mandatory for all staff. The service is expecting a CQC inspection in early 2023.	
Item: Medical Certificate Cause of Death Delays	Level of assurance gained: Reasonable
Following a patient story at the Board, Prof Purva updated the Committee on the progress to date in addressing the issues. The actions included; weekly plotting of any delays, a monthly newsletter to update staff of the ME service, a surgeon to lead on a series of QI initiatives and a presentation at the Medical Grand Round and similar meetings to promote ME service.	
Item: TARN Data Collection	Level of assurance gained: Reasonable
There is a risk regarding the Trust's ability to submit TARN data due to sickness in the team, which could result in the Trust becoming a clinical outlier. A review of the issues is being undertaken and an action update would be submitted to the Quality Committee in January 2023.	
Item: Quality Strategy Update	Level of assurance gained: Good
The first year priorities had been achieved, there had been 150 QSIR staff trained and harm free care priorities had been allocated to a QI lead. The Mental Health and Delirium and Dementia strategies had been approved, PSIRF training had commenced and Greatix and learning from excellence had been launched.	
Item: CQC Update	Level of assurance gained: Reasonable
The ED action plan had been submitted to the CQC and feedback was that additional actions should be added in relation to consistency. The ED had been very busy when the CQC re-visited but there were no patient harm concerns raised. A joint cohort risk assessment with Yorkshire Ambulance Service had taken place. From January the CQC will received the monthly Quality Committee report and an updated action plan and the Safety Oversight Group will continue to meet to review the actions. Dr Haslam is completing assurance reviews to ensure safety and consistency is maintained. Data and outcome measures will be shared in January 2023.	
The committee received the following papers for assurance and there were no escalations raised and the committee accepted the ratings suggested; • Safety Oversight Group • Patient Safety and Clinical Effectiveness Sub-Committee Escalation Report • Non Clinical Quality Sub-Committee Escalation Report	

Hull University Teaching Hospitals NHS Trust

Trust Board

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	14.02.23
Title	Our People				
Lead Director	Simon Nearney - Director of Workforce and Organisational Development				
Author	Simon Nearney - Director of Workforce and Organisational Development				
Report previously considered by (date)	This report has not been received at any other meeting.				

Purpose of the Report		**Reason for submission to the Trust Board private session**		**Link to CQC Domain**		**Link to Trust Strategic Objectives 2021/22**	
Trust Board Approval		Commercial Confidentiality		Safe	✓	Honest Caring and Accountable Future	✓
Committee Agreement		Patient Confidentiality		Effective	✓	Valued, Skilled and Sufficient Staff	✓
Assurance	✓	Staff Confidentiality		Caring	✓	High Quality Care	✓
Information Only		Other Exceptional Circumstance		Responsive	✓	Great Clinical Services	✓
				Well-led	✓	Partnerships and Integrated Services	✓
						Research and Innovation	✓
						Financial Sustainability	✓

Key Recommendations to be considered:
The Trust Board is requested to note the content of the report and provide any feedback.

Hull University Teaching Hospitals NHS Trust

Trust Board

14th February, 2023

Our People

1. Purpose

The purpose of the report is to provide the Board with an overview of the key people issues.

2. Background

At the previous Board meeting in November, 2022 the Trust had 35 Covid-19 inpatients. As at 8th February, 2023 the Trust have 37 Covid-19 inpatients. The Trusts key challenge remains the number of 'No Criteria to Reside' patients in a hospital bed which is currently 190 patients which affects the number of surgical patients that can be seen and treated. The Trust's Emergency Department also remains under extreme pressure and the flow of patients through our acute assessment areas and wards. This pressure continues to have an adverse impact upon staff morale and staff feeling they are providing sub-optimal care.

3. Key Issues

The total staff sickness absence for the financial year 2020-21 was 3.91%. The total absence including sickness and Covid-19 for 2021-22 was 6.71%. The Trust attendance target for attendance is 96.1% (sickness not to be greater than 3.9%).

The Trust currently has 31 staff absent due to Covid-19 which is 0.34% of the workforce. Total sickness and Covid-19 absence is currently 3.5%. This is a reduction from 3.68% as at the last Board meeting in November, 2022.

4. Employee Services

On-Demand Earnings

Earnings on Demand was introduced into the Trust in November 2022 and allows employees to access a portion of their pay as it is earned, rather than waiting for pay day; this is particularly helpful where staff may have undertaken additional shifts. There are safeguards built into the scheme to ensure that a member of staff cannot draw down all their pay before pay day. The system works by calculating the employee's earnings as they work and allowing them to draw down a proportion as required. The amount withdrawn plus fees where applicable is then deduced from the employee's monthly pay (the first withdrawal each month up to £100 is free of charge, thereafter a fee of 2.5% is charged). Since the launch of the scheme in November 2022, 125 staff have registered withdrawing circa £68K in total.

Industrial Action

A number of NHS trade unions have been successful in achieving a mandate for industrial action across a number of key staffing groups within the NHS. The industrial action is linked to demands being made at a national level for a meaningful pay rise and a package of additional retention measures related to settlement of the 2022/2023 pay round. To date only the Chartered Society of Physiotherapist (CSP) and the Hospital Consultants & Specialists Association (HCSA) have a mandate for action within HUTH. The CSP's mandate within HUTH is for "action short of a strike". To date nationally the CSP are focusing on taking industrial action in those NHS Trust where the ballot outcomes allowed for full strike action; to date this has not impacted on the provision of physiotherapy services within HUTH. Although membership of the HCSA within HUTH is minimal they do have a mandate for industrial action and will be required to provide 14 days' notice of any action.

The BMA ballot of junior doctors is due to close on 20th February 2023 with the outcome expected soon after that date. If the ballot is successful the BMA are advising a "walk out for 72 hours in

March. The 'full walk out' will mean junior doctors in England will not provide emergency care during the strike". Although 14 days' notice of any action will be required the Trust, via the Industrial Action Planning Group, continue to review and prepare for the impact of strike action.

Local Clinical Excellence Awards (2022/23)
Following a joint agreement between management and staff side the 2022/23 Local Clinical Excellence Awards (LCEA) scheme will be via an equal distribution method for eligible consultants. This is to allow for the development of a local system taking into account local priorities.

To be eligible for an award in the 2022/23 round Consultants must have an in-date appraisal as at 28th February 2023, be actively participating in job planning or have an agreed job plan (or be in the mediation process as at 28th February 2023) and have all mandatory training completed by 28th February 2023.

5. Staff Vacancies
The Trusts overall vacancy position as at 31st December 2022 is as follows:

Staff Group	Establishment WTE	Staff in Post WTE	Temp Workforce WTE	Vacancies WTE	Vacancy Rate %
Additional Clinical Services	1461.8	1341.8	58.6	61.4	4.2%
Add Prof Scientific and Technical	367.7	332.5	3.2	32.0	8.7%
Administrative and Clerical Staff	1640.7	1650.0	8.4	0.0	0.0%
Allied Health Professionals	520.0	508.4	2.4	9.2	1.8%
Estates and Ancillary	622.9	526.7	5.0	91.1	14.6%
Healthcare Scientists	188.8	155.8	0.9	32.1	17.0%
Medical & Dental - Consultant	512.8	480.8	9.9	22.1	4.3%
Medical & Dental - SAS	71.2	62.0	0.2	9.1	12.8%
Medical & Dental – Trainee Grades	722.8	678.9	21.1	22.8	3.1%
Nursing and Midwifery Registered	2492.2	2436.4	34.8	21.0	0.8%
Trust Total	8600.7	8173.3	144.5	283.0	3.3%

Overall the Trust vacancy position is 3.3%. The Consultant vacancy rate has reduced to 4.3%. The vacancy rate for Registered Nursing and Midwifery is currently 0.8% across the organisation, however this includes 51 international registered nurses who are currently taking their OSCE exam and will be working in a ward area shortly.

6. Vaccination programme
Our Head of Occupational Health and Chief Nurse Information Officer operationally jointly manage the staff seasonal flu and Covid-19 vaccination programme.

The 2022/23 Covid-19 Autumn Booster programme will shortly cease but Flu vaccines will be available for staff until the end of March.

Approximately sixty three per cent of Trust frontline staff have received their Covid-19 booster compared with fifty four per cent regionally and forty six per cent nationally. Sixty one per cent of Trust frontline staff received a seasonal flu vaccine compared with fifty-six regionally and forty six per cent nationally.

There are discussions on going regarding a further Covid-19 booster for frontline staff in autumn to coincide with the 2023/4 seasonal flu vaccine programme.

7. Communications and engagement

The National Staff Survey is embargoed until the end of February, when NHS England will publish its reports. The Trust's results indicate a further deterioration against the nine key themes and our key measure of the staff engagement score, however this is very much reflected nationally. Health Group management teams have received their reports to discuss action plans at their business meetings. Following the lifting of the embargo the report will be widely communicated to senior managers to understand what key actions will have a positive impact on the 2023 survey, and a meeting with the executive team to discuss remedial and corrective actions is diarised for the 7th March.

The Humber Acute Services consultation is scheduled to begin in early summer. This will see options for the future of hospital services in the Humber region communicated to the population for comment and feedback. The Trust's Communications team is part of an ICB-led regional group tasked with delivering this consultation. Worked to develop key messages, scripts and branding as well as map all relevant stakeholders is at an advanced stage.

Work is underway to redevelop and rebuild the Trust's website. A small project team has completed a patient and stakeholder engagement process, and has looked at website analytics to understand how and why people are accessing our website. We are working with clinical and non-clinical services to understand what level of presence they require in the future. There is a separate sub group established to improve the way in which staff, patients and other hospital users access phone numbers and contact details for the Trust services and individuals. We anticipate the new website will be relaunched before the end of 2023.

Planning for the NHS 75 celebrations is underway. All local health partners (CHCP, Humber ICB) have agreed to partner for this year's staff fun day, providing funding and support. The Golden Hearts Awards 2023 have been launched and managers are encouraged to nominate teams and individuals.

8. Staff Support

Occupational Health Services remain the main route for staff to access support and help for a wide range of mental and physical challenges at work. The staff support service continues to work alongside our Occupational Health Service and offers an email and telephone hotline service. The Trust is promoting and advertising the Humber, Coast and Vale Resilience Hub widely for staff to access support. The Trust continues to support staff via Focus Counselling, Occupational Health Team, Clinical Psychology, Coaching Services and the Pastoral and Spiritual Care Team for general mental wellbeing support.
The 24/7 staff support hotline continues to be available and is run by the Pastoral and Spiritual Care team. The OD team continue to monitor and signpost staff through the hyp-tr.staff.support@nhs.net email address.

TRiM Service Update

The Trust has had a Trauma Risk Incident Management (TRiM) service in place since September 2022. TRIM is an evidence-based, post-incident management process, which promotes an organisational approach to staff support following potentially traumatic incidents. The service currently has 40 TRiM Practitioners, 4 TRiM Managers with a further 8 TRiM managers being trained in March 2023. The service has responded to eight incidents requesting TRiM support with 12 individuals accessing TRiM Interviews. Feedback received from those who received support:

- *"Safe and supportive and I was able to talk openly without judgement"*
- *"Being seen initially after the incident. All the checks on me felt caring and professional*
- *"Helped me with processing the event and understanding how to go forward in the future with traumatic events"*

New Health Education England Pilot – Health Psychology

We have been successful in receiving 2 years fixed term funding for a Health Education England pilot for a Health Psychology Trainee. This is a new pilot, (we are one of seven), exploring how health psychology can positively impact on workforce transformation in the NHS. This role will be focus on work within Maternity Services, to support with the cultural transformation work currently taking place.

New Temporary Health & Wellbeing Lead Appointed

A 12-month secondment post has been created for a Health and Wellbeing Senior OD Practitioner using some temporary vacancy factor. This is a much-needed post as the Trust has not had one person in post with a sole focus on staff health and wellbeing with the agenda being absorbed into several senior managers portfolios. This is a key enabling agenda in the current NHS Climate of high stress due to post pandemic burn out and due to the external pressures on all our services.

9. Learning and Organisational Development

Organisational Development

The OD team are experiencing extremely high demand for bespoke support and interventions. This ranges from full cultural transformation programmes through to support for time out and team building sessions. Below are some of our current activities to highlight capacity being used:

- Cardiology – Improving the Learning and Working Environment (large scale and long term)
- Maternity Services – Kindness, Professionalism and Culture Improvement (large scale and long term)
- ICU – Supporting Nursing Leaders (Ongoing support and Leadership Supervision)
- Mortuary – Recruitment and Retention (team and culture support)
- Infection Prevention Control Team (team and culture support)
- Emergency Department (Equality, Diversity and Inclusion, Staff Support and Culture)
- Paediatric Consultant Team (Team and Business Development)
- Support for HUTH/NLAG P1 services – ENT, Cardiology

Apprenticeships
This year is the 10th anniversary of apprenticeships – we have had 862 starts (both new apprentices and existing staff) since May 2013, planning to celebrate this with support from communications team in May 2023

- Current levy funding available (in levy account) = £3,701,577
- Current levy spend (since Feb 2022) = £1,098,03
- Current number of staff (apprentices and existing staff) studying apprenticeships = 208

W/C 6th February is apprenticeship week team will be visiting six schools as well as JobCentrePlus to promote opportunities.

Career Engagement
We now have 96 ambassadors on board and event requests from schools. Are also looking at opportunities to bring students to experience the NHS first hand. This is supported by the launch of Med Shed a new NHS Career Engagement Website. This allows kids aged 11-16 to access resources to signpost them to NHS Careers. The new site can be found here: https://www.hull.nhs.uk/medshed/

Learning and Development
We now have in place our Required Learning policy and new clear processes in place for staff wishing to create training that is mandatory for key groups of staff to complete. This ensure will that informed decisions are made about including key staff groups in required learning and avoids overload of demand on staff time and rota's.

The staff Special Educational Needs (SEN) support service is now up and running and referral forms are available on Pattie. Our staff can self-refer, be referred on by their manager or the occupational health team. This is not a diagnostic service but instead design to offer practical support for learning or work needs.

The following courses are developed are ready for launch:

- Autism Awareness,
- Intro to Attention Deficit Hyperactivity Disorder

Human Tissues Licence Granted to HUTH
The Surgical Skills Centre at CHH (Suite 22) has their Human Tissue Licence provisionally granted for using human body parts on courses. The final revisions for the licence were sent in on 2nd February 2023 and the team are awaiting the final signed off report. The lab will be licensed to run courses with human parts but not full bodies (cadavers). This will be a real boon to the Trust as these courses are highly sought after and will bring both demand and income generation opportunities to the department. We already hold highly popular courses run by the suture centre faculty and this licence will further enhance the already excellent service provided.

10. Equality, Diversity & Inclusion (EDI)
During the month of February 2023 the LGBTQ+ Network are celebrating LGBTQ+ History month in a number of ways. Every year, there is a different theme. This year it is "BehindTheLens" which celebrates LGBTQ+ people's contribution to cinema and film from behind the lens. Pattie will be the focal point for the celebrations and will include:

- Blogs from the LGBTQ+ Staff Network leadership team about their favourite LGBTQ+ films, artists and musicians
- Blogs from the EDI Manager featuring some of the famous LGBTQ+ figures from BehindTheLens
- Exciting news about the Trust's first ever LGBTQ+ Staff Network conference planned for Friday 23 June 2023.
- Information about how the Trust are being assessed for the NHS Rainbow Badge programme and the launch of the NHS Rainbow Badge pledge scheme within the Trust.

All of the above is complimented by the development and agreement of specific LGBTQ+ objectives for the 2023/24 year which will also include the development of a Zero Tolerance Framework specifically related to LGTBQ+.

11. Recommendations

The Trust Board is requested to note the content of the report and provide any feedback.

Officer to contact:
Simon Nearney
Director of Workforce and OD

Report to the Board in Public
Workforce, Education and Culture Committee December 2022

Item: Guardian of Safe Working	Level of assurance gained: Reasonable

The Guardian of Safe Working shared that there were 186 exceptions reporting in Q2 with the majority related to staying above contracted hours due to workload and that medicine remains the highest health group receiving exceptions.

The Phlebotomy business case was now being implemented but there remained issues around e-rostering, missed self-development time and ECG's which have been raised by the trainees.

A discussion was held over the junior doctor's request to use the funds and what spending parameters are for use of the funds.

It was noted that a new Standard Operating Procedure is being devised at the request of the Chief Medical Officer due to a particularly large fine.

Item: National Awards	N/A

The Trust have celebrated the number of awards won recently which are;

- Nursing Times, best UK employer for nursing staff. Predominately for our nurse associate programme and developing our own staff through our apprenticeship programmes, including our international nursing recruitment and experience. This is one of the best awards they can award.
- Allocate Workforce award for our vaccination programme for the ICS. We established 650 staff on the bank and provided staff across primary care, pharmacy and vaccination hubs and supported other providers with vaccinators.
- Hull Live's diversity in work place due to our zero tolerance framework and policy, which we have implemented and are expanding.

Item: LGBTQ+ Equality Objectives	Level of assurance gained: Reasonable

The network chair presented the LGBTQ+ Equality Objectives, which are designed to create a more inclusive culture in the Trust, delivery of the key actions and achievement of the objectives will be monitored;

- Rainbow Badge – The Trust has been accepted on the NHSE national Phase 2 assessment for the Rainbow Badge accreditation.
- Bridging the Gap Measure – Create an inclusive environment within the Trust that enables people to feel confident to be open about their sexual orientation and/or gender identity.
- Launch a Zero Tolerance to LGBTQ+ Discrimination Framework Q3 2023.
- Conference – Organise a conference for the 2nd Quarter of 2023 to raise the visibility and accessibility of the LGBTQ+ network. CEO very keen following success of other network conference and some inspirational local speaker.
- Pride Recruitment Event – At 2023 Pride in Hull event organise for a recruitment and careers stall to be present on behalf of the Trust.

Known obstacles were shared and the committee acknowledged the work that the network has achieved.

Item: People Management Performance Report	Level of assurance gained: Reasonable

The Director of Workforce and Organisational Development shared that the overall vacancy rate is 3.6% with Nursing and Midwifery at 6.4%. An update was provided on higher vacancy areas within the Trust.

An issue was raised regarding the retention of staff who have been in position less than 12 months however, this figure also shows temporary staff and those who have been promoted.

A bi-annual report on exit interviews is discussed at the Workforce Transformation Committee.

Item: Nursing and Midwifery Staffing Report	Level of assurance gained: Reasonable
The Director of Workforce and Organisational Development shared that the Care Hours Per Patient Day (CHPPD) has dropped due to the additional NCTR wards and staff were stretched due to the established nursing numbers not increasing. It was noted that 117 newly qualified adult RNs have been appointed and started their substantive roles, 17 Registered Midwives have been appointed.	
Item: Covid and Flu Vaccination Progress Report	N/A
The uptake for the Covid booster and flu vaccination has been much lower than previous years, there will be a financial penalty for HUTH not meeting the CQUIN target.	
Item: E-Rostering roll out and usage	Level of assurance gained: Reasonable
During a recent counter fraud overtime audit it was recognised that the use of an electronic rostering system mitigates against the risk of fraud and it was recommended that all staff should be paid via the system as opposed to submitting paper claims for overtime. However, no significant fraud was detected during the audit from either a roster or a paper timesheet perspective. Phase 1 of the project is nearly complete. Phase 2 will include clinical administration staff. It was noted that there is an app available where staff can view and book / cancel shifts.	
Item: Medical Bank Report	Level of assurance gained: Reasonable
The HUTH Remarkable Bank was set up to reduce higher cost agency spend. Doctors registered with the Bank are able to directly book available shifts via an app. HUTH would have significantly higher costs if the same level of cover provided by the Remarkable Medical Bank had been provided by agencies. All grades are on the bank however, it is primarily junior doctors that are registered with the Bank.	
The committee also received an update on strike action with Nurses at HUTH not striking.	

Agenda Item		**Meeting**	**Performance and Finance Committee**	**Meeting Date**	**30th January 2023**
Title	Performance Report				
Lead Director	Ellen Ryabov – Chief Operating Officer				
Author	Louise Topliss – Assistant Director of Operations (Operational Performance)				
Report previously considered by (date)					

Purpose of the Report		**Reason for submission to the Trust Board private session**		**Link to CQC Domain**		**Link to Trust Strategic Objectives 2021/22**	
Trust Board Approval		Commercial Confidentiality		Safe		Honest Caring and Accountable Future	✓
Committee Agreement		Patient Confidentiality		Effective	✓	Valued, Skilled and Sufficient Staff	✓
Assurance	✓	Staff Confidentiality		Caring		High Quality Care	✓
Information Only		Other Exceptional Circumstance		Responsive	✓	Great Clinical Services	✓
				Well-led		Partnerships and Integrated Services	✓
						Research and Innovation	
						Financial Sustainability	✓

Key Recommendations:

The Performance and Finance Committee is asked to receive, discuss and accept this update on key performance issues.

Performance and Activity Report

December 2022 Performance

November 2022 for Cancer data

Produced January 2023

Table of Contents

1. Executive Summary

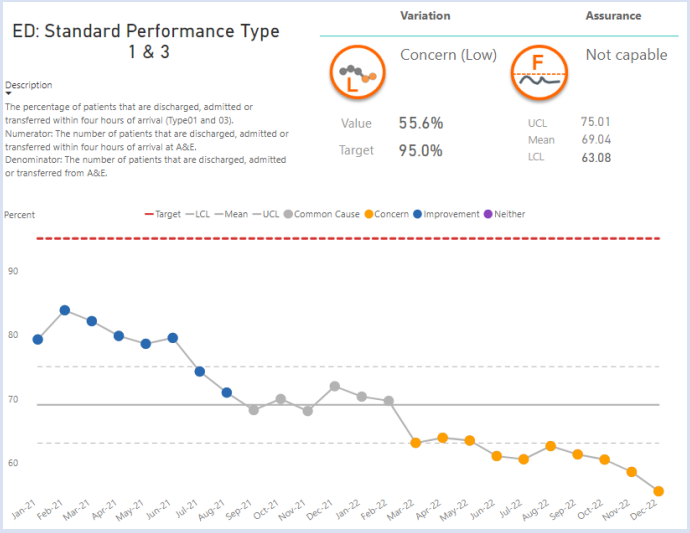
Areas requiring improvement	
Urgent Care performance – ED and Ambulance handovers	• For December 2022, the Ambulance handover position remained highly challenged due to the number of lodged patients within ED, however this has shown signs of improvement in January 2023. In December 2022, YAS reported a 30% increase in Category 1 calls (immediate response) – a reduced position in January 2023. • YAS and HUTH continue to work on improving ambulance handover times to enable the release of ambulance crews to support the community, albeit there continues to be significant challenges in this area. The use of cohorting has increased, there have been discussions and a risk assessment completed for continuing to use the Atrium or Fracture Clinic for cohorting; Fracture Clinic is not being used whilst identified risks are addressed. Reduction in cohorting in January 2023 linked to improved ED flow. • The number of patients in December 2022 with No Criteria to Reside continues to be the single largest factor affecting performance with a daily average of 231 (-26 on last month) patients per day remaining within the hospital who have no medical need for acute services.
Cancer performance	• Overall cancer performance remains comparable with previous months. 2WW referrals have increased by 6.6% compared to the same period last year; there is no significant increase in confirmed cancers for any tumour site. • Only 3 of 9 cancer-waiting times' national standards were achieved (31-Day Drug, FDS and 2WW performance). • The number of patients on the 62-day from 1st OPA to treatment Cancer PTL varies considerably from 1,300 – 1,600 and in itself is not monitored but used as the denominator when considering the +63 day backlog. From January 2023, the Trust will report patients on the 62-day PTL from referral to treatment, in line with the required Cancer Waiting Times guidance. This will increase the PTL by 500-700 patients on a weekly basis. • HUTH remains a Tier 1 provider for cancer performance and is the focus of the 2/52 NHSE assurance and recovery meetings – with particular emphasis on those patients +62 and +104 days, and the recovery trajectory to 31 March 2023. The Trust did not achieve the recovery trajectory requirements in December 2022 – lost activity due to bank holidays and cancelled surgeries due to NCTR patients outlied to CHH.

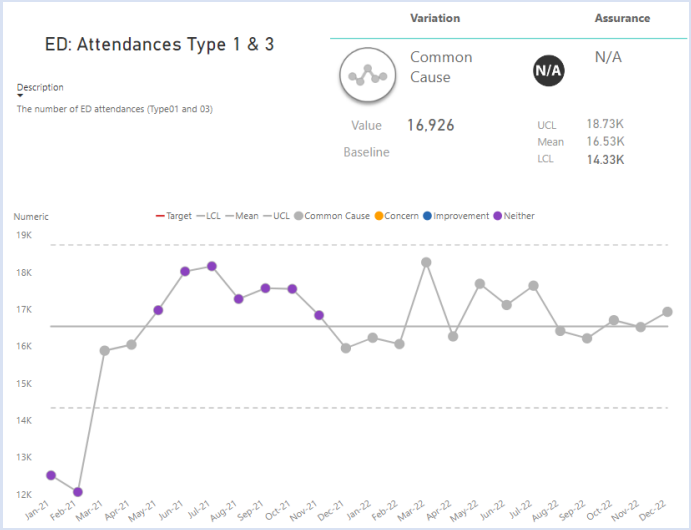
	• Internally a new 2/52 meeting with the top 4 tumour sites (colorectal, skin, Gynae and urology) are well established; chaired by the DCOO (Elective Recovery & Cancer) and attended by DGMs and the Trust Lead Cancer Manager to review all patients at +80 days in order to support achievement of the 62-day standard. • Following the Urology Service Improvement session in November 2022, an improvement action plan is in place and being actively progressed. Priorities are ensuring that there is sufficient prostate referral OPA capacity for key clinicians to accommodate referrals; this will ensure each patient is directed on the correct pathway first time therefore reducing delays at the beginning of the pathway and haematuria backlog clearance. • The Colorectal tumour site continues to improve following improvement in CT Colon waiting times/processes. Non-recurrent funding has been secured from the Cancer Alliance to increase the number of Cancer Nurse Specialists (CNS) to improve the front end of the pathways – this will required a recurrent funding source from the 23/24 and 24/25 cancer allocations. • A Gynae-oncology service improvement session is planned for 13 January 2023; an improvement action plan will be developed with the service focussing on the diagnostic part of the pathway, including a review of the impact on histology. • Late inter-hospital transfers (IHTs) from within the HNY ICS adversely affect urology; discussions with referring Trusts are planned for January 2023. • Histopathology delays impact on the Skin tumour site performance in particular – revised Cancer Waiting Times guidance has enabled removal from the Cancer PTL where an excision (treatment) is complete, and where the patient has been told of their expected diagnosis, prior to the histology result being reported. Whilst this has improved week to week +62 day and +104 day long wait, the delay in receipt of pathology results impacts on the overall performance upload – e.g. where results are not available the treatment (if cancer) is not captured and reflected in the national performance. Therefore further work is required to improve the skin pathology turnaround times (TAT) and this is underway.
Recovery of elective activity	• Recovery of elective activity in December 2022 did not achieve the plan except for Day Case at 100% of plan and 104% of baseline. Ordinary elective activity was 81% of plan, which is a deterioration on previous months. This was due to challenges with NCTR, ICU bed capacity; ward bed capacity and infection outbreaks (VRE). The indicative activity requirement of 110% of 19/20 baseline was not delivered.

	• The operational plan also includes a reduction of outpatient follow-ups by 25% by March 2023. In December 2022, follow up activity was 105% of baseline and 96% of plan; further work is required to transform outpatient pathways to support this operational requirement. Focussed meetings with each Health Group commenced in November 2022 to drive performance improvement and/or under identify the reasons for any deviation, i.e. a number of clinic/activity types were previously excluded. • Outpatient new activity delivered 96% of plan and 105% of baseline. • There has been a counting change in Clinical Support Services HG for Radiotherapy that has shifted approximately 17,000 new outpatients per year to follow up activity, this shift accounts for 80% of the variance from new to follow ups in Clinical Oncology. • Ward C9a remains an oncology ward (12 patients), which will now be the case until February 2023 to enable essential works at the Queen's Centre to be finalised; however further bed capacity is required to achieve recovery plans for neurosurgery and orthopaedic speciality areas. Over Christmas and New Year period, elective capacity at CHH had to be used due to acute bed and NCTR bed pressures at HRI to maintain acute admission capacity; there was some impact in early January 2023 on elective recovery as a result • Following the paediatric move to new accommodation on the 2nd floor of HRI, vacated wards H130 East and West are being converted to NCTR capacity to release other bed capacity and reduce risk of impact on elective capacity; this will create a workforce pressure but is proving necessary while community/discharge capacity continues not to meet demand • Mutual aid continues albeit in limited numbers to improve waiting times and support the reduction of the overall size of the Trust's PTL.
Improving treatment times for long waiting patients	• There were 794 x 104 week wait patients to treat in 2022/23 Q1 and the Trust had been designated a Tier 1 organisation. • At the end of December 2022, the Trust reported Zero 104 week waits and it was confirmed that the Trust had been stepped down as a Tier 1 organisation (national oversight and assurance) to Tier 2 (regional oversight/assurance) for long waits.

	• Enhanced internal governance processes continue to support the daily monitoring against the trajectories and on-going work to identify capacity internally and seek/take up offers of mutual aid from other providers. • A risk related to corneal transplant (unmatched) patients has been identified. If these pathways were converted to RTT ticking pathways (from a planned pathway – not ticking), there would have been 22 breaches of the 104-week metric. • 5,245 patients have waited more than one year for their appointment/procedure, this is below the trajectory of 5,510. • Mutual aid continues to be progressed in challenged specialties.
Reducing the delays in people leaving acute setting	• Nationally, there has been an increase in the number of patients who no longer "meet the criteria to reside (NCTR) in an acute hospital". NCTR patients are medically fit from an acute perspective, but may still have other care needs, and are delayed in receiving that care, moving home either with care, or to a community or care home setting for their needs. • At 31 December 2022, there were on average 231 patients per day with NCTR, increased from last month. This is 22% of the total general & acute beds, and 34% of the beds at HRI (total G&A beds 680 HRI/347 CHH) occupied by NCTR patients who should be receiving appropriate care elsewhere with the support of other partner organisations or settings. • The Interim Deputy Chief Nurse leads a regular review of patients delayed for 7-days or more and all patients over 30 days NCTR are discussed weekly between the System Chief Operating Officers and Directors of Adult Social Services. • A system level plan has been agreed; increasing both bedded and care at home capacity, and continues to be enacted. ➢ The system ran a "12 days of Christmas discharge event (12 to 23 December 2022) to reduce NCTR to 100 by the 31 December 2022. At the beginning of December, the number of NCTR patients in the Trust was at 222. During the first week of the event, NCTR had reduced to 176. However, due significant winter pressures, the figure rose to 197 at 31 December (25 less than the start point of 222). ➢ The Fracture Neck of Femur (#NOF) community pathway began on 4 December 2022; however, the pathway was suspended on 20 December 2022 due to the presence of Covid in the community unit. ➢ Next discharge initiative 27 February 2023, for 1 week, focusing on smaller number of initiatives with system partners.

2. Emergency Care Standards – 4 hour Performance





What the chart tells us

The 4-hour performance delivery has deteriorated, and is significantly below the required standard. In December 2022, performance was 55.6% for all Types.

ED attendances are just above the mean at 16,926, and there has been a small increase in attendances for December 2022.

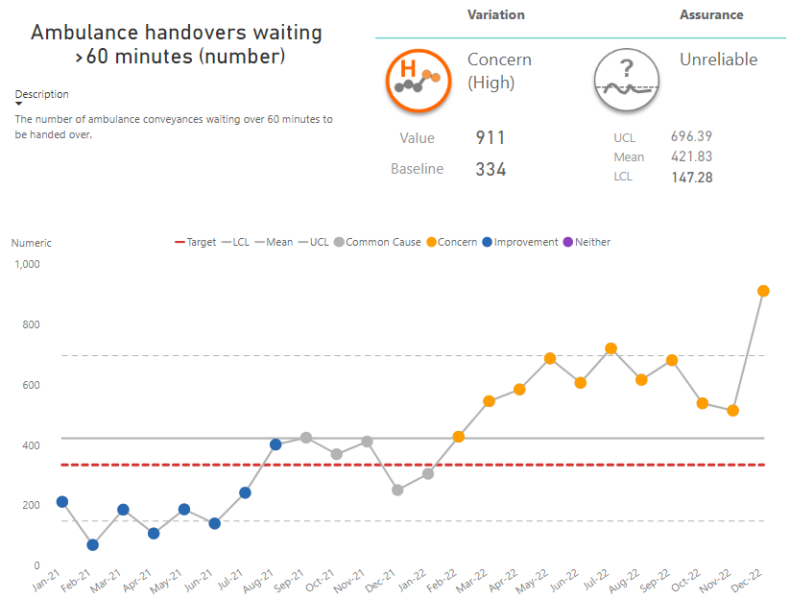
Intervention and Planned Impact

- The RAT model for the Emergency Care area has been in place since 4 November 2022, Monday to Friday, day shift and evening shift as times of greatest demand and greatest potential impact
- Increased capacity at Storey Street commenced from 2 December 2022 to enable more patients to be directed to that service while urgent care capacity for Hull is assessed through a Place-led Task-and-Finish Group
- Keeping SDEC free from bedded patients overnight and therefore able to function from 8am continues to be a priority.
- Use of National streaming tool to direct appropriate patients to primary or urgent care commenced 14 December 2022.
- Patients with a NEWS score of 5+ on ambulances are brought through to ED as a priority – this is the right step to take for patient safety but has delayed lodged patients in ECA exiting ED or moving through to Majors
- HUTH Flow Model (boarding patients throughout day) – commentary below

Risks / Mitigations

- Continued delays in flow and discharge are a significant impediment to an improvement in the initial assessment and majors' area; with some impact on ECA as rooms are occupied for an extended period.
- Significant increase in Paediatric demand across primary and secondary care due to Strep A concerns – this has now decreased but accounted for significant additional activity in December 2022 and extended waiting times as a result.
- Increasing the number of support workers using overseas recruitment pool to provide care for lodged patients.

3. Ambulance Handovers waiting over 60 minutes



What the chart tells us

There were 911 (+413 on previous month) over 60 minute ambulance handover delays in December 2022 that equated to 35.5%.

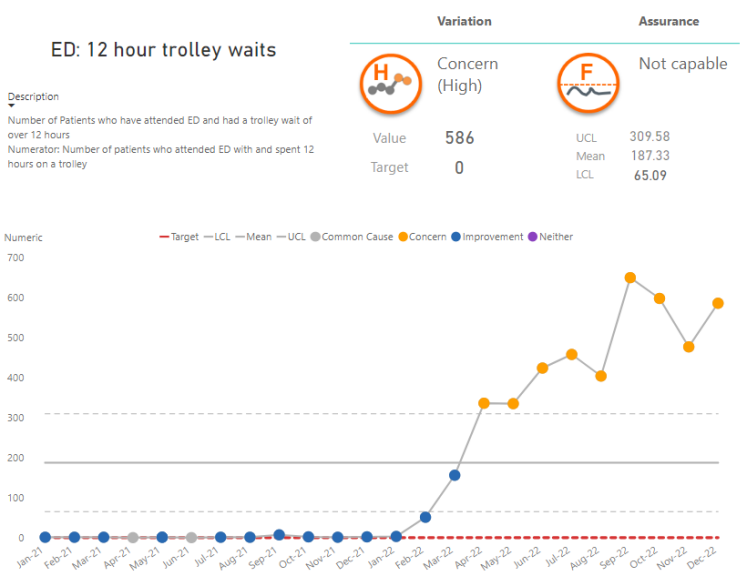
Intervention and Planned Impact

- HUTH Flow Model designed to reduce the number of lodged patients in ED by 10:30am daily, thereby creating space in majors to handover ambulances and reduce queuing in the morning. Not always achieved consistently, which impacts on action below.
- Focusing on afternoon flow of patients through December 2022 to ensure that movement is maintained so that ambulances are available for the community – however, increase in NCTR patients, higher acuity of patient admissions and general discharge patterns particularly in the medicine bed base meant that performance is very variable and did not have desired impact.
- Cohorting of ambulances jointly with YAS enables a single crew to monitor a selected group of patients and enable the other crews to be available to respond to the community.

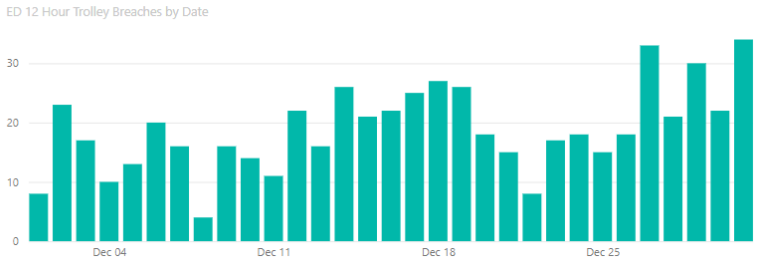
Risks / Mitigations

- Flow remains challenged as the number of patients with No Criteria to Reside, who are unable to be discharged, are occupying over 30% of the medical bed base.
- The first 30 patient admissions per day are yesterday's lodged patients as the Trust experienced its highest number of morning lodged patients throughout month of December of at least 20 patients per morning, usually 30)
- The additional wards remain open thereby placing additional pressure on Nurse and Medical Staffing
- Increasing IPC concerns/restrictions (e.g. Flu, Covid positive patients, VRE & Norovirus) reduce the ability to board patients

4. 12 Hour Trolley Waits (from DTA to Depart)



Day of Week Number	1	2	3	4	5	6	7	Total
	Mon	Tue	Wed	Thu	Fri	Sat	Sun	
ED Departures (Type 01)	1,411	1,449	1,330	1,673	1,638	1,599	1,219	**10,319**
ED 12 Hour Trolley Breaches	79	87	78	71	100	108	63	**586**
ED 4 Hour Standard Performance (Type 01)	41.6%	34.8%	39.9%	41.7%	41.3%	37.9%	41.1%	**39.8%**



What the chart tells us

There were 586 x12 hour trolley wait breaches in December 2022 with the longest wait from Decision to Admission (DTA) of 40 hours. In December 2022, Saturday was the highest daily figure for patients affected by trolley waits in excess of 12 hours.

The national standard now measures total wait from arrival in department and not from DTA for those waiting over 12 hours. Performance against that standard for December 2022 was that 19.6% of patients (2,023 patients) waited over 12 hours against a national tolerance of 2%.

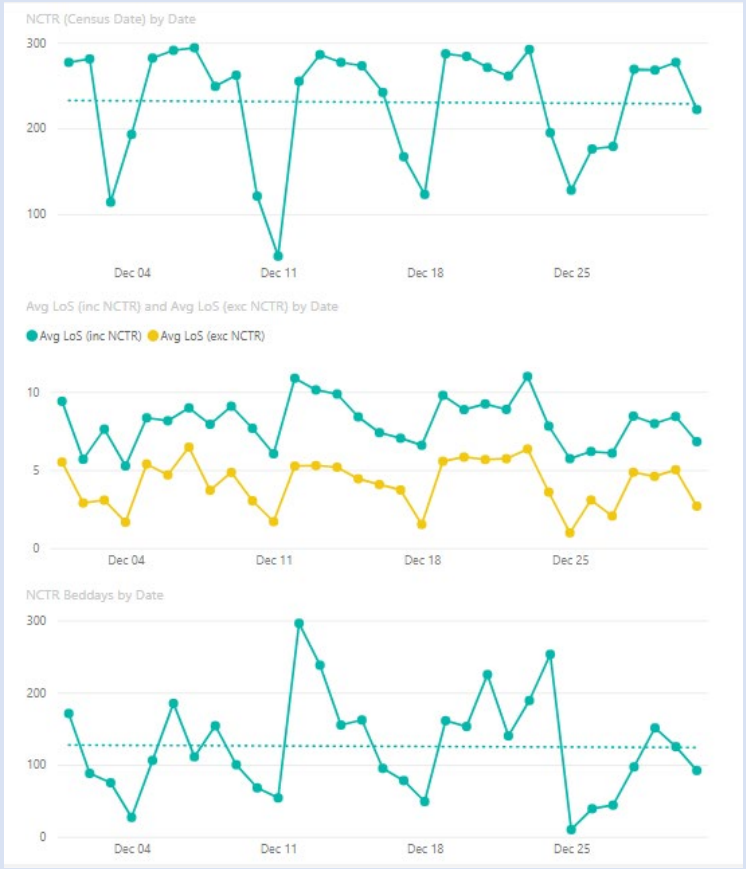
Intervention and Planned

- Implementation of HUTH flow model from mid-October 2022 initially reduced the number of 12hr trolley waits. The inability to undertake this model consistently as described above had a particular impact in December 2022
- Board and Ward rounds in the Medicine Health Group implemented across HRI, auditing of compliance was due to begin from 12 December 2022.
- Operations Director of the Day put in place Monday – Friday from 15 December 2022 to drive flow

Risks / Mitigations

- High numbers of No Criteria to Reside patients continue to occupy acute beds thereby reducing the capacity for acute work
- Reinforce the requirements for escalation and implementation of professional standards for service delivery across all teams to support flow and management of risk.
- Board round process will take time to embed; there is a risk that the pace of change is not sufficient to get the benefits of shorter lengths of stay to aid flow before winter

5. No Criteria to Reside



What the chart tells us

On average, there were 231 patients per day with No Criteria to Reside in December 2022. There was an average impact of 4.0 days increase on Length of Stay due to the NCTR.

The NCTR accounted for 3,891 lost bed days in December 2022, which is a marginal decrease on the previous month.

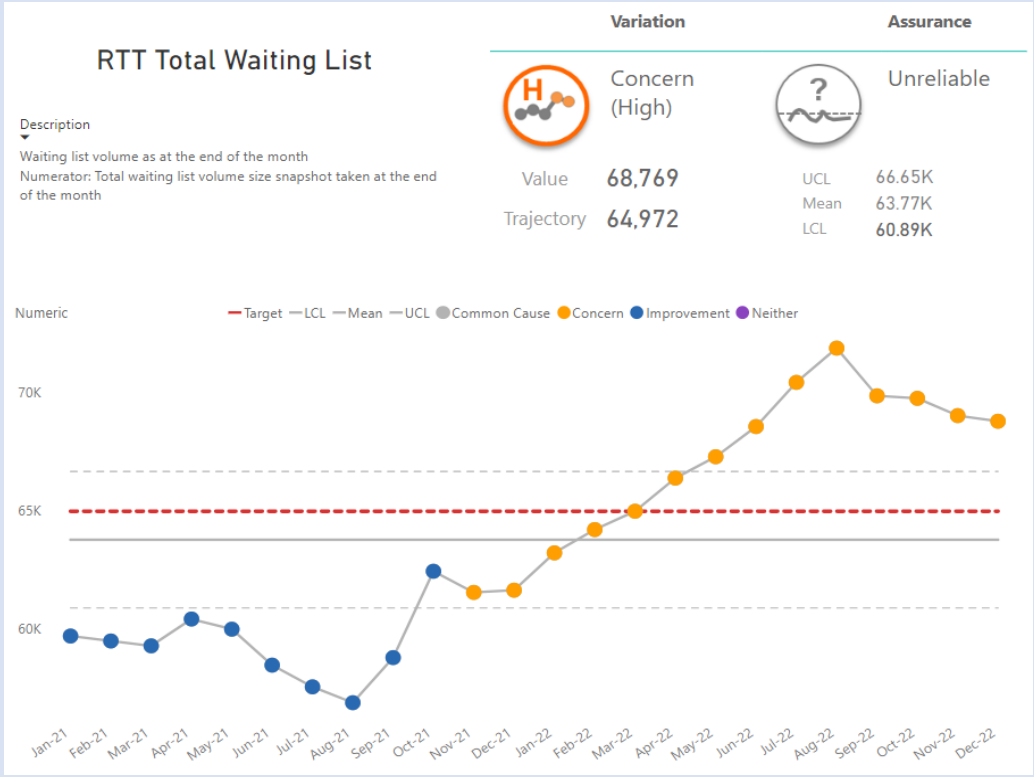
Intervention and Planned Impact

- System leaders are focused on reducing the number of NCTR patients to sub-100, with a further trajectory of 50 planned. This will be in part achieved by increasing both bedded and care at home capacity, including the additional 30 community beds put in place in December 2022.
- The Fracture Neck of Femur community pathway began on the 4th December 2022, suspended 20 December 2022 due to the presence of Covid. Work continues to restart this pathway urgently.
- There was a marginal reduction in NCTR patents during the 12 days of Christmas event. The next discharge initiative begins on the 27 February 2022, for 1 week, focusing on smaller number of initiatives that will include system partners.

Risks / Mitigations

- Domiciliary capacity remains lower than demand.
- Recruitment challenges due to competition from retail
- Winter infections (Flu/D+V) closing care home capacity

6. Referral to Treatment – Total Waiting List Volume



What the chart tells us

The Trust's total waiting list volume (WLV) has reduced marginally. At the end of December 2022, the provisional position is 68,769. The total WLV is above the trajectory of 64,972.

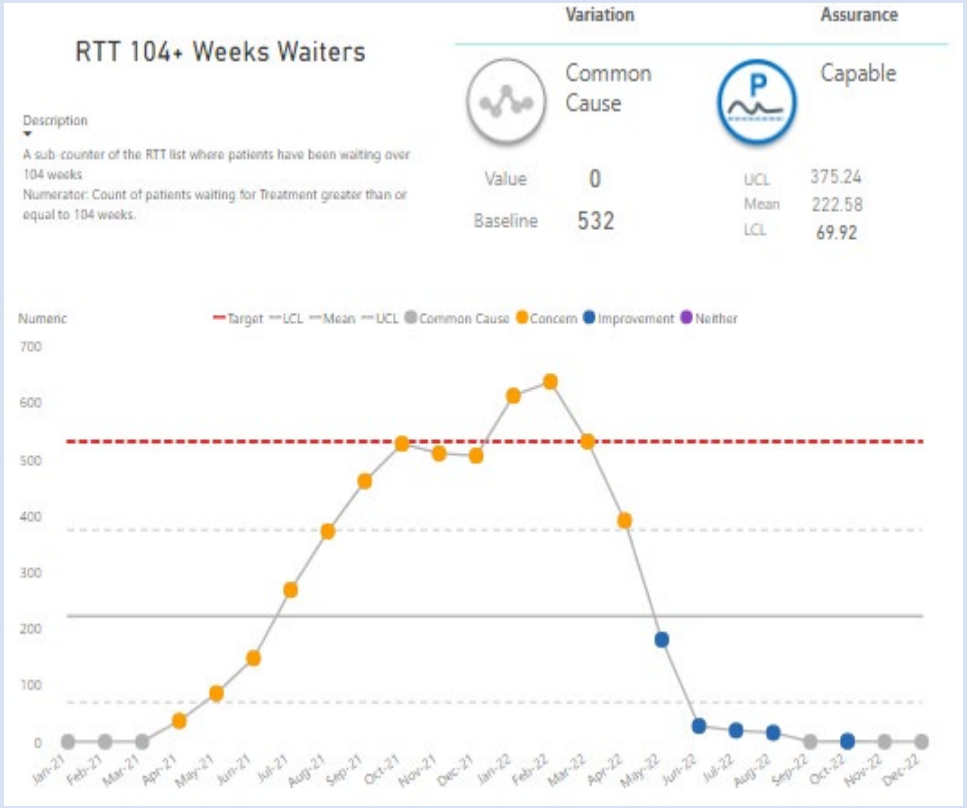
Referrals in December 2022 were the same as the same period last year. The operational plan for 2022/23 assumes no further increase in referrals.

Intervention and Planned Impact

- Continued focus and achievement of zero 104-week breaches.
- Targeted speciality meetings continue to support the achievement of a Trust internal milestone of no patient waiting more than 70-weeks at 31 March 2023 (national target is zero +78-week at 31 March 2023).
- Additional internal milestones have been set:
  - Zero +52 week non-admitted waits at 31 March 2023. This initiative will progress reductions on the Total WLV
- Mutual aid from other providers is supporting the total WLV reduction overall.
- Capacity alerts in x6 pressured specialities are live – with monitoring arrangements to consider the effectiveness and impact (2x specialities – referrals have increased)
- Continuing with patient transfers (outsourcing) to Independent Sector Providers and insourcing from a range of providers. Additional support for Gynaecology is a priority.
- The risk for the on-going theatre timetable is anaesthetic and theatre staffing due to vacancies and absence.
- Text validation will be delivered as a business as usual validation process for the remainder of 2022/23 & into baseline from 2023/24.
- RTT pathway training to 1,700 staff across the Trust who are primarily involved with pathway management has commenced through Learn RTT e-learning.
- Digital Mutual Aid System being used to find alternative providers in colorectal surgery, vascular surgery and Gynaecology.

	Risks / Mitigations • Further increase in GP referrals – referral triage and A&G in place to mitigate • Orthopaedic bed base reduction (-12) due to oncology using C9 offset by support from C15. Despite Executives confirming that C9/9A (35 beds) will be returned to orthopaedics/neurosurgery in December 2022 the bathroom refurbishment in the Queen's Centre will not be complete until February 2023. • Patients with No Criteria to Reside does not reduce • Infections and the management of contacts reduces bed availability and/or affects staff availability • Increase in non-elective demand displacing elective capacity • Impact of any Industrial Action

7. 104 Week Waits & Planned Trajectory



What the chart tells us

At the end of December 2022, the Trust reported Zero 104-week waits.

Intervention and Planned Impact

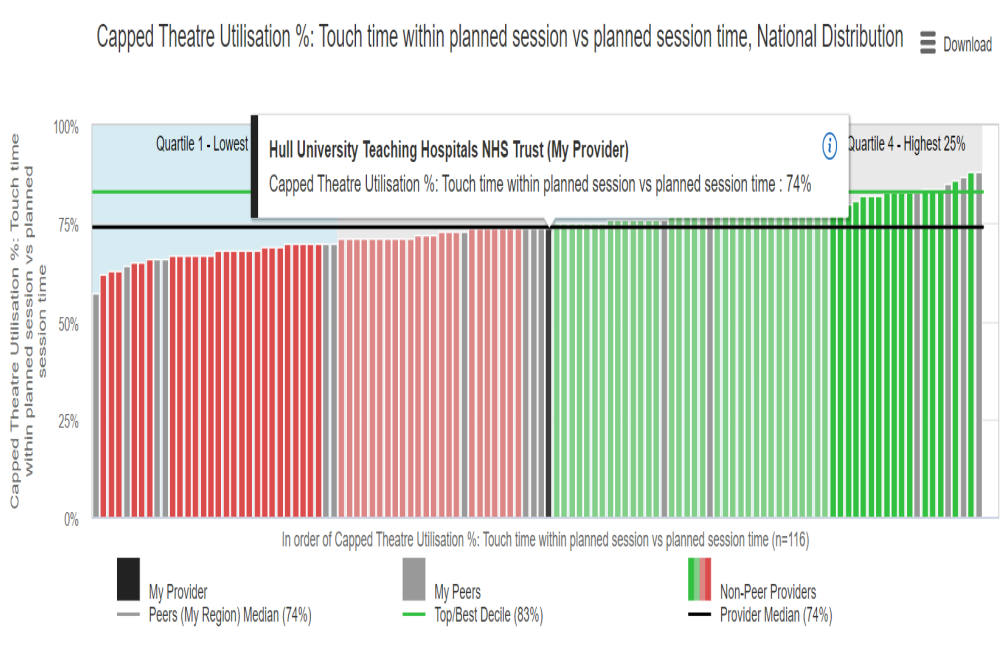
- Continued focus at speciality level of patients dated and/or risks now focussed through to 31 December 2022 to achieve and maintain zero 104-week waits.
- Internal milestone set to achieve zero x 80 week waits at 31 December 2022, however due to capacity constraints this was not achieved in challenged specialties (mainly Colorectal and Gynaecology).
- Clinical Admin Service continue to proactively contact patients with TCIs/appointments to check they are attending/if treatment is still required – small number of removals
- Progressing mutual aid support from providers within and without of H&NY and continuing to in-source capacity where possible to support pressured specialities.

Risks / Mitigations

- Current patients dated are treated as planned – delivered through micro-management
- Corneal transplant (unmatched) pathways which are managed by HUTH as planned are mandated to RTT ticking pathways by NHSE – x22 breaches of 104-weeks risk at December 2022, with increases in January to March 2023
- January 2023 (at 16/1/2023) risk of 104- week breaches with x3 patients dated in February 2023 due to capacity in Colorectal (patients cancelled in January 2023 due to the emergency demand/NCTR patients in elective bed base at CHH
- IPC risks including VRE affecting (staff absence & patient numbers, NCTR and/or non-elective (winter) demand increases – impacting on elective bed base
- Staff absence increases or does not reduce
- Priority 2, cancer and trauma demand – including ICU capacity & delays in repatriation (in & out of network)
- Patient choice & willingness to accept alternative providers and/or do not meet criteria
- Validation – no long wait “pop-ups”
- Speciality capacity risks:
  - Gynaecology (capacity and obstetric clinical prioritisation)
  - Colorectal (cancer demand & HOB bed requirements)
  - ENT (surgeon & complex operating time)

	• Plastic Surgery (ward based enhanced monitoring requirements) • Orthopaedics (bed base) • Neurosurgery (P2/acute demand, theatres & bed base) • Orthodontics (clinical capacity) • Oral Surgery (surgeon capacity) • Cardiac Surgery (acute demand, P2 volume and ICU capacity)

8. Capped Theatre Utilisation



What the chart tells us

This new metric was introduced as a response to the Elective Recovery Self-Assessment requirements. The elective recovery standard is a minimum of 85% capped theatre utilisation.

Data from Model Health for 2022/23 (up to 4.12.22) shows capped theatre utilisation at 74% and in Quartile 2 nationally, this is an improvement on the last reported position of 66%, in the lowest quartile nationally.

There is considerable variation in performance, with further work is required on data quality, understanding the definitions and the Model Health outputs compared to the internal monitoring.

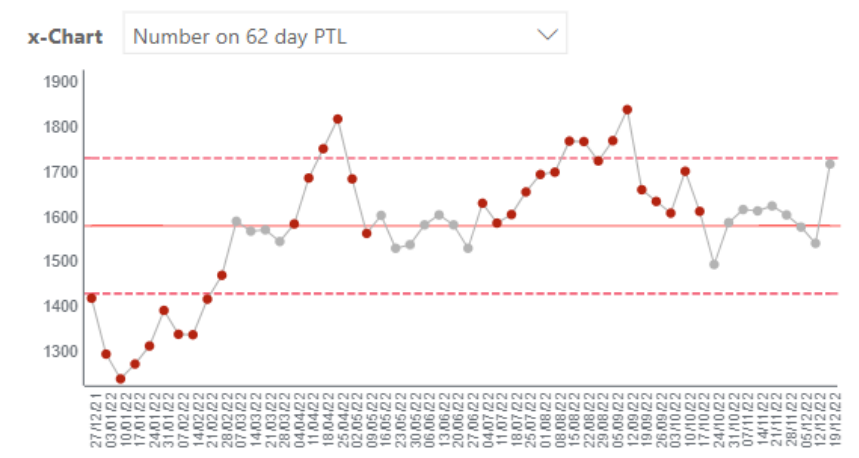
Intervention and Planned Impact

- Review of theatre timetable and configuration of ORMIS sessions. There are some theatres and sessions that need amending from elective to acute.
- Review of start and finish times of planned sessions in ORMIS.
- The changes will be made to the sessions in ORMIS from 12 December 2022.
- Some changes to consultant job plans required to utilise the Trust standard 4-hour theatre session
- Model Health to share the reporting methodology so that the capped theatre utilisation can be replicated for internal reporting at Trust and specialty level.
- All BI dashboards to be aligned to capped theatre utilisation methodology.

Risks / Mitigations

- Late starts and/or cancellations on the day as a result of being unable to confirm beds
- Delay in confirming/lack of ICU beds
- Inaccurate theatre timings used in ORMIS
- Consultant job plans do not match theatre schedule

9. Cancer 62 day Waiting List Volume



What the chart tells us

The number of patients waiting to start treatment or benign diagnosis patients waiting to be removed, on a 62-day pathway reduced over the last month and was 1,564 at the end of November 2022. This was slightly higher than at the end of October 2022, which can be attributed to cancer tracker annual leave (tracking is only partially covered by other member of the team in addition due to their own tumour site workload).

At week commencing 16 January 2023, the PTL size was 1,337, demonstrating ongoing improvements. The focus nationally, and through the Tier 1 meetings remains on long waiting patients rather than PTL volume.

Colorectal and Skin are demonstrating reductions in PTL volume and delivery of their respective cancer recovery backlog trajectories. Conversely, Gynae and Urology tumour sites still require significant attention, as they are off-track.

- Gynae-oncology – a service improvement meeting was held on 13 January 2023. An improvement action plan is being developed to take forward the proposed actions
- Colorectal have exceeded the backlog trajectory in December 2022 and early indications show that they are on track in January 2023
- Skin continues to make progress and reducing the backlog trajectory and in November 2022 close to meeting the backlog trajectory, with December 2022 demonstrating that the trajectory was being met.
- Urology has remained static, however, improvement following the action plan progress will not be demonstrated until into February 2023

The Subsequent Radiotherapy 31-day target of 94% has not been achieved since May 2022; a dip in achievement for the first time in the life of the Cancer Waiting Times targets.

Performance is not expected to improve for the remainder of the calendar year and highly unlikely to significantly improve in Q4 2022/23. Performance for November 2022 was 47.4%, which was a small improvement when compared to October 2022 (41.3%).

Intervention and Planned Impact
The capacity and/or pathway issues fall into 5 broad categories.

Imaging/Diagnostic - waiting times/capacity review underway supported by the Operational Improvement Team and enhanced performance management meetings with the CSSHG Imaging Division to address:

- CT Colon additional capacity continues internally with short-term capacity at the Spire. Waiting times now at approx. 3 weeks compared to 10-weeks in June 2022. Monitoring continues and the improvement in the colorectal PTL is demonstrated.
- CT backlog of reports continues to reduce which supports FDS performance and PTL volume

Histology capacity/delays – continue to be a concern for skin (less so for long waits due to new CWT guidance) and Gynae-oncology (increasing delays), the following actions remain current

- Daily results file has been made available to tracking staff
- Escalations to the SHYPS manager are communicated where results remain outstanding
- Insourced additional histopathologist capacity and outsourced histology continue. New outsourced histopathologist capacity (Backlogs) with clinician attending the Gynae-oncology MDT commencing January 2023
- Longer to medium term related to workforce solutions through the NEY Regional Clinical Leads continues with monthly meetings however the impact is yet to be seen in the backlog
- National cancer recovery funding for temporary administration support to reduce the reporting backlog agreed; post holder commenced 12 December 2022. Metrics will be developed to monitor improvement; good early signs from shorter turnaround times in availability of reports

Tracking capacity and decision making

- Tracker annual leave is noticeable – the persistent volume of the PTL is now having a significant impact on the ability for tracking staff to cross cover each other for planned absences.
- Temporary funding agreed to appoint to a floating tracker post and establish proof of concept for recurrent support. Post holder commenced early January 2023 and training underway.

Radiotherapy capacity/delays

- Staffing vacancies, long-term sickness and international recruitment processes continue to affected by a number of hurdles/constraints.
- Recent recruitment drive for radiographers' – shortlisting complete; 50% of those shortlisted are 3rd year students who qualify summer 2023
- Senior radiographer vacancy – shortlist complete with one suitable applicant to interview
- Maternity leave due back to work in July and September 2023. One person will return January 2023 - requires full preceptorship as was newly qualified when maternity leave commenced
- Clinical Oncology workforce shortages remains a challenge

The result of these challenges is that Radiotherapy and Chemotherapy waiting times for treatment has declined to a point where the Cancer Waiting Times performance is adversely affected. As a result, Subsequent Radiotherapy 31-day target failed to achieve the target of 94% for the first time in the life of the Cancer Waiting Times targets for May 2022. Performance will not improve for the remainder of the calendar year. November 2022 performance was 47.7%, which was a small improvement; however, subsequent treatment with chemotherapy/drug (e.g. hormones) exceeded the standard (98%) with a 100% performance in November 2022.

Mutual aid being sought across a range of providers to assist delivery improvement.

Transformation Opportunities

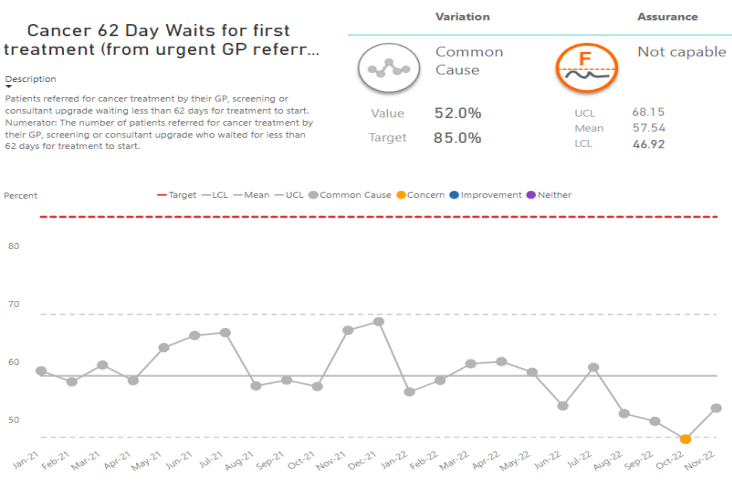
- Improvement in the Lower GI triage processes will shorten the pathway and lead to performance improvement – non-recurrent funding in place; will need recurrent support from the 23/24 & 24/25 growth for cancer
- Increasing numbers of 2WW referrals received with a FIT test result will enable more patients to be effectively triaged; locally at +60% which continues to be monitored and on-going discussions with primary care planned to further improve uptake by GPs
- Gynae-oncology – service improvement meeting (13.01.23) identified a programme of work that will support improvement in cancer pathways for patients and performance against Cancer Waiting Times
- Urology action plan developed and agreed with the service and already gaining traction, although improvement will not be realised until into the new year

- Upper GI – newly introduced steps at the beginning of the pathway that allows patients to have a CT scan on the same day as endoscopy if the results of the endoscopy indicates a likely cancer. This will speed up the pathway, reduce the number of times patients are discussed at MDT meeting and improve compliance with the 62 day standard
- Head and Neck – service improvement session being planned to share pathway analysis and recommendations for improvement
- These action plans form part of the overall Cancer Transformation programme of work

Risks / Mitigations

- Referral rate catch up impacts on the cancer PTL and waiting times
- High profile patients which result in an influx of referrals
- Staff gaps (vacancies and absence) further impact on diagnostic capacity & waiting times
- Histology tracking systems implemented locally to prioritise long-wait patients
- Radiotherapy delivery continues to be a considerable challenge
- Improvement plans fail to impact on performance metrics
- Mutual aid for radiotherapy is not forthcoming
- Cancer Transformation programme

10. Cancer 62 day Performance



What the chart tells us

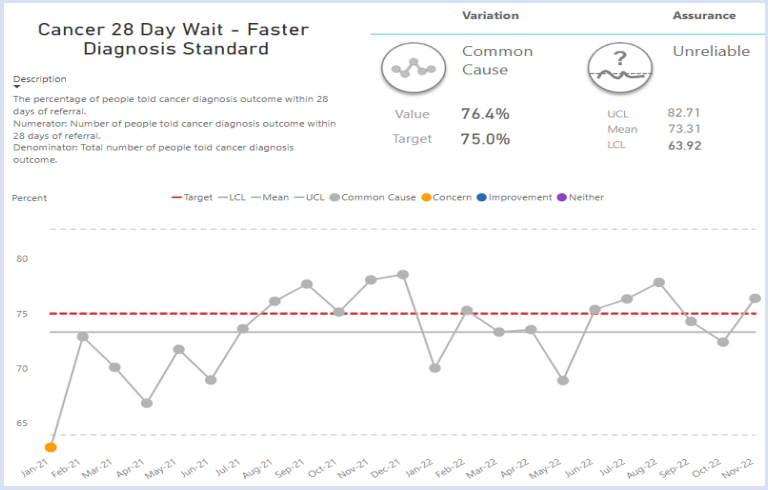
Performance for November 2022 was 52.0%, which is higher than the previous month; performance has not been achieved for some time.

The Faster Diagnosis Standard (combined) November 2022 achieved the target with performance of 76.4%.

Intervention and Planned Impact

Largely the same as Section 8. Above.

- Additional CT Colon capacity has largely addressed the backlog of patients
- Administration processes continue to be reviewed and actions implemented
- CT colon mutual aid from the Spire
- Improved access to CT Colon internally should have a direct impact on FDS performance for colorectal; November 35.8% October 2022 at 39% which was an improvement on September 2022 30% and August 2022 at 23%. December 2022 performance has further improved and will be reported next month



- Radiotherapy capacity and patient prioritisation continues to adversely affect performance with no mutual aid available in the region to date
- Urology – prostate OPA capacity increased to meet weekly referral demand; key clinicians only seeing suspected prostate patients to ensure they are directed to the correct diagnostic pathway or discharged

Risks / Mitigations

- Referral rate catch up impacts on the cancer PTL and waiting times
- Staff gaps (vacancies and absence) further impact on diagnostic capacity, radiotherapy & waiting times)
- Histology tracking systems implemented locally to prioritise long-wait patients – concern that improvements in timeliness of results have not yet been seen
- Mutual aid sourced for CT Colon with some success –however, requires further refinement to ensure the capacity offered is utilised more effectively
- Additional internal CT Colon capacity continues through December 2022
- Mobile CT capacity continues to be provided by the IS

11. Cancer 63 day+ Performance – Lower GI, Urology, Skin

What the chart tells us

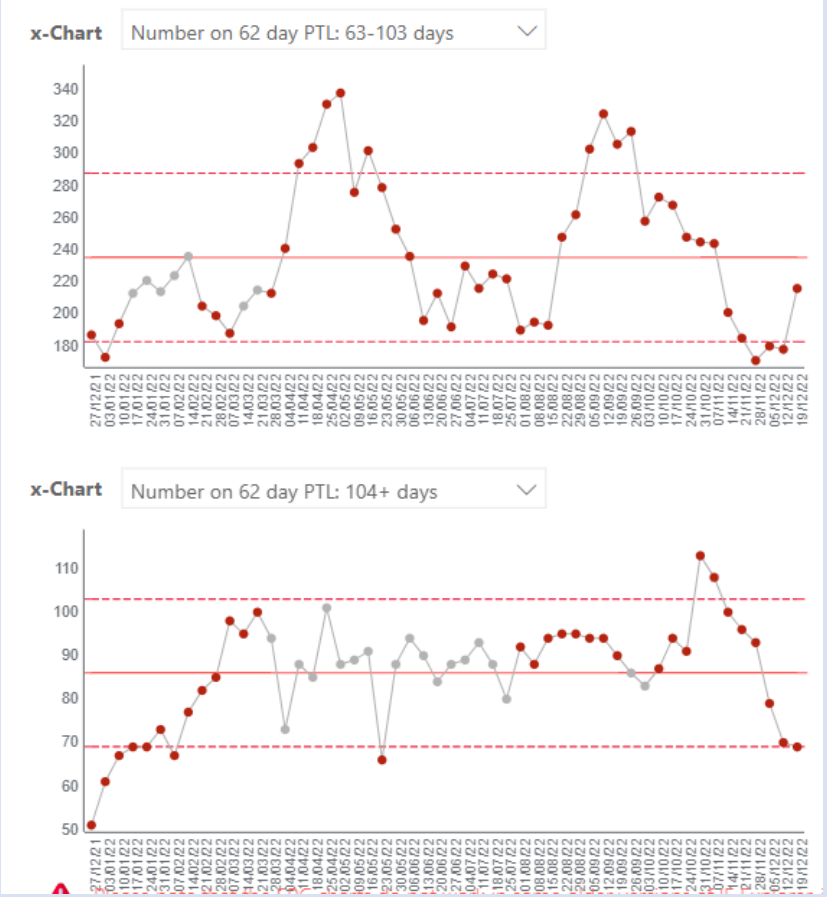
This metric has been added in response to the Elective Recovery Self-Assessment requirements.

The cancer PTL +62-day backlog is beginning to reduce in size, with Colorectal making good progress towards the planned recovery trajectory. In December 2022, there was an expected seasonal increase; patients cancel or DNA appointments, clinical and administration staff annual leave impacts on the efficient tracking of the PTL.

Additionally, NCTR in the CHH bed base affected elective/planned procedures, including for cancer, from week commencing 19 December 2022, which had a detrimental effect on the 63+ day backlog - the recovery trajectory was not achieved.

Week commencing 16.01.23 the PTL showed signs of recovery.

Skin is showing considerable improvements in the reduction of the backlog and was marginally 'off trajectory' in November but within trajectory in December 2022.



Urology backlog had remained static week on week with improvement actions in progress. The December 2022 cancellations had a detrimental effect on the urology trajectory with worsened performance – 8 out of 10 operations in urology are for cancer.

The Gynae-oncology backlog is tracking in the wrong direction with the 63+ and 104+ days increasing most weeks. Some immediate improvements opportunities are being considered with an action plan developed from the service improvement session on 13 January 2023.

The recovery trajectory for December 2022 and January 2023 will not be achieved; however, the 130 target at 31 March 2023 is still expected to achieve, with late IHTs a factor.

The number of 104+ days, although making slow progress is reducing; 94 patients were waiting 104+ days in November however, in December this reduced to 72. Patients are constantly progressing and moving off the PTL and new patients take the place from the 63+ day's backlog. The improvement trajectory to 31 March 2023 remains a challenge, which is affected by late IHTs received at day 80+.

Intervention and Planned Impact

- Additional tracking resource for LGI, funded by the Cancer Alliance, has demonstrated benefits as the primary PTL continues to reduce; further reductions are expected to ensure the Trust backlog does not exceed 130 by 31 March 2023. The recovery trajectory is being met/exceeded demonstrating good progress in this tumour site. Further funding into 23/24 has been secured to continue to support this pathway
- CTC capacity and demand improvements has had a positive impact for patients waiting for diagnostic tests. Further improvements are required to reach the planned sustainable list of no more than two weeks by the end of November 2022; this deadline has not been achieved with waiting times remaining static at ~3 weeks.
- LGI Nurse led triage, currently in development, is intended to shave off up to 7 days at the front end of the pathway (removes a two-step triage process) which continues into December 2022. Further discussions with the MDT lead clinician into January to agree an implementation plan.
- The front end of the Prostate cancer pathway has been identified for transformation intervention to ensure the right patient is on the right prostate pathway (there are 3 distinct treatment pathways); improvement in backlog numbers and Faster Diagnosis Standard is the expected impact
- Understand reasons for and proactive actions to reduce late IHTs

	Risks / Mitigations • Pathology turnaround times for skin and Gynae-oncology remain unacceptably long. Histology tracking systems have been implemented locally to prioritise long-wait patients; concern that improvements in timeliness of results are not yet visible • Mutual aid sourced for CT Colon with some success plus in-house prioritisation • Urology service improvement action plan has been developed and agreed to address gaps and delays • Skin CWT guidance implemented to counteract the long delays in availability pathology results to ensure the PTL is not in accurately reflecting the volume • Gynae-oncology diagnostic pathways coupled with histology turnaround times are of concern • Upper GI pathway 8-week pilot (endoscopy indicative of cancer are escorted to radiology to have a CT scan on the same day)

12. Elective Recovery Fund

	Target	104%	104%	104%	104%	104%	104%	104%	104%	104%		
POD	DATA	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Q3 Total	Grand Total
01 Day Case	2019-20 M10 FOT Baseline	4,044,191	4,230,361	4,014,832	4,402,456	3,913,770	4,165,038	4,412,862	4,115,086	3,670,549	12,198,498	36,969,146
	22-23 Baseline Plan	3,886,720	4,212,249	4,344,252	4,380,168	4,263,009	4,657,413	4,156,644	4,488,322	3,917,096	12,562,062	38,305,873
	Actuals	3,617,775	4,536,981	4,183,067	4,396,718	3,900,595	4,403,513	4,516,998	4,848,261	3,754,771	13,120,030	38,158,680
	Baseline 19/20 %	89%	107.2%	104%	100%	100%	106%	102%	118%	102%	108%	103%
	Plan %	93%	108%	96%	100%	91%	95%	109%	108%	96%	104%	100%
	Indicative Gain/Loss	(441,138)	103,054	5,731	(136,377)	(127,294)	53,906	(54,284)	426,429	(46,950)	325,194	(216,924)
02 Elective	2019-20 M10 FOT Baseline	5,360,427	5,489,596	5,843,159	5,773,436	5,236,041	5,704,305	6,127,880	6,099,478	5,758,620	17,985,978	51,392,943
	22-23 Baseline Plan	5,702,897	6,110,717	5,990,456	6,217,486	6,286,858	6,352,712	6,297,363	6,376,087	6,025,671	18,699,121	55,360,247
	Actuals	4,159,135	5,031,179	5,117,440	5,016,301	4,655,601	4,945,029	4,900,694	5,403,913	4,624,967	14,929,574	43,854,259
	Baseline 19/20 %	78%	92%	88%	87%	89%	87%	80%	89%	80%	83%	85%
	Plan %	73%	82.3%	85%	81%	74%	78%	78%	85%	77%	80%	79%
	Indicative Gain/Loss	(1,061,782)	(508,501)	(719,584)	(741,054)	(592,411)	(740,586)	(1,104,226)	(704,658)	(1,022,998)	(2,831,883)	(7,195,801)
05 Outpatient Firsts	2019-20 M10 FOT Baseline	2,640,750	2,759,378	2,662,984	2,955,371	2,380,527	2,777,070	3,014,479	2,750,214	2,435,809	8,200,501	24,376,581
	22-23 Baseline Plan	2,603,906	2,846,753	2,802,015	2,888,876	2,856,419	3,028,043	2,970,465	3,131,591	2,872,928	8,974,984	26,000,997
	Actuals	2,653,862	3,118,094	2,830,050	2,864,386	2,749,973	2,773,439	2,886,279	3,129,630	2,341,717	8,357,625	25,347,429
	Baseline 19/20 %	100%	113%	106%	97%	116%	100%	96%	114%	96%	102%	104%
	Plan %	102%	109.5%	101%	99%	96%	92%	97%	100%	82%	93%	97%
	Indicative Gain/Loss	(69,388)	186,256	45,410	(156,900)	205,669	(86,035)	(186,584)	202,055	(143,643)	- 128,172	(3,161)
06 Outpatient Followups	2019-20 M10 FOT Baseline	2,555,279	2,764,825	2,600,678	2,932,571	2,407,671	2,748,114	3,033,729	2,795,192	2,439,755	8,268,677	24,277,816
	22-23 Baseline Plan	2,718,188	3,011,828	2,950,842	3,000,947	3,029,555	3,187,902	3,036,939	3,200,108	2,976,863	9,213,910	27,113,171
	Actuals	2,863,690	3,201,316	3,010,946	2,948,237	3,019,027	3,057,324	3,041,667	3,485,657	2,804,659	9,331,983	27,432,524
	Baseline 19/20 %	112%	116%	116%	101%	125%	111%	100%	125%	115%	113%	113%
	Plan %	105%	106%	102%	98%	100%	96%	100%	109%	94%	101%	101%
	Indicative Gain/Loss	-	-	-	-	-	-	-	-	-	-	-
Outpatient Procedures	2019-20 M10 FOT Baseline	1,205,211	1,312,244	1,183,512	1,406,665	1,212,842	1,278,148	1,416,215	1,310,520	1,161,571	3,888,305	11,486,928
	22-23 Baseline Plan	977,002	1,079,583	1,045,209	1,048,279	1,054,034	1,129,927	1,135,024	1,180,063	1,074,673	3,389,760	9,723,793
	Actuals	1,018,405	1,213,055	1,076,913	1,096,077	1,118,283	1,181,536	1,157,324	1,293,137	1,141,190	3,591,652	10,295,922
	Baseline 19/20 %	85%	92%	91%	78%	92%	92%	82%	99%	98%	92%	90%
	Plan %	104%	112%	103%	105%	106%	105%	102%	110%	106%	106%	106%
	Indicative Gain/Loss	(176,261)	(113,759)	(115,454)	(275,141)	(107,305)	(110,804)	(236,654)	(52,352)	(50,132)	(339,139)	(1,237,863)
	2019-20 M10 FOT Baseline	15,805,858	16,556,404	16,305,166	17,470,500	15,150,851	16,672,676	18,005,165	17,070,490	15,466,304	50,541,960	148,503,414
	22-23 Baseline Plan	15,888,713	17,261,130	17,132,773	17,535,756	17,489,875	18,355,997	17,596,435	18,376,171	16,867,230	52,839,836	156,504,081
	Actuals	14,312,867	17,100,625	16,218,416	16,321,719	15,443,481	16,360,842	16,502,962	18,160,597	14,667,304	49,330,863	145,088,813
	Baseline 19/20 %	91%	103%	99%	93%	102%	98%	92%	106%	95%	98%	98%
	Plan %	90%	99%	95%	93%	88%	89%	94%	99%	87%	93%	93%
	Inicative Gain/Loss	(1,748,569)	(332,950)	(783,897)	(1,309,472)	(621,340)	(883,520)	(1,581,749)	(128,527)	(1,263,724)	(2,974,000)	(8,653,749)

What the chart tells us

Recovery of elective activity in December 2022 against the operational plan delivered:

- New Activity 86%
- Follow up Activity 96%
- Day Case Activity 100%
- Ordinary Elective Activity 81%

The indicative activity requirement of 110% of 19/20 baseline was not delivered in any POD.

Overall financial position delivered 87% of the plan and 95% of baseline in December 2022, which is the highest during this financial year.

Intervention and Planned Impact

Access to HOB and ICU capacity remain the limiting factor in relation to IP elective recovery; as is the use of C9A for oncology rather than orthopaedics. Further affected by NCTR patients in the CHH bed base during December 2022 and January 2023.

Additional funding to support HOB expansion at HRI and 8 beds on C15 provided however, physical space and workforce is limiting the delivery.

Day case delivered 104% of plan in December 2022 (108% of 19/20). The December 2022 theatre sessions were reduced by bank holidays and actual delivery further reduced due to the NCTR patients in the CHH bed base. Anaesthetic shortfalls continue which has affected the cardiac surgery theatre provision (also impacted by ICU capacity issues).

OP 1st attendances achieved 93% of the plan in December 2022 and 102% of 19/20 baseline.

Activity data up to	10/01/2023		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
			*Actual activity for current month is projected using working days; actual activity is based on data submitted to SUS								
			Plan activity is from health group submissions with corporate adjustments for a small number of specialties								
Indicative Activity Requirement (% of baseline):			104%	104%	104%	104%	104%	104%	104%	104%	104%
Ceiling target for follow up activity (% of baseline):			75%	75%	75%	75%	75%	75%	75%	75%	75%
TRUST TOTAL	New	Baseline	17,637	17,096	16,632	18,386	14,792	17,746	18,482	17,249	15,263
		Plan	14,229	16,146	15,726	16,348	16,183	17,259	17,044	18,072	16,388
		Actual*	14,276	16,994	15,525	15,573	15,412	15,954	16,467	18,267	14,014
		Plan %	100%	105%	99%	95%	95%	92%	97%	101%	86%
		19/20 Baseline %	81%	99%	93%	85%	104%	90%	89%	106%	92%
	Follow Up	Baseline	33,158	37,048	34,967	38,951	32,800	35,396	40,453	36,572	31,595
		Plan	30,529	35,206	34,395	34,371	34,910	37,462	35,973	37,893	34,517
		Actual*	34,128	38,202	36,070	35,654	36,720	37,079	37,128	41,673	33,030
	(minimise)	Plan %	112%	109%	105%	104%	105%	99%	103%	110%	96%
	(minimise)	19/20 Baseline %	103%	103%	103%	92%	112%	105%	92%	114%	105%
	Day Case	Baseline	6,080	6,198	5,817	6,488	5,948	6,167	6,688	6,244	5,702
		Plan	5,800	6,369	6,594	6,741	6,505	7,118	6,175	6,775	5,888
		Actual*	5,596	6,820	6,273	6,633	6,183	6,590	6,697	7,096	5,902
		Plan %	96%	107%	95%	98%	95%	93%	108%	105%	100%
		19/20 Baseline %	92%	110%	108%	102%	104%	107%	100%	114%	104%
	Ord Elect	Baseline	1,203	1,276	1,296	1,341	1,177	1,275	1,403	1,383	1,244
		Plan	1,175	1,266	1,244	1,296	1,314	1,326	1,316	1,338	1,259
		Actual*	888	1,049	1,072	1,067	973	1059	1,008	1,209	1,025
		Plan %	76%	83%	86%	82%	74%	80%	77%	90%	81%
		19/20 Baseline %	74%	82%	83%	80%	83%	83%	72%	87%	82%

OPFU continue to over-perform at 101% of the plan and 113% of the 19/20 baseline, income is capped at 85% of 19/20 baselines.

Focussed review of OPFU rates and comparison to regional and national performance is continues with the development of OP Transformation Plans at Health Group speciality level. Many procedures are counted/coded in the HUTH follow-ups – work is underway to understand if this activity should be excluded from the reduction in follow up rates.

Risks / Mitigations

- On-going anaesthetic staff shortfalls – rolling recruitment in place and development of Anaesthetic Assistant roles
- Elective activity and elective bed base is not ring-fenced through winter or Covid surges
- OPFU continue to be in excess of 75% of 19/20 baseline at March 2023
- The new day surgery centre does not come on line in January 2023

13. Non-Elective Activity

10/01/2023		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
		*Actual activity for current month is projected using calendar days; actual activity is based on data submitted to SUS								
		100%	100%	100%	100%	100%	100%	100%	100%	100%
Non-elective	Baseline	4,735	4,952	4,603	4,765	4,531	4,537	4,850	4,745	4,790
	Plan	3,934	5,059	4,897	5,249	5,439	5,447	5,818	5,631	5,818
	Actual*	3,672	4,998	4,524	4,888	4,597	4,545	4,861	4,992	5,088
	Plan %	93%	99%	92%	93%	85%	83%	84%	89%	87%
	19/20 Baseline %	78%	101%	98%	103%	101%	100%	100%	105%	106%

What the chart tells us

Non-elective activity in December 2022 was higher than the baseline of 19/20.

Intervention and Planned Impact

-

Risks / Mitigations

-

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	14.2.23
Title	Finance Report – 2022/23 - Month 9				
Lead Director	Lee Bond, Chief Finance Officer				
Author	Stephen Evans, Operational Finance Director				
Report previously considered by (date)					

Purpose of the Report		**Reason for submission to the Trust Board private session**		**Link to CQC Domain**		**Link to Trust Strategic Objectives 2021/22**	
Trust Board Approval		Commercial Confidentiality		Safe		Honest Caring and Accountable Future	
Committee Agreement		Patient Confidentiality		Effective	√	Valued, Skilled and Sufficient Staff	
Assurance	√	Staff Confidentiality		Caring		High Quality Care	
Information Only		Other Exceptional Circumstance		Responsive	√	Great Clinical Services	
				Well-led	√	Partnerships and Integrated Services	
						Research and Innovation	
						Financial Sustainability	√

Key Recommendations to be considered:

a) The reported position of break-even at month 9, which is £0.5m away from plan, chiefly driven by additional wards to support NCTR patients.

b) The in-month pressure on non-pay spend related to Supply Chain, which is being investigated.

c) The risk on elective recovery income if value of activity is below plan and NHSEI enact the clawback in the second half of the year.

d) The uncovered risk of £1.8m in the year-end forecast and the actions needed if the Trust is to deliver its plan. This has improved by £0.1m in month due to additional income.

e) The need to increase in-house productivity and to continue to identify CRES opportunities to reduce the unidentified balance.

f) The underlying deficit of £50m - £56m

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

TRUST BOARD: TUESDAY 14th FEBRUARY 2023

FINANCIAL UPDATE 2022/23 – MONTH 9

1. Purpose of Paper

To update the Trust Board on the financial position at month 9 and the year-end forecast.

2. Background

The Trust has submitted a balanced financial plan for 2022/23. This included agreement to release £9.7m from the balance sheet and non-recurrent income of £28.1m. With additional full-year effects of agreed slippage and developments (£5.7m), this meant that the Trust began the year with an underlying deficit of £43.5m.

3. Month 9

The table in appendix 1 shows the month 9 reported position against the revised NHSI plan, at health group level. The Trust is reporting a break-even position, which is £0.5m worse than the plan. This is unchanged from month 8.

Income

Confirmation has been given that there will be no clawback of Elective Recovery Funding (ERF) in the first six months of the financial year. This removes the risk of the Trust losing up to £6m in the first half of the year due to activity value being below 104% target. Details of the process for months 7 – 12 are to be confirmed but ICBs have been told to assume no clawback. ICBs may still enact clawbacks and redistribution within systems.

The Trust position includes the receipt of capacity funding for additional NCTR beds in quarter 3 (£1.1m).

The Trust has received an additional £1.1m from NHSE specialist commissioning and £0.8m has been included in the position at month 9.

Education income is also above plan (£0.6m), which is being utilised to pay for additional accommodation costs for Junior Doctors, clinical nurse educators and additional medical posts in Medicine health group.

The Trust has received and additional £0.7m of income from the ICB to offset the shortfall in the cost of the 2022/23 pay award. The pay award has now been fully funded for 2022/23, although £1m of this has only been provided non recurrently.

The Trust is £0.7m above plan on interest receivable, an increase of £0.2m in month.

The Trust plan assumed receipt of Salix grant income but this will not happen until 2023/24. This does not affect the Trust reported performance position.

Expenditure
Health groups and corporate areas are reporting that they have a deficit of £4.2m at month 9. This is an increase of £0.7m in month.
The CRES position is on plan at month 9, an improvement of £0.1m in month. The overall forecast is now for 100% delivery of the CRES plan in 2022/23. Over delivery in Estates, Facilities and Development due to a non-recurrent rates rebate is offsetting shortfalls in the Health Groups. £4.7m of this is non-recurrent, an improvement of £0.3m from previous month. Health Groups need to continue focusing on identifying recurrent schemes. The breakdown by Health Group is as per the following table:

	YTD CRES Plan £'k	YTD CRES Actual £'k	YTD CRES Variance £'k	% Achieved YTD
Medicine	1,571	1,571	0	100%
Emergency Medicine	290	215	-75	74%
Surgery	2,189	1,962	-227	90%
Family & Womens Health	1,382	1,171	-211	85%
Clinical Support Services	1,615	1,481	-134	92%
Corporate	1,293	1,293	0	100%
Estates, Facilities & Development	429	1,041	612	243%
Energy	3,862	3,862	0	100%
Central	268	268	0	100%
TOTAL	**12,899**	**12,864**	**-35**	100%

	Annual CRES Target £'k	Forecast CRES Achievement £'k	Forecast CRES Variance £'k	% Achieved Forecast
Medicine	1,825	1,764	-61	97%
Emergency Medicine	397	297	-100	75%
Surgery	3,070	2,767	-303	90%
Family & Womens Health	1,814	1,533	-281	85%
Clinical Support Services	2,150	2,052	-98	95%
Corporate	1,709	1,709	0	100%
Estates, Facilities & Development	865	1,680	815	194%
Energy	5,149	5,149	0	100%
Central	357	357	0	100%
TOTAL	**17,336**	**17,308**	**-28**	100%

Excluding CRES the overall HG position deteriorated by £0.8m.This was after receipt of £1.5m transferred from reserves at month 9 to cover costs of Junior Doctors pressures. Without this funding, the Health Groups would have deteriorated by £2.3m. The main issue was within non-pay areas especially linked to Supply Chain expenditure. Health Groups are investigating and it looks like it relates to increased use of disposable consumables, switching of products to higher cost alternatives due to Supply Chain having problems sourcing original orders and inflation increases. The expenditure is to be monitored closely over next few months to ensure a grip is maintained on the position.

Surgery Health Group overspent by £0.9m in month after receiving £0.75m funding to support Junior Doctors spend. The main element was non-pay spend as detailed above (£0.6m) with premium cost of Anaesthetic Consultants (£0.2m) and small other income shortfall (£0.1m).

Medicine Health Group overspent by £0.5m in month, driven by non-pay expenditure in Cardiology linked to high cost devices.

Family and Women's Health Group is £0.4m over-spent in month after receiving £0.75m funding to support Junior Doctors. The main driver was the high level of Wet AMD cases (£0.2m), Consultant agency usage and paediatric devices (£0.1m).

High cost drugs within the block ontract increased by £0.3m to £0.8m overspent.

ED Health Group deteriorated by £0.1m with higher expenditure on nursing and non-pay areas.

Corporate position deteriorated by £0.1m due to expenditure on Covid19 including storage and some supplies bought centrally.

Estates, Facilities and Development overspent by £0.1m with pressure on water usage.

4. Agency Spend

NHSEI have re-established controls on Trust agency expenditure. They have set targets for individual Trusts to reduce agency expenditure by a minimum of 10% in 2022/23 compared to 2021/22 levels. The targets for HUTH are as follows:

2021/22 Expenditure	£10.6m
Expected Reduction	£1.1m
Maximum expected spend	£9.5m

The Trust initial plan had forecast expenditure of £11.0m for 22/23 so £1.5m above the new target.

Expenditure to Month 9 was £7.8m with year-end forecast of £10.3m. This would be £0.8m above the revised target but is £0.7m below the Trust initial plan. The main reduction has been on Consultant expenditure but there is pressure on use of agency to cover trainee grades.

5. Forecast

The Trust is currently reporting that it will deliver its financial plan for 22/23. This includes two major risks.

a) £1.8m of uncovered risk within Health Group expenditure plans.
b) ERF target of 104% activity value is delivered or funding is not clawed back in second half of the year.

The £1.8m expenditure risk can be broken down into the following areas.

ERF Capacity	£2.2m
NCTR wards	£0.8m
High Cost Drugs	£0.8m
Virtual Ward	£0.2m
Spec Comm Funding	(£1.2m)
Various Underspends	(£1.0m)
Total	£1.8m

The uncovered risk has improved by £0.1m with additional funding received to cover pay award shortfall offsetting additional pressures on non-pay expenditure.

Action will need to be taken to address the remaining risk. This will include:

a) Review expected IS usage in final quarter to bring expected spend back down in line with annual funding. This will include increasing in-house productivity to reduce the need to outsource.
b) Continue to push for identification and delivery of CRES schemes through Productivity and Efficiency Board and potentially bring forward schemes from next year.
c) Continue to review reserves/balance sheet for further slippage/offsets.

6. Underlying Position

The Trust started the year with an underlying deficit of £43.5m (assuming ERF and Covid19 income are non-recurrent). Including the level of non-recurrent CRES (£4.7m) and additional in-year pressures will move this to a position of between £50m - £56m. This will be reviewed and updated as part of 2023/24 planning to reflect agreed funding.

7. Statement of Financial Position (SOFP) and Statement of Cash flow (SOCF)

The SOFP and SOCF for month 9 are reported in appendices 2 and 3.

Capital

The reported capital position at month 9 shows gross capital expenditure of £14.9m against a plan of £22.8m. The main areas of expenditure relate to the Digestive Disease Scheme, Day Surgery Scheme and PFI lifecycle costs. The main variance from plan relates to the Salix Grant scheme (£6m) which has now slipped to 2023/23.

The forecast capital expenditure for 2022/23 (incl PFI/IFRIC12 impact) is £37.8m; this has changed from plan due to the Salix Grant scheme (£10m) mentioned above. The revised total also now includes confirmed PDC schemes including Lung Health check (£1.136m); Endoscopy (£0.6m); MH ED (£0.8m); NICU (£0.8m) and early drawdown Phase 2 Day Surgery (£5.4m). It does not yet include other PDC bids the Trust has submitted in relation to Community Diagnostics.

The planned capital spend is £0.7m above the Trust CDEL limit. This is to support slippage across the ICS. The Trust has brought forward planned expenditure from 23/24 into this year to offset undershoots in other Trust in the ICS.

Stocks

Stock levels are at £18.8m, an increase of £2.3m in month and £2.9m higher than year-end.

Health Group	Mar 22 £000	Nov 22 £000	Dec 22 £000	Change from March 22 £000
Clinical Support	7,178	7,555	9,099	1,921
Surgery	4,489	4,718	4,823	334
Medicine	2,326	2,367	2,935	609
F & WH	1,096	1,020	1,154	59
Other	434	438	441	7
PPE Stock	345	345	345	0
Total	15,867	16,441	18,797	2,929

Stock levels increased in the run up to Christmas, especially in Pharmacy. This will return to normal for month 10.

All health groups have been tasked with reviewing stock levels and confirming that the levels held represent the appropriate level of risk compared to expected delivery times.

Cash

The Trust's liquidity position remains healthy with a cash balance of £61.5m at the end of December. The estimated forecast cash balance by the end of March 23 remains at £55m but this is dependent on the timing of expected PDC.

To date the Trust has paid 95.2% by volume and 84.2 by value of non-NHS invoices within best practice terms. In December, the figures were 96.9% and 76.9% respectively

Debtors

The Trust currently has £3.5m of debt that is over 90 days, a reduction of £0.5m from month 8. The main debtors are as follows:

Debtors Over 90 Days	November 22	December 22	Change
	£	£	£
Northern Lincolnshire And Goole Nhs Ft	772,399	736,419	-35,980
Humber Teaching Nhs Foundation Trust	285,831	255,911	-29,921
Astrazeneca Ltd	61,225	61,225	0
Crawford & Company Adjusters (Uk) Ltd	60,720	60,720	0
East Riding Fertility Services Ltd	65,636	59,154	-6,482
York & Scarborough Teaching Hospitals Nhs Ft	279,719	58,837	-220,882
Ge Healthcare	51,962	51,962	0
University Of Hull	43,074	51,574	8,500
Fresenius Medical Care Renal Services Ltd	77,505	37,298	-40,207
City Health Care Partnership	128,253	31,524	-96,729
East Riding Of Yorkshire Council	96,082	-70,778	-166,860
Other	2,092,668	2,131,355	38,687
Total	4,015,075	3,465,203	-549,872

£286k of the NLAG debt relates to a recharge for the running of the ICS. This is under review with the CFO and the risk of this invoice lies with the ICS. £154k of the Humber FT value also relates to the same reason. This invoice was paid at the beginning of February 23.

Recommendations

The Trust Board is asked to note the following:

a) The reported position of break-even at month 9, which is £0.5m away from plan, chiefly driven by additional wards to support NCTR patients.

b) The in-month pressure on non-pay spend related to Supply Chain, which is being investigated.

c) The risk on elective recovery income if value of activity is below plan and NHSEI enact the clawback in the second half of the year.

d) The uncovered risk of £1.8m in the year-end forecast and the actions needed if the Trust is to deliver its plan. This has improved by £0.1m in month due to additional income.

e) The need to increase in-house productivity and to continue to identify CRES opportunities to reduce the unidentified balance.

f) The underlying deficit of £50m - £56m

Stephen Evans
Operational Finance Director
January 2023

APPENDIX 1

Financial Year 2022/23 Month 9

	Annual Budget £000	Budget £000	Actual £000	Variance £000	Month 8 £000	Change In Month £000	Month 9 Forecast £000	Month 8 Forecast £000	Change In Month £000
Nhs Contract Income	651,560	488,960	491,159	2,199	766	1,433	3,941	3,832	109
ERF Income	19,718	14,789	14,789	0	0	0	0	0	0
Nhs Other Clinical Income	209	157	168	11	10	1	14	14	0
Education + Training Income	21,556	16,100	16,676	576	467	109	874	874	0
Other Income	2,320	1,740	1,673	(67)	(162)	95	(90)	(122)	32
Donated/Grant Income	10,460	7,360	11	(7,349)	(6,260)	(1,089)	(9,728)	(10,000)	272
Total Income	**705,823**	**529,105**	**524,475**	**(4,630)**	**(5,179)**	**549**	**(4,989)**	**(5,402)**	**413**
Surgery	(151,141)	(114,243)	(116,229)	(1,986)	(1,857)	(129)	(3,462)	(3,121)	(341)
Medicine	(94,239)	(70,675)	(71,578)	(903)	(405)	(498)	(1,623)	(1,081)	(542)
Clinical Support Services	(104,705)	(78,953)	(78,470)	483	503	(20)	408	335	73
Pass through drugs	(68,284)	(51,213)	(52,049)	(836)	(568)	(268)	(855)	(837)	(18)
Family + Womens Health	(91,494)	(69,109)	(69,947)	(838)	(1,161)	323	(1,085)	(1,999)	914
Corporate Directorates	(80,368)	(60,486)	(60,394)	92	185	(93)	353	433	(80)
Reserves	472	1,595	1,933	338	1,774	(1,436)	(948)	(626)	(322)
Pay Award	11,200	8,400	8,400	0	(445)	445	0	0	0
Other Operating Expenditure	(6,802)	(5,104)	(4,890)	214	95	119	258	105	153
Emergency Care Health Group	(19,148)	(14,295)	(14,297)	(2)	97	(99)	(129)	(62)	(67)
Estates Facilities & Developmt	(55,619)	(40,791)	(41,211)	(420)	(350)	(70)	(517)	(521)	4
Unaddressed Risk	0	0	0	0	0	0	1,837	1,895	(58)
Total Operating Expenditure	**(660,128)**	**(494,874)**	**(498,732)**	**(3,858)**	**(2,132)**	**(1,726)**	**(5,763)**	**(5,479)**	**(284)**
Donated Asset Income	(10,460)	(6,260)	0	6,260	6260	0	9,728	10,000	(272)
EBITDA	**35,235**	**27,971**	**25,743**	**(2,228)**	**(1,051)**	**(1,177)**	**(1,024)**	**(881)**	**(143)**
Depreciation	(22,161)	(16,626)	(16,691)	(65)	(1)	(64)	0	0	0
Interest Payable	(6,236)	(4,620)	(4,802)	(182)	(161)	(21)	(163)	(158)	(5)
Interest Receivable	217	162	873	711	533	178	947	799	148
Pdc Dividends	(8,195)	(6,146)	(6,146)	0	0	0	0	0	0
Total Non Operating Expenditure	**(36,375)**	**(27,230)**	**(26,766)**	**464**	**371**	**93**	**784**	**641**	**143**
Net Surplus/Deficit	**9,320**	**7,001**	**(1,023)**	**(8,024)**	**(6,940)**	**(1,084)**	**(9,968)**	**(10,240)**	**272**
Donated Asset Adjustment (NEW)	(9,320)	(6,505)	1,023	7,528	6,420	1,108	9,968	10,240	(272)
Adjusted Financial Performance before Profit/Loss Adjustment	**0**	**496**	**0**	**(496)**	**(520)**	**24**	**0**	**0**	**0**
Profit/Loss Disposal Assets Adjustment	0	0	0	0	0	0	0	0	0
Adjusted Financial Performance Surplus/Deficit	**0**	**496**	**0**	**(496)**	**(520)**	**24**	**0**	**0**	**0**

APPENDIX 2

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

STATEMENT OF FINANCIAL POSITION

	Accounts 31/03/2022 2021/22 £000	Actual 31/09/2022 YTD £000	Actual 30/10/2022 YTD £000	Actual 30/11/2022 YTD £000	Actual 30/12/2022 YTD £000	Movement from 31/03/22 £000	Forecast 31/03/2023 YTD £000
Non-current assets							
Intangible assets	8,790	9,213	9,103	8,993	8,884	94	8,683
Property, plant and equipment: on-SoFP IFRIC 12	63,165	62,369	62,236	62,118	61,986	(1,179)	65,573
Property, plant and equipment: other	322,078	317,919	318,264	318,864	320,594	(1,484)	353,294
Right of use assets - leased assets for lessee (exc	0	8,408	8,249	8,250	8,067	8,067	7,777
Investment property	100	100	100	100	100	0	100
Investments in joint ventures and associates	0	0	0	0	0	0	0
Other investments / financial assets	536	536	536	536	536	0	536
Receivables: due from NHS and DHSC group bodi	1,338	1,398	1,398	1,398	1,338	0	1,469
Receivables: due from non-NHS/DHSC group bod	1,953	1,887	1,887	1,887	1,946	(7)	2,253
Other assets	0	0	0	0	0	0	0
Total non-current assets	**397,960**	**401,830**	**401,773**	**402,146**	**403,451**	**5,491**	**439,685**
Current assets							
Inventories	15,867	16,347	16,565	16,441	18,795	2,928	15,897
Receivables: due from NHS and DHSC group bodi	17,732	13,618	29,284	17,150	19,859	2,127	12,124
Receivables: due from non-NHS/DHSC group bod	15,227	16,254	17,304	16,263	8,712	(6,515)	9,134
Other investments / financial assets	0	0	0	0	0	0	0
Other assets	0	0	0	0	0	0	0
Non-current assets for sale and assets in disposal	0	0	0	0	0	0	0
Cash and cash equivalents: GBS/NLF	79,415	72,272	71,250	75,490	61,455	(17,960)	55,000
Cash and cash equivalents: commercial / in hand	13	10	16	39	22	9	20
Total current assets	**128,254**	**118,501**	**134,419**	**125,383**	**108,843**	**(19,411)**	**92,175**
Current liabilities							
Trade and other payables: capital	(32,732)	(7,842)	(5,929)	(5,543)	(3,245)	29,487	(33,353)
Trade and other payables: non-capital	(108,479)	(115,806)	(129,429)	(119,600)	(107,311)	1,168	(99,724)
Borrowings	(2,989)	(5,115)	(5,176)	(5,361)	(5,425)	(2,436)	(5,436)
Other financial liabilities	0	0	0	0	0	0	0
Provisions	(3,997)	(3,949)	(492)	(492)	(490)	3,507	(447)
Other liabilities: deferred income including contr	(3,277)	(10,728)	(18,859)	(20,415)	(20,415)	(17,138)	(6,532)
Liabilities in disposal groups	0	0	0	0	0	0	0
Total current liabilities	**(151,474)**	**(143,440)**	**(159,885)**	**(151,411)**	**(136,886)**	**14,588**	**(145,492)**
Total assets less current liabilities	**374,740**	**376,892**	**376,307**	**376,118**	**375,408**	**668**	**386,368**
Non-current liabilities							
Trade and other payables	0	0	0	0	0	0	0
Borrowings	(51,377)	(54,370)	(54,037)	(53,744)	(53,390)	(2,013)	(51,694)
Other financial liabilities	0					0	
Provisions	(2,924)	(2,924)	(2,924)	(2,924)	(2,924)	0	(2,928)
Other liabilities	0	0	0	0	0	0	0
Total non-current liabilities	**(54,301)**	**(57,294)**	**(56,961)**	**(56,668)**	**(56,314)**	**(2,013)**	**(54,622)**
Total assets employed	**320,439**	**319,598**	**319,346**	**319,450**	**319,094**	**(1,345)**	**331,746**
Financed by							
Taxpayers' equity							
Public dividend capital	330,863	330,863	330,863	330,863	330,863	0	342,817
Revaluation reserve	26,537	26,538	26,537	26,537	26,537	0	26,537
Financial assets at FV through OCI reserve	536	536	536	536	536	0	536
Other reserves	0	0	0	0	0	0	0
Merger reserve	0	0	0	0	0	0	0
Income and expenditure reserve	(37,497)	(38,339)	(38,590)	(38,486)	(38,842)	(989)	(38,144)
Others' equity							
Non-controlling Interest	0	0	0	0	0	0	0
Charitable fund reserves	0	0	0	0	0	0	0
Total taxpayers' and others' equity	**320,439**	**319,598**	**319,346**	**319,450**	**319,094**	**(989)**	**331,746**

APPENDIX 3

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

STATEMENT OF CASH FLOWS

	Accounts 31/03/2022	Actual 31/12/2022 YTD
	£000	£000
Cash flows from operating activities		
Operating surplus/(deficit) from continuing operations	14,669	8,746
Operating surplus/(deficit) of discontinued operations		
Operating surplus/(deficit)	**14,669**	**8,746**
Non-cash or non-operating income and expense:		
Depreciation and amortisation	18,210	16,626
Impairments and reversals	15,919	0
Income recognised in respect of capital donations (cash and non-cash)	(17,454)	(11)
Amortisation of PFI deferred income / credit	0	0
On SoFP pension liability - employer contributions paid less net charge to the SOCI	0	
(Increase)/decrease in receivables	(11,730)	2,236
(Increase)/decrease in other assets	0	0
(Increase)/decrease in inventories	(885)	(2,928)
Increase/(decrease) in trade and other payables	38,392	(12,288)
Increase/(decrease) in other liabilities	2,547	(3,277)
Increase/(decrease) in provisions	1,031	(3,519)
Corporation tax (paid) / received		
Movements in operating cash flows of discontinued operations		
Other movements in operating cash flows	(1)	
Net cash generated from / (used in) operations	**60,698**	**5,585**
Cash flows from investing activities		
Interest received	41	873
Purchase of financial assets / investments		
Proceeds from sales / settlements of financial assets / investments		
Purchase of intangible assets	(3,062)	(1,084)
Proceeds from sales of intangible assets		
Purchase of property, plant and equipment and investment property	(71,910)	(11,376)
Proceeds from sales of property, plant and equipment and investment property	136	0
Receipt of cash donations to purchase capital assets	12,249	11
Prepayment of PFI capital contributions (cash payments)		
Cash flows attributable to investing activities of discontinued operations		
Cash movement from acquisitions of business units and subsidiaries (not absorption transfers)		
Cash movement from disposals of business units and subsidiaries (not absorption transfers)		
Net cash generated from/(used in) investing activities	**(62,546)**	**(11,576)**
Cash flows from financing activities		
Public dividend capital received	38,616	0
Public dividend capital repaid	0	0
Movement in loans from the Department of Health and Social Care	(1,260)	(630)
Movement in other loans	0	0
Other capital receipts		0
Capital element of finance lease rental payments	(56)	(1,567)
Capital element of PFI, LIFT and other service concession payments	(1,583)	(1,244)
Interest on DHSC loans	(395)	(184)
Interest on other loans		
Other interest (e.g. overdrafts)		
Interest element of finance lease	(4)	(44)
Interest element of PFI, LIFT and other service concession obligations	(5,520)	(4,495)
PDC dividend (paid)/refunded	(7,450)	(3,795)
Cash flows attributable to financing activities of discontinued operations		
Cash flows from (used in) other financing activities		
Net cash generated from/(used in) financing activities	**22,348**	**(11,959)**
Increase/(decrease) in cash and cash equivalents	**20,500**	**(17,950)**
Cash and cash equivalents at 1 April - brought forward	58,927	79,427
Prior period adjustments		
Cash and cash equivalents at 1 April - restated	**58,927**	**79,427**
Cash and cash equivalents at start of period for new FTs	0	
Cash and cash equivalents transferred by absorption	0	
Unrealised gains/(losses) on foreign exchange		
Cash transferred to NHS foundation trust upon authorisation as FT	0	0
Cash and cash equivalents at Month (Year) End	**79,427**	**61,477**

Humber & North Yorkshire
Health & Care Partnership
Procurement Collaborative

HUMBER & NORTH YORKSHIRE PROCUREMENT COLLABORATIVE

Business Case for the establishment of a shared procurement collaborative

Version 1.6
February 2023

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	HNY Procurement Collaborative	12/10/2022	n/a	n/a	Incorporating comments from L Bond and A Bertram
0.3	Edward James	HNY Procurement Collaborative	28/10/2022	n/a	n/a	Updated recommended structure following Procurement Board 26/10/22.
1.0	Edward James	HNY Procurement Collaborative	01/12/2022	Procurement Board	01/12/2022	Version updated to reflect approval at Procurement Board.
1.1	Edward James	HNY Procurement Collaborative	19/12/2022	HUTH Performance & Finance Committee	19/12/2022	Approval from HUTH Performance & Finance Committee
1.2	Edward James	HNY Procurement Collaborative	23/12/2022	n/a	n/a	Including comments from YSTH Business Case Panel
1.3	Edward James	HNY Procurement Collaborative	16/01/2023	Collaborative of Acute Providers	16/01/2023	Approval from Collaborative of Acute Providers
1.4	Edward James	HNY Procurement Collaborative	23/01/2023	NLAG Trust Management Board	23/01/2023	Approval from NLAG Trust Management Board
1.5	Edward James	HNY Procurement Collaborative	25/01/2023	HUTH Productivity & Efficiency Board	25/01/2023	Approval from HUTH Productivity & Efficiency Board
1.6	Edward James	HNY Procurement Collaborative	01/02/2023	YSTH Executive Committee	01/02/2023	Approval from YSTH Executive Committee

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:

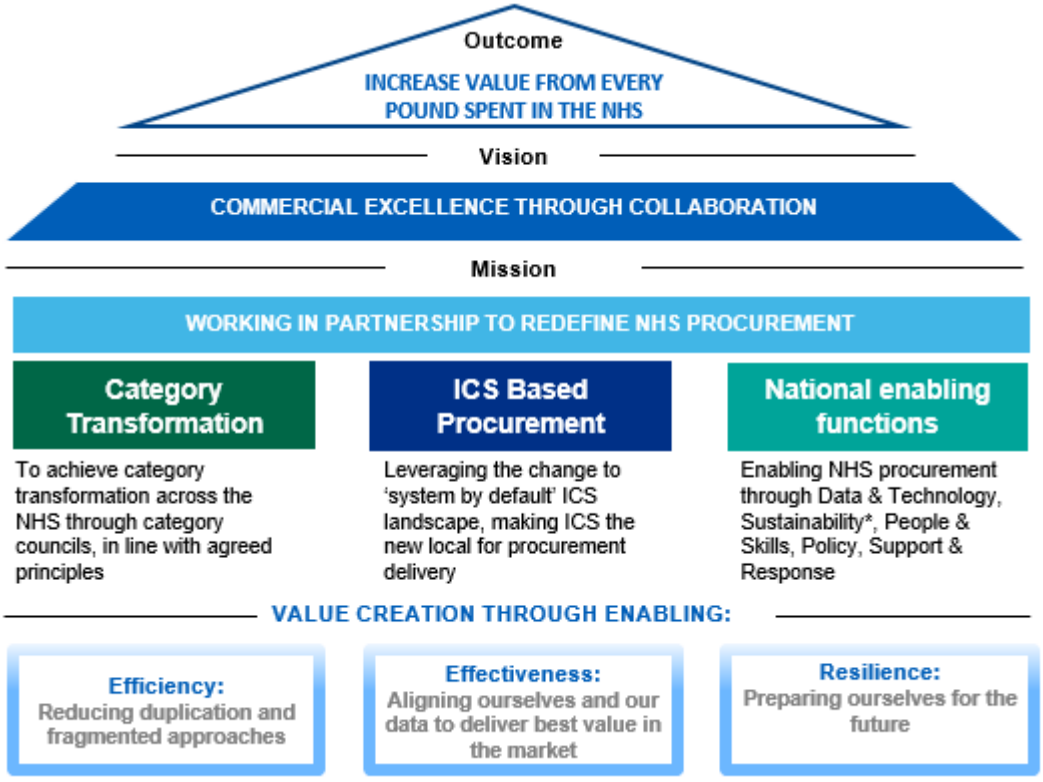


Figure 5 – PTOM Vision & Mission

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:

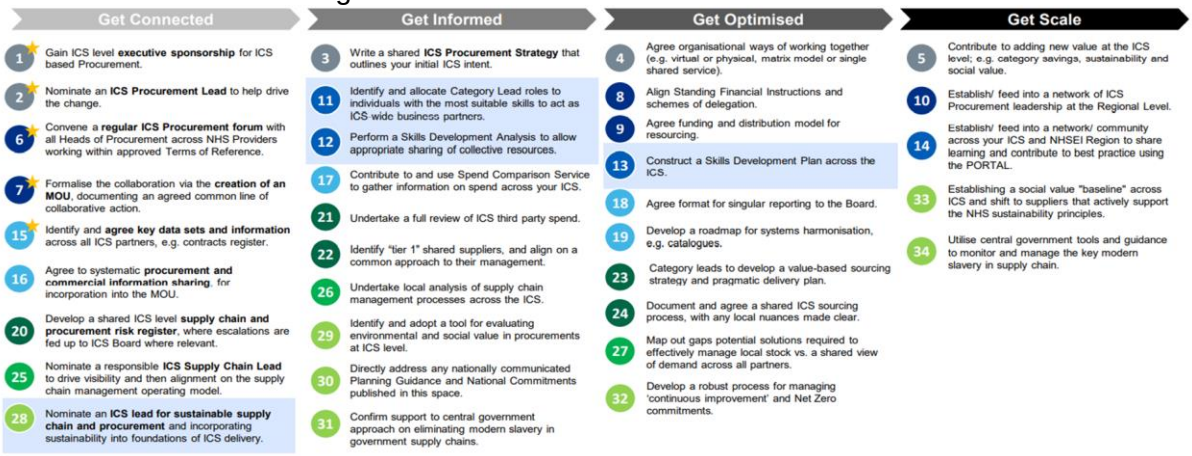


Figure 6 – PTOM 34 Actions

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.

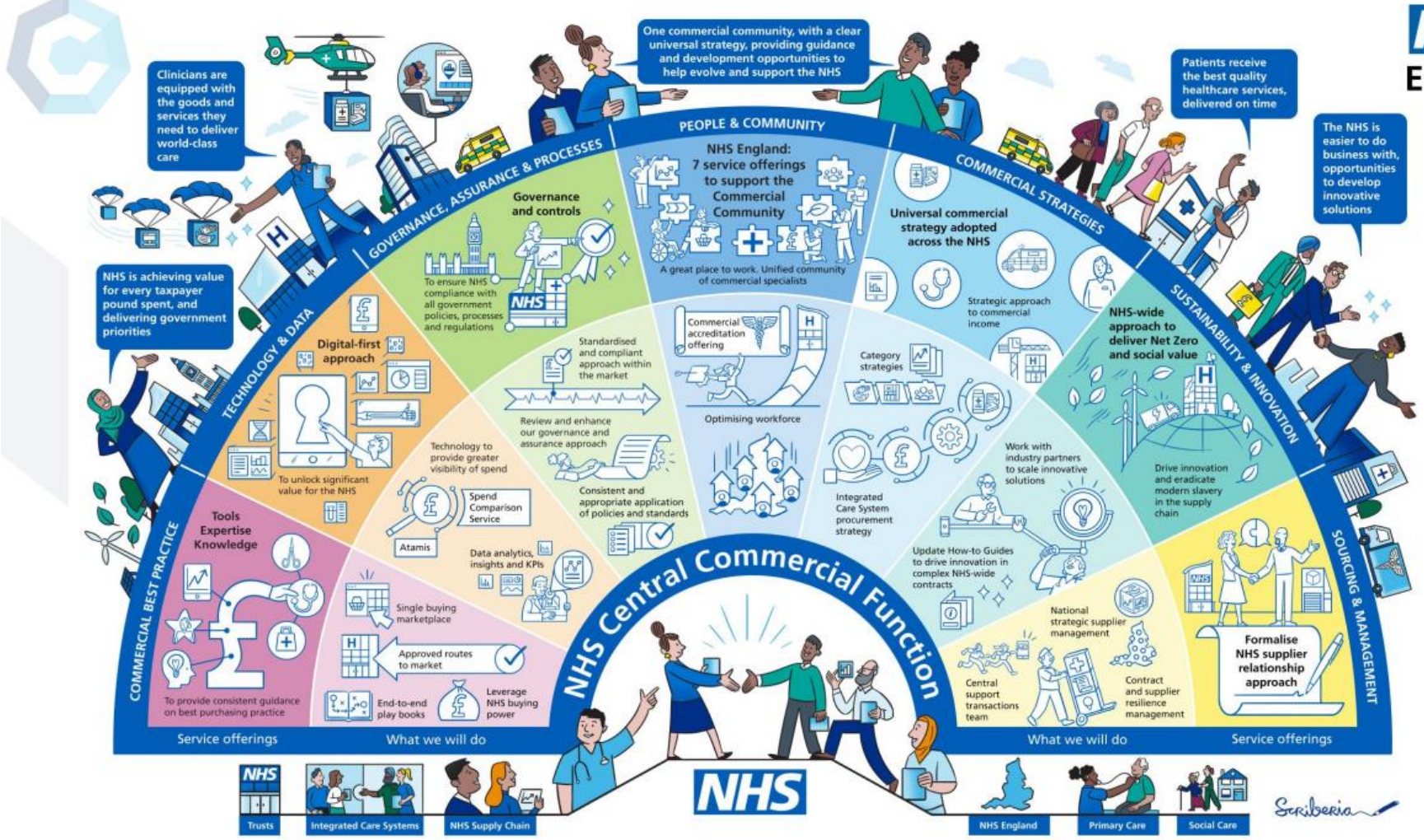


Figure 7 – CCF 7 Areas of Focus

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:

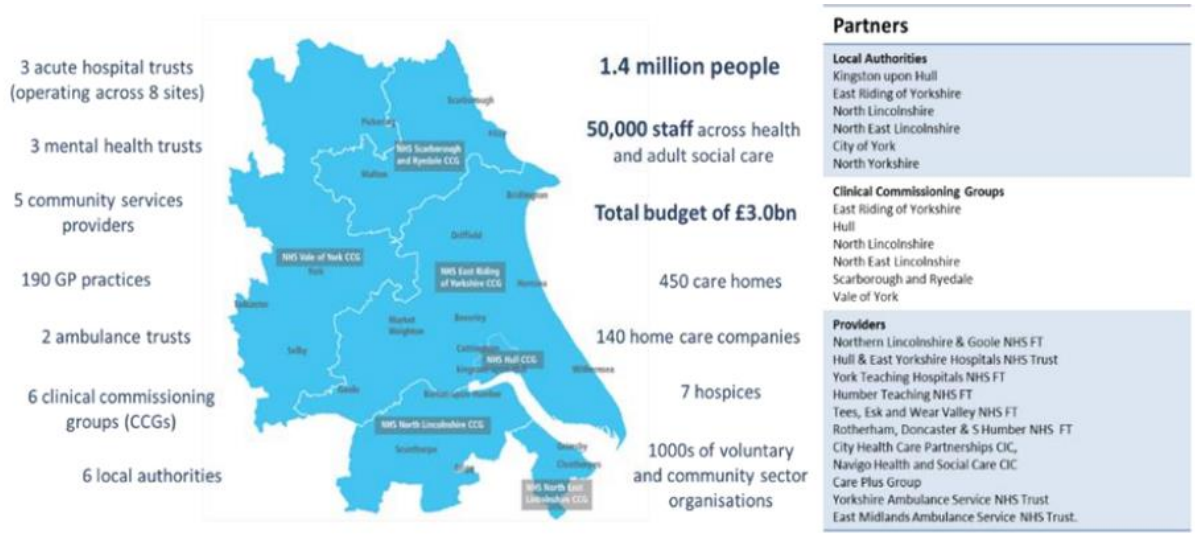


Figure 8 – HNYICS Footprint

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:

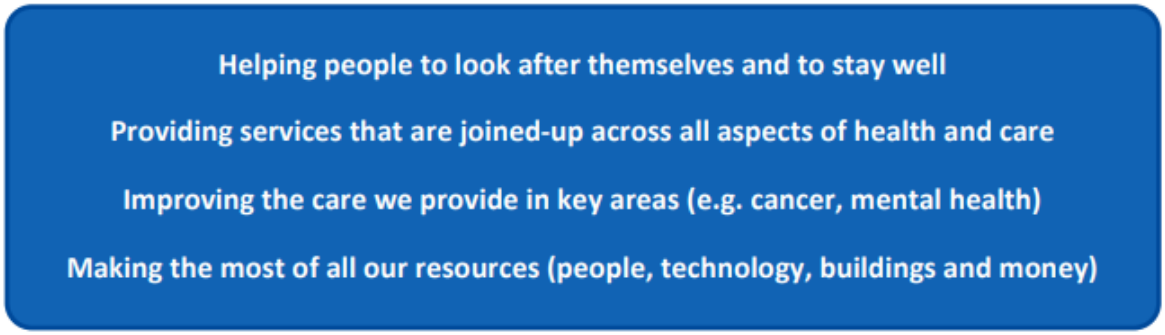


Figure 9 – HNYICS Priorities

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.

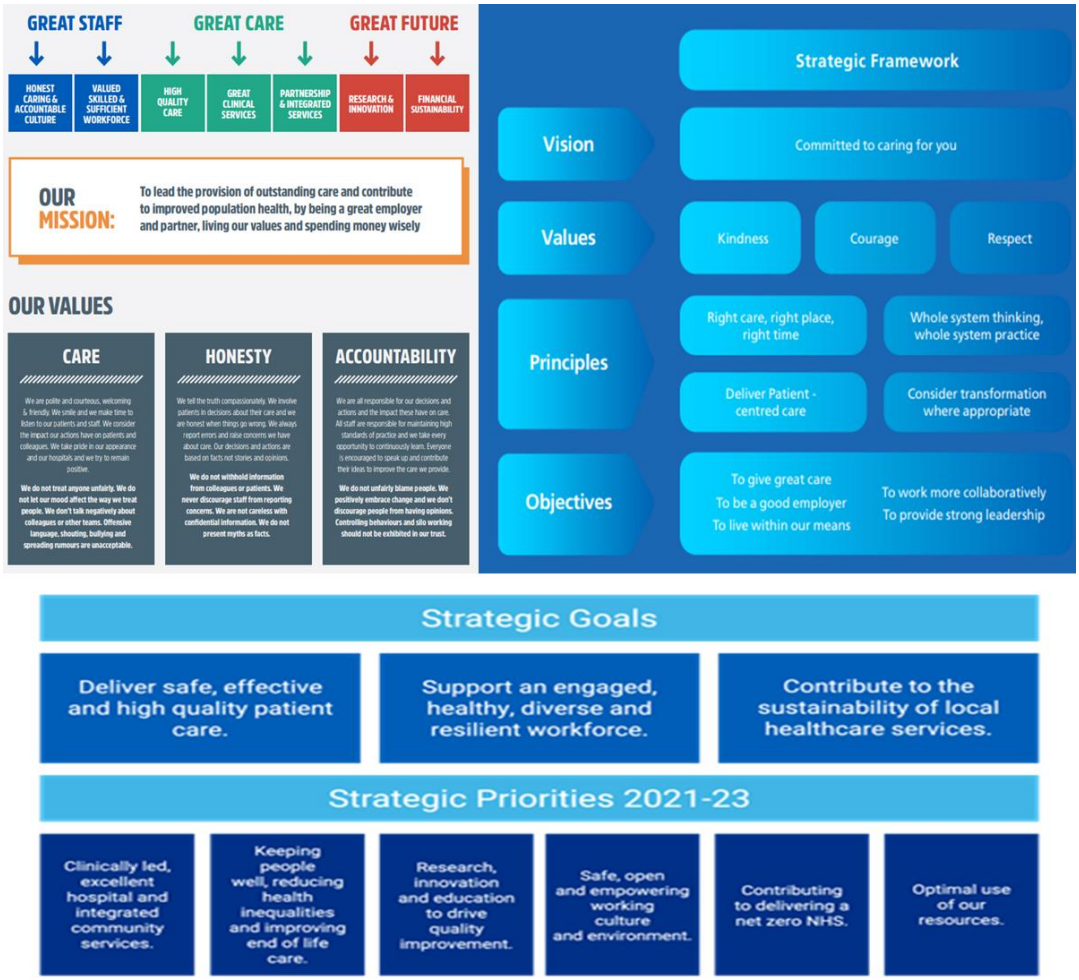


Figure 10 – Partner Trust Priorities

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.

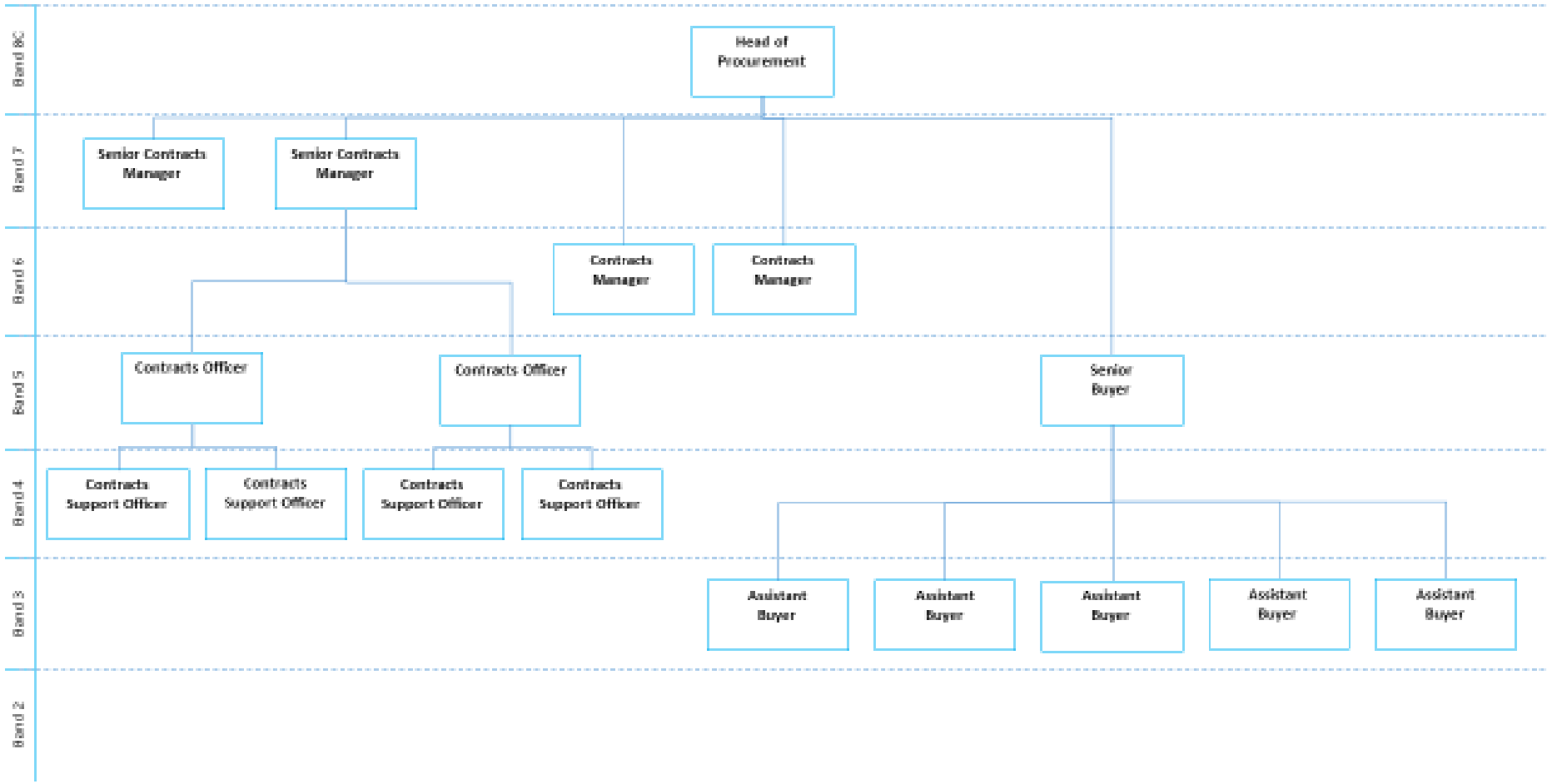


Figure 13 – HUTH Procurement Team

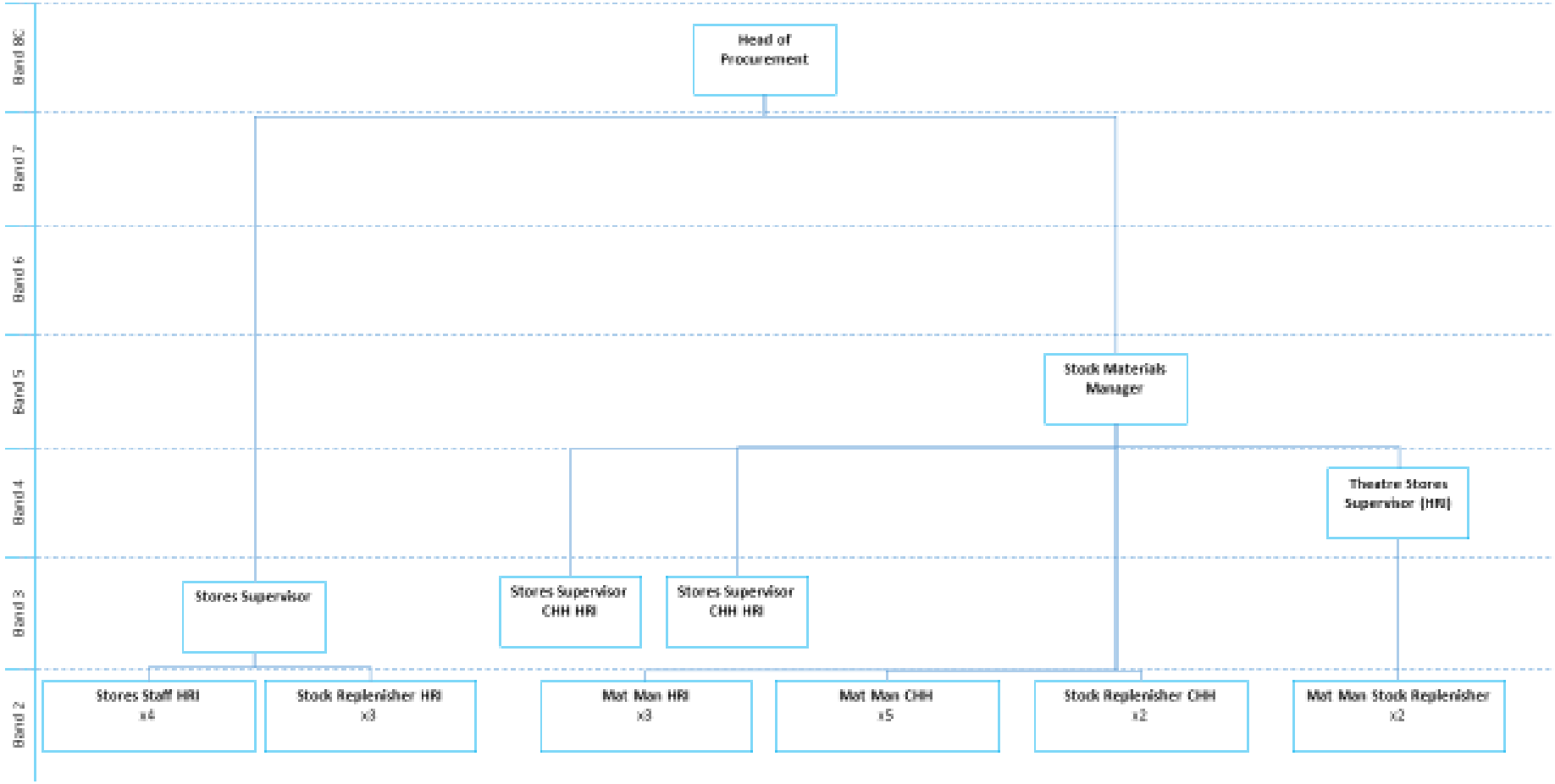


Figure 14 – HUTH Stores and Mat Man

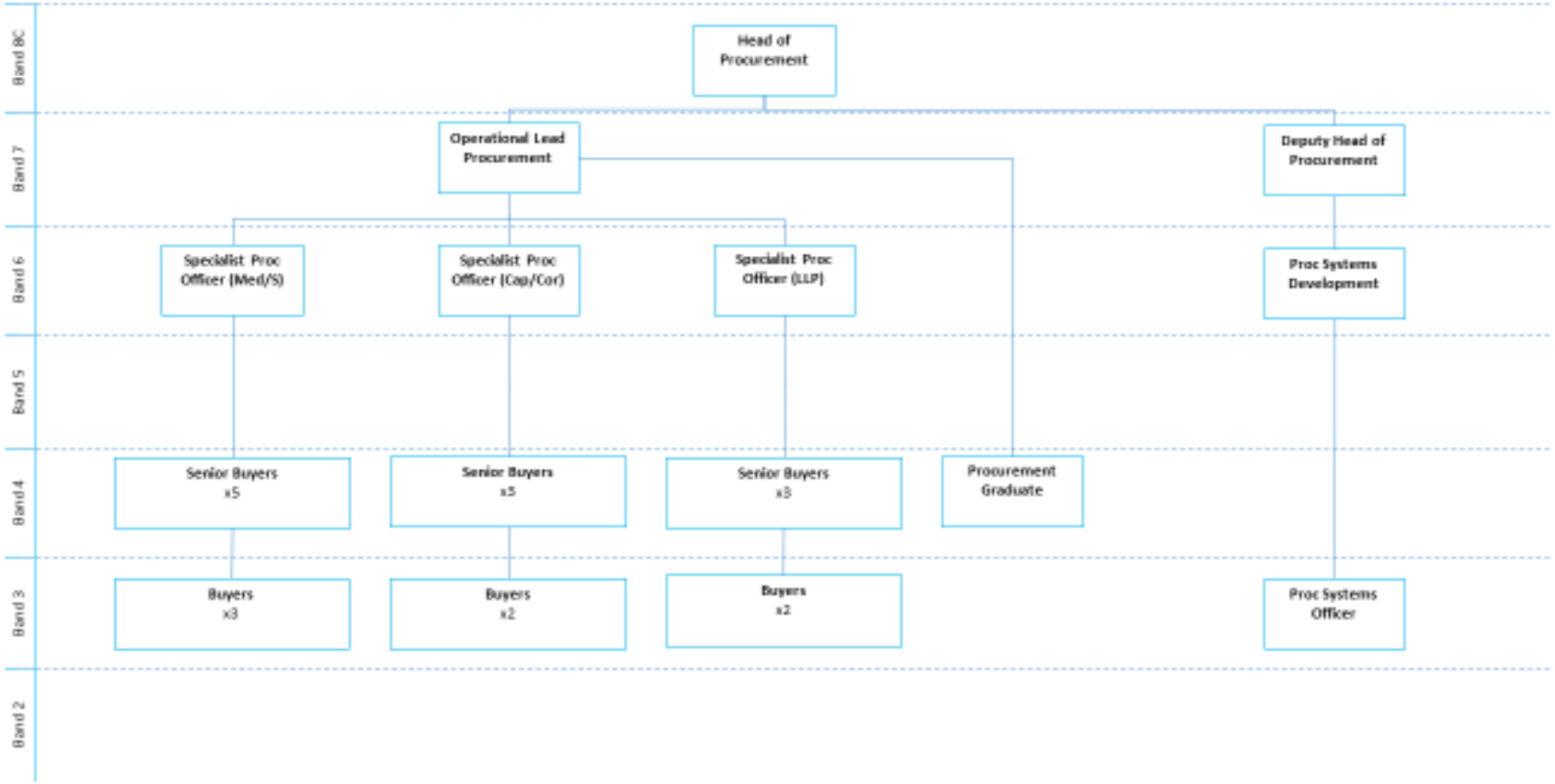


Figure 15 – YSTH Procurement Team

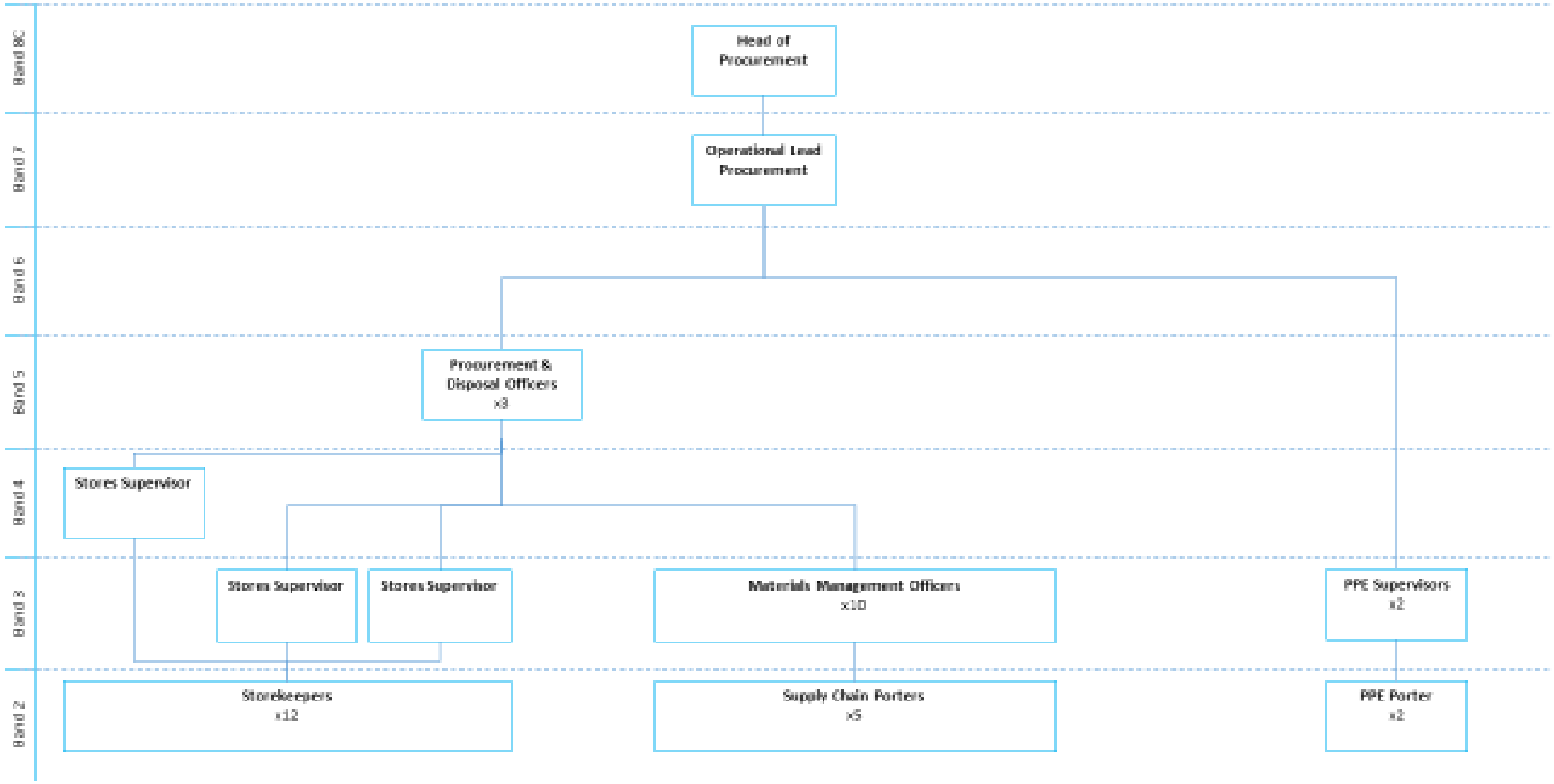


Figure 16 – YSTH Stores & Mat Man

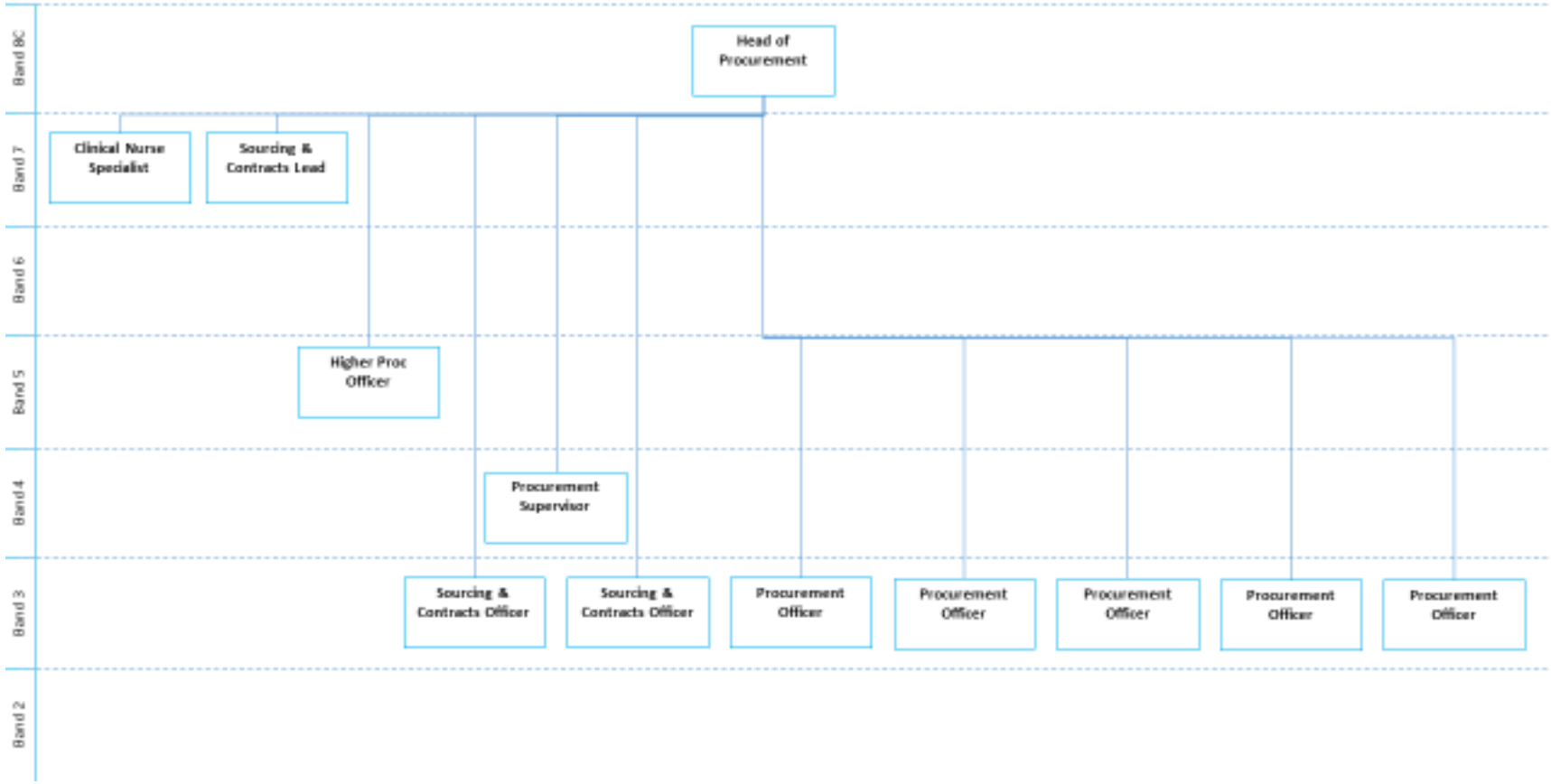


Figure 17 – NLAG Procurement Team

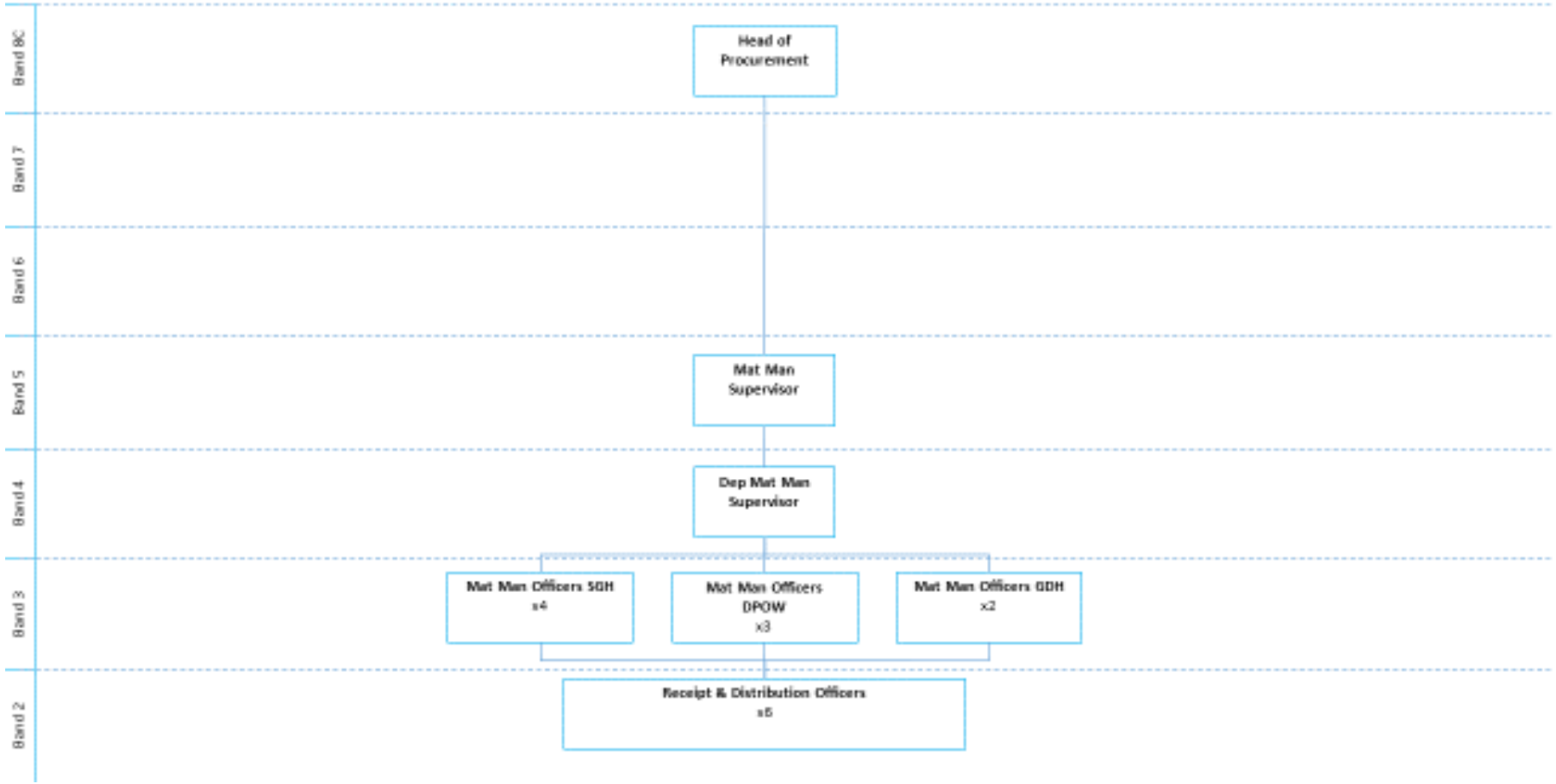


Figure 18 – NLAG Stores & Mat Man

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.

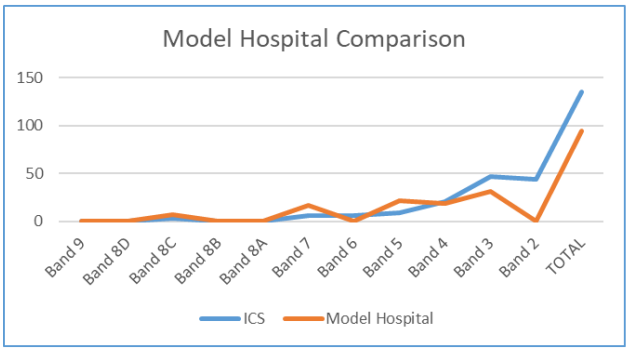
Model Hospital data allows the comparison of back office functions across the NHS based on their as-is operations, it does not provide a 'should-be' status as the NHS moves to working in ICS structures.

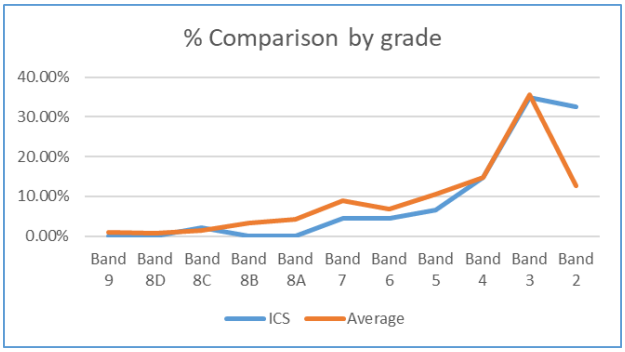
It is still important to compare the performance of the three acute trusts to understand how they perform compared to other NHS providers. Key findings from Model Hospital show:

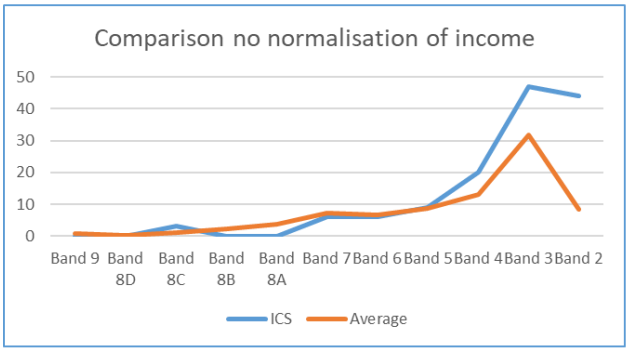
- The national average pay cost of the function is £3.7m against an actual cost of £3.69m;
- The national average FTE in Model Hospital is 95 against an actual FTE return from the Partner Trusts of 118.44;
- Average national cost per post is £39k against an actual cost per post of £34k;
- The majority 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:







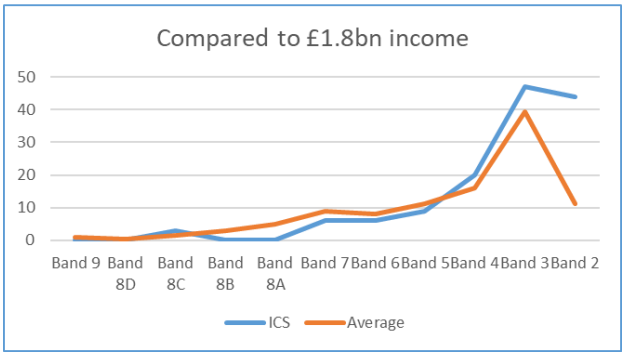


Figure 23 – Model Hospital Grade Data

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:

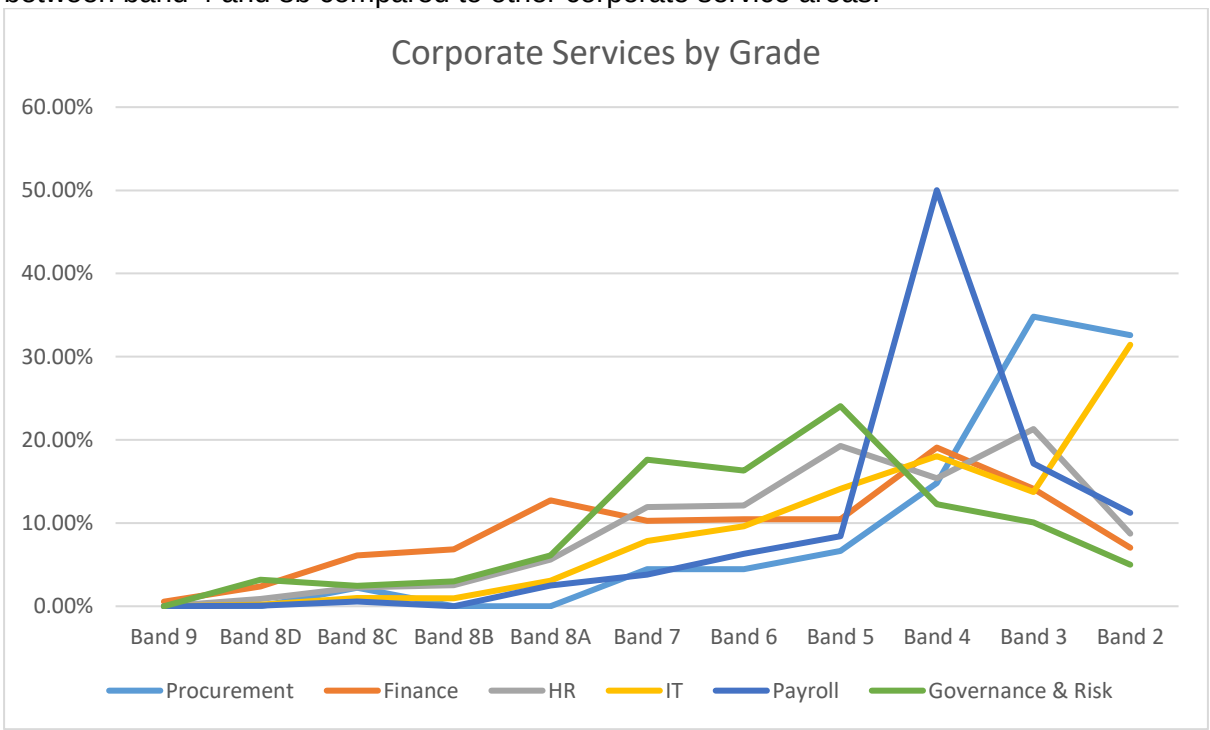


Figure 25 – Corporate Services by Grade

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:

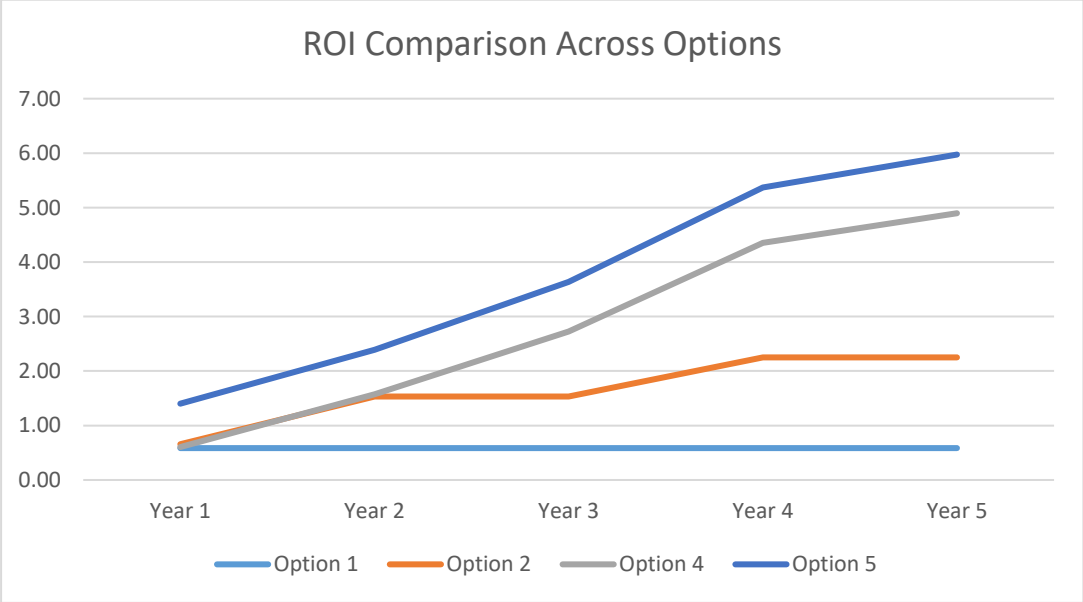


Figure 37 – ROI Comparison

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:

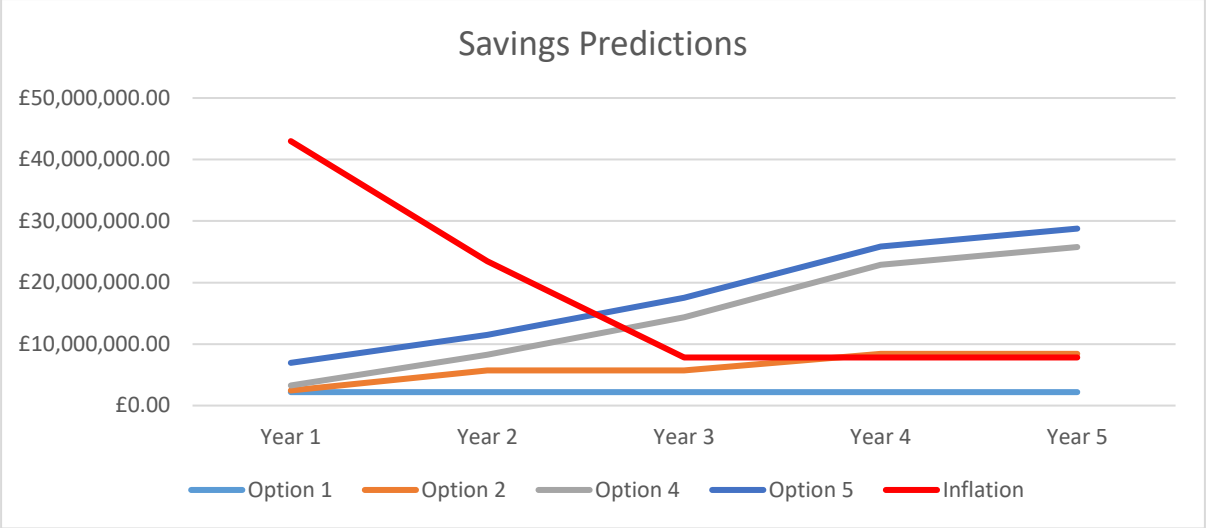


Figure 38 Savings Predictions

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.

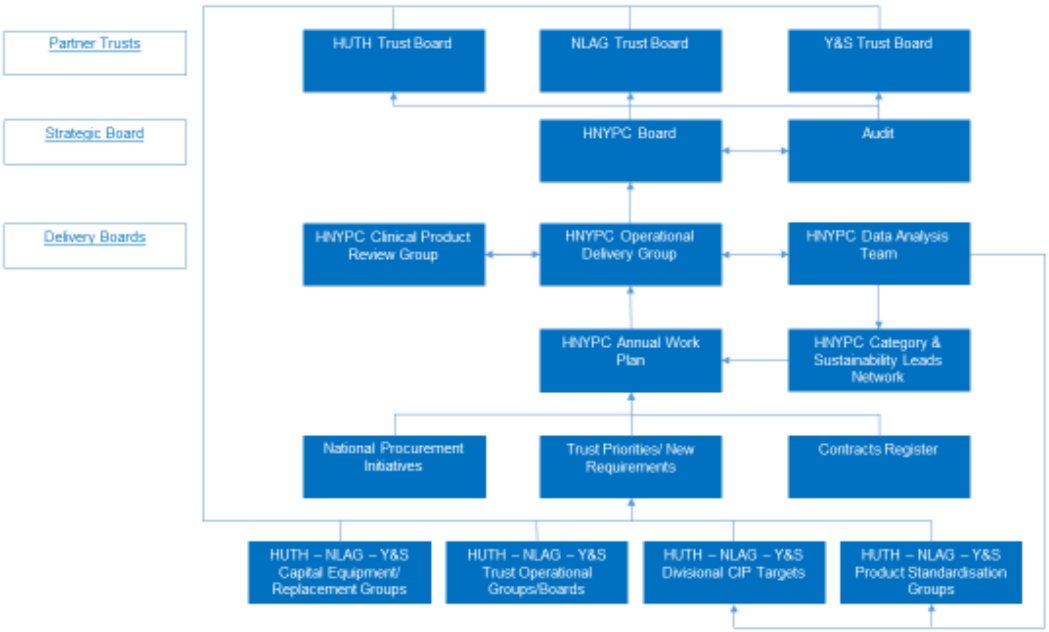


Figure 54 – Governance Structure

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

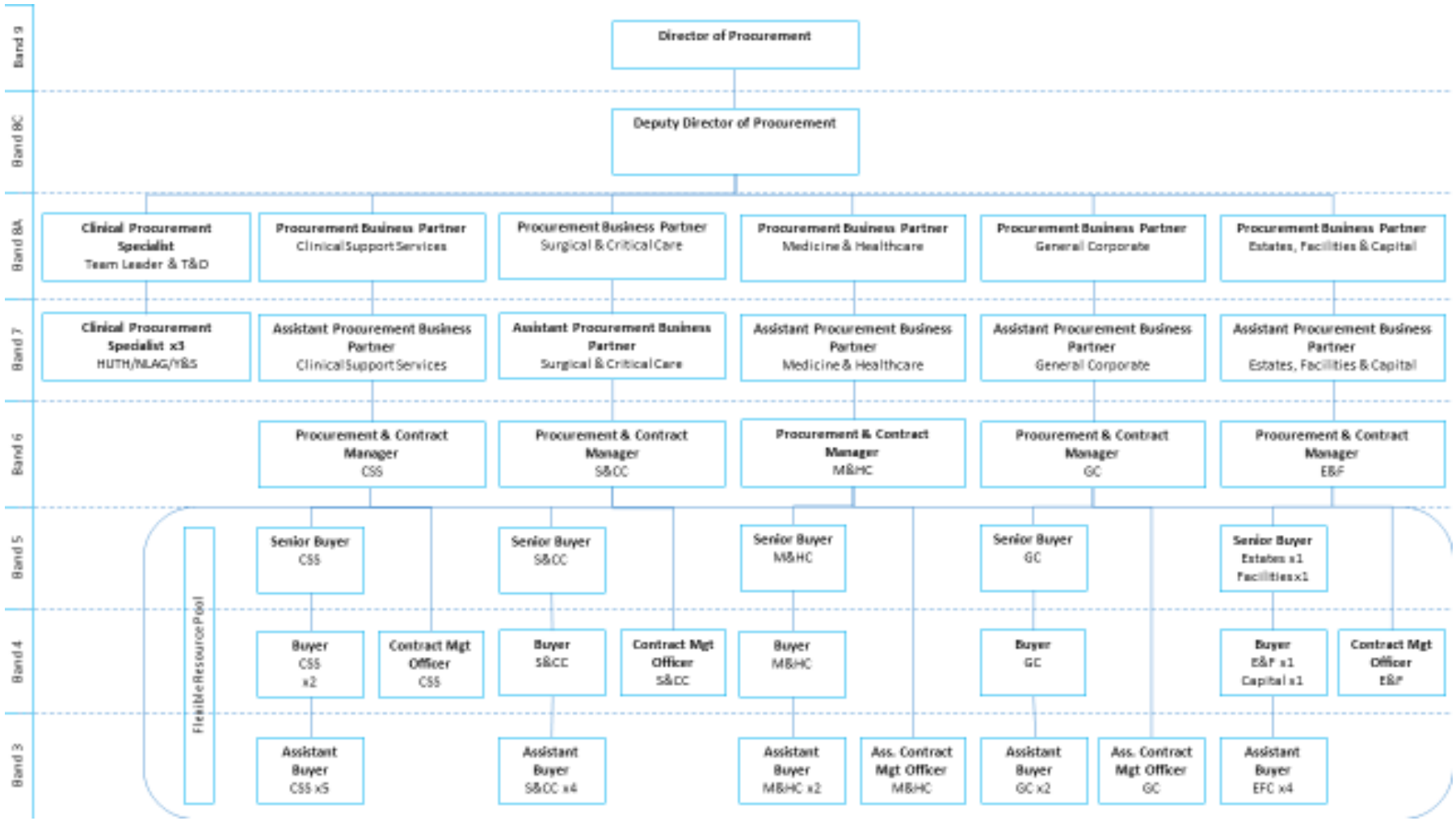
Figure 64 – Existing Job Profiles

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
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Assistant Buyer
EFC x4

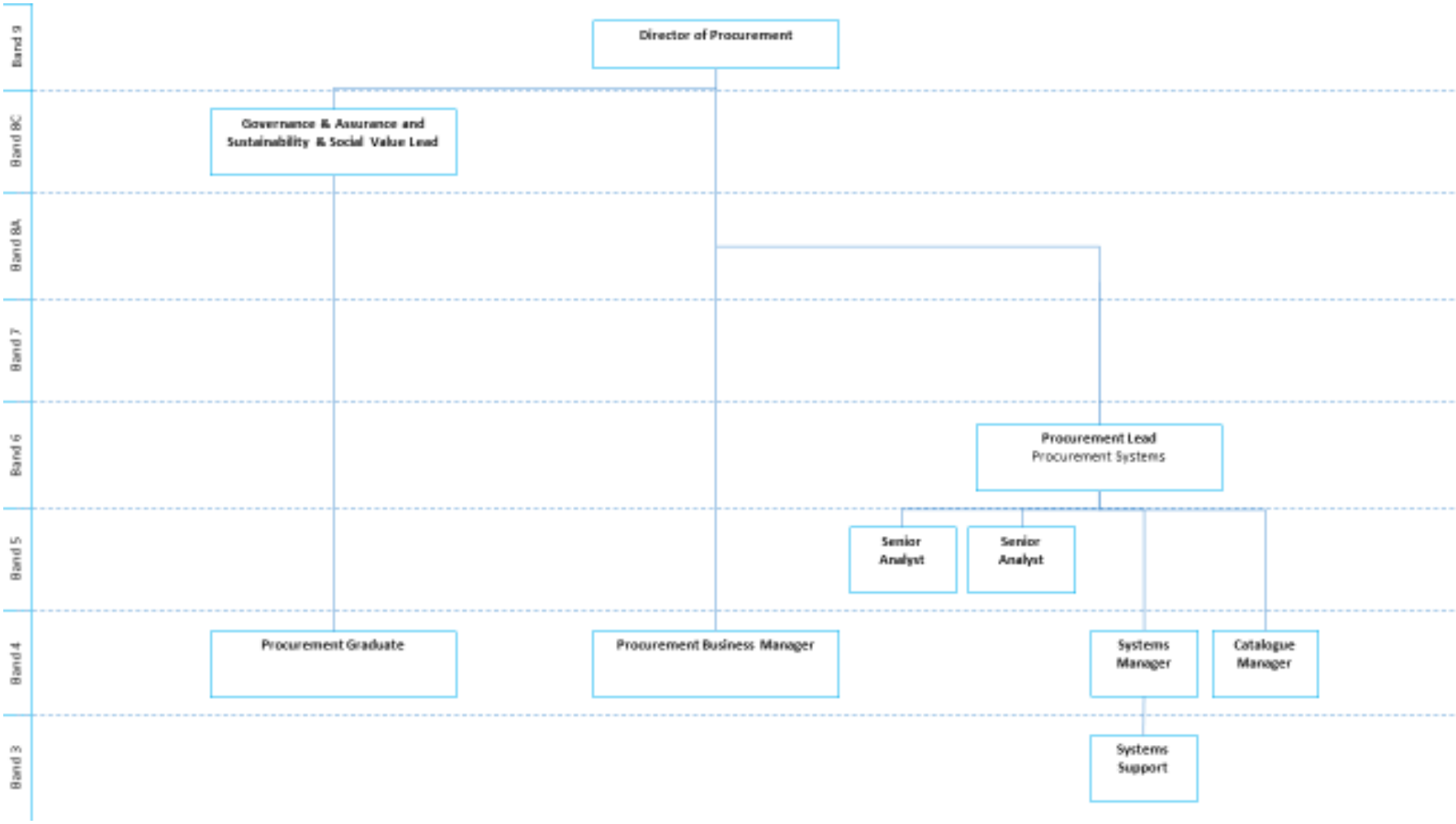

Figure 65 – Procurement Structure

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:

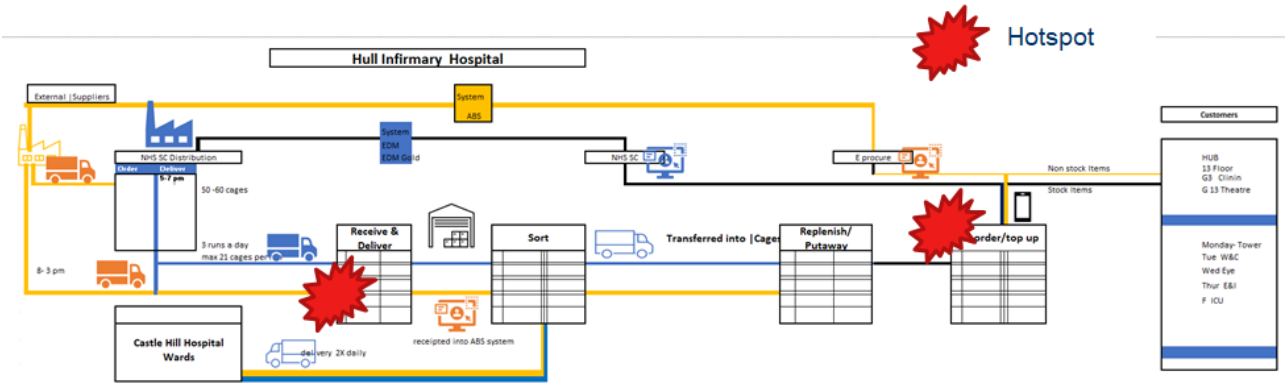

Figure 69 – HRI Materials Flow

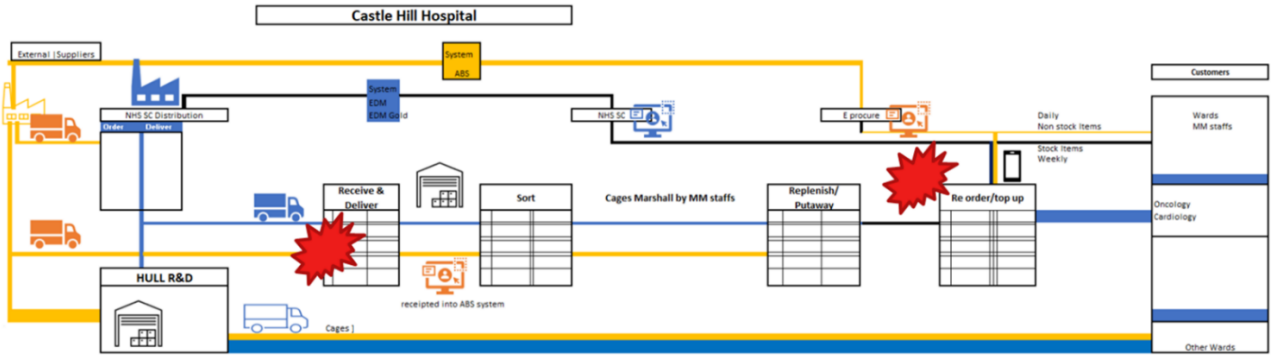

Figure 70 – Castle Hill Materials Flow

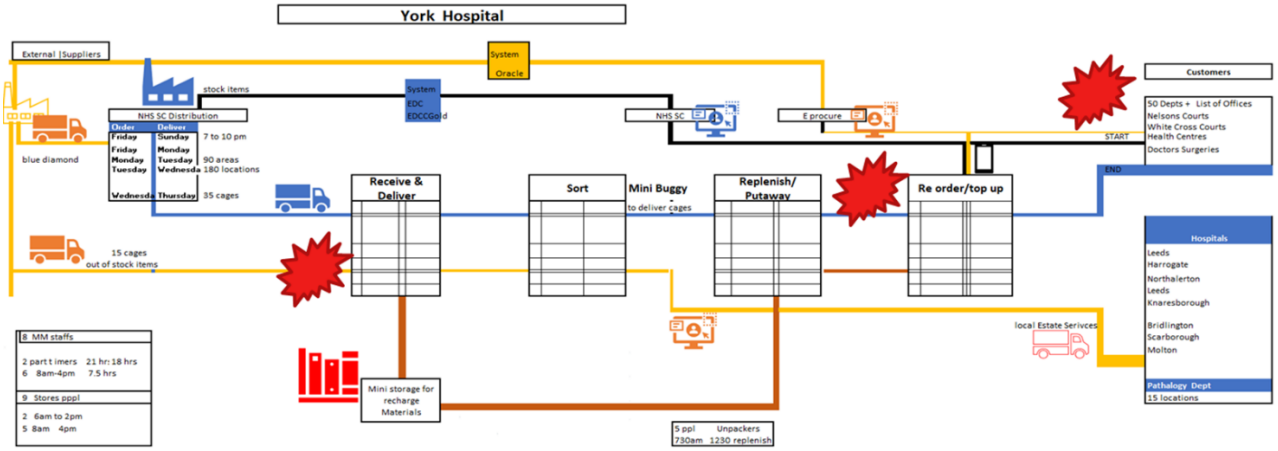

Figure 71 – York Materials Flow

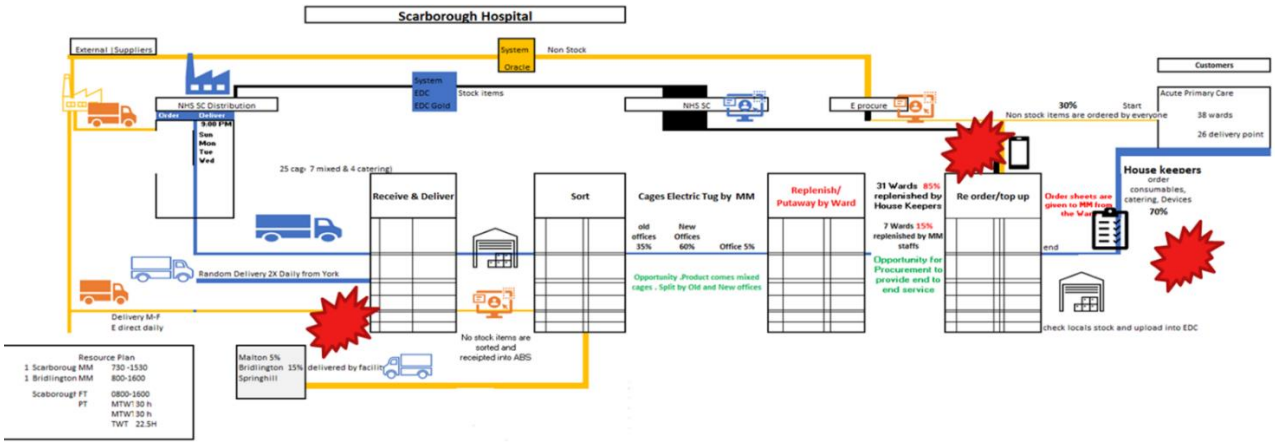

Figure 72 – Scarborough Materials Flow

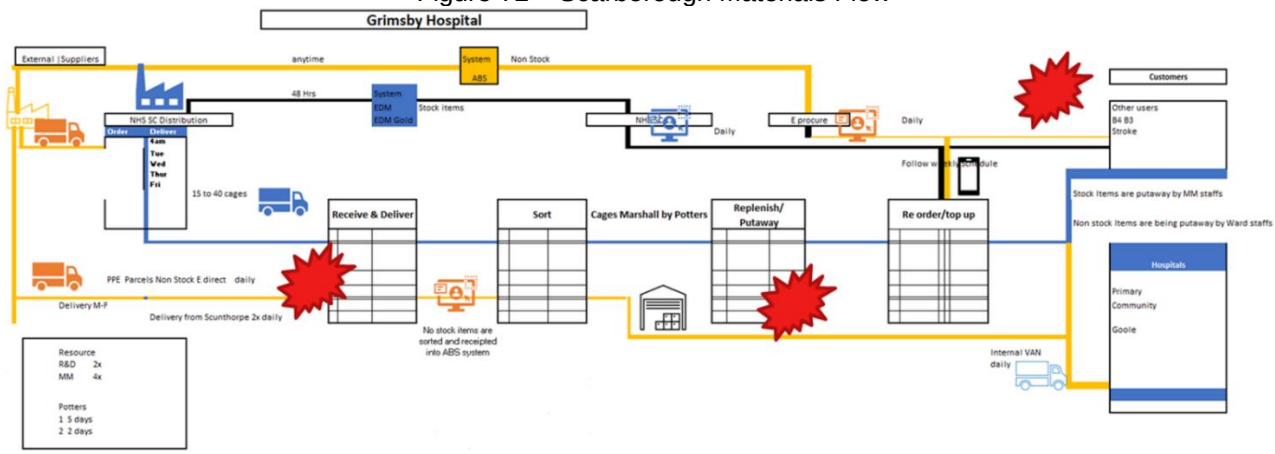

Figure 73 – Grimsby Materials Flow

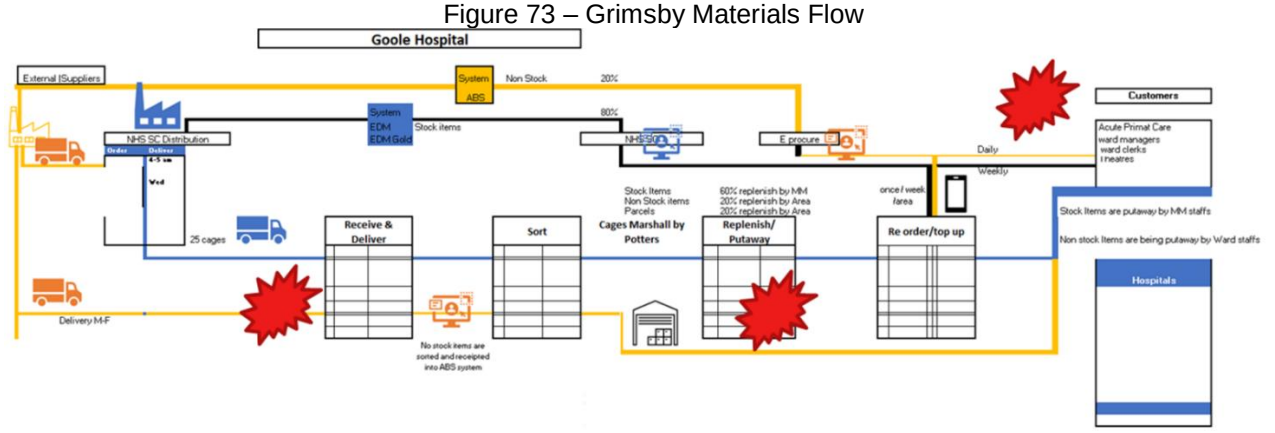

Figure 74 – Goole Materials Flow

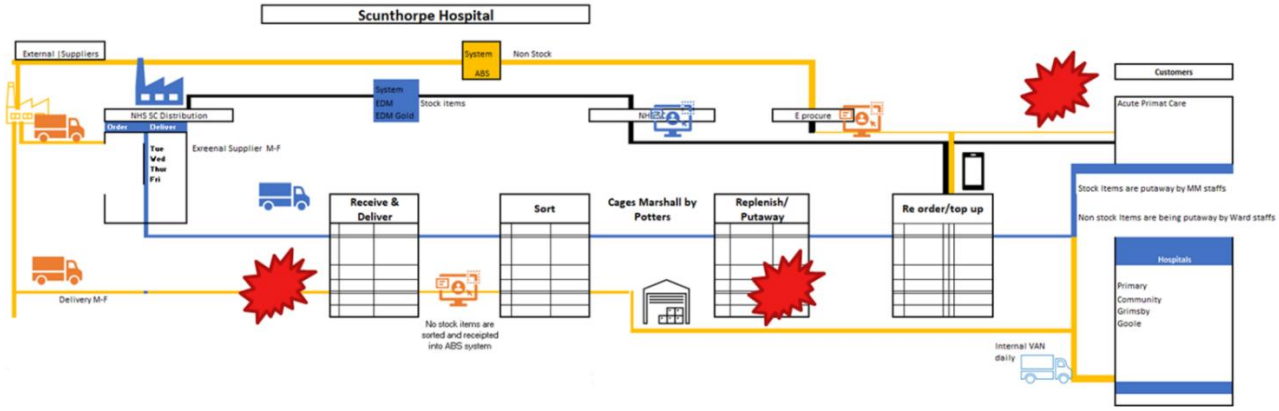

Figure 75 – Scunthorpe Materials Flow

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.

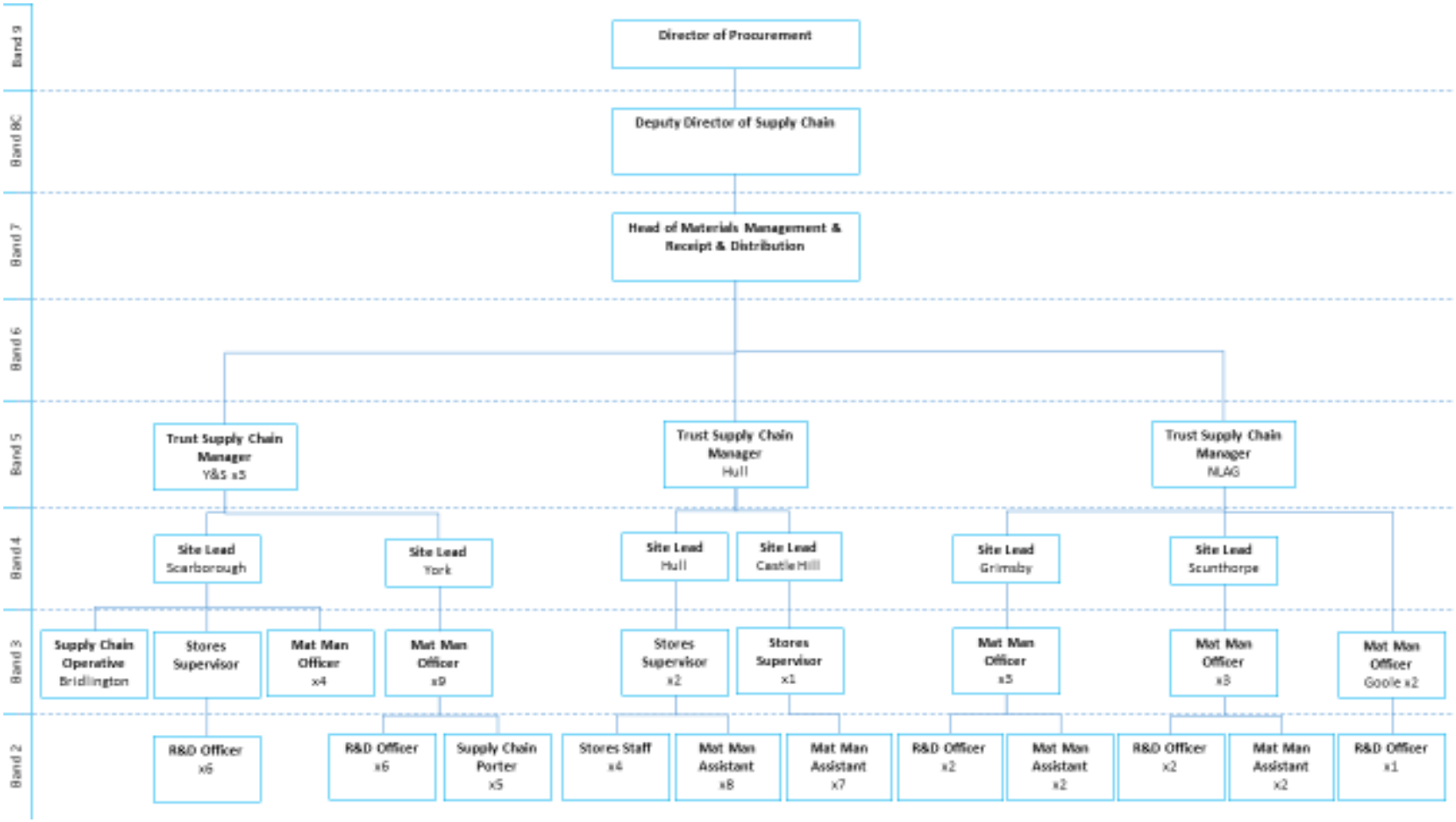

Figure 78 – Proposed Supply Chain Structure

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:

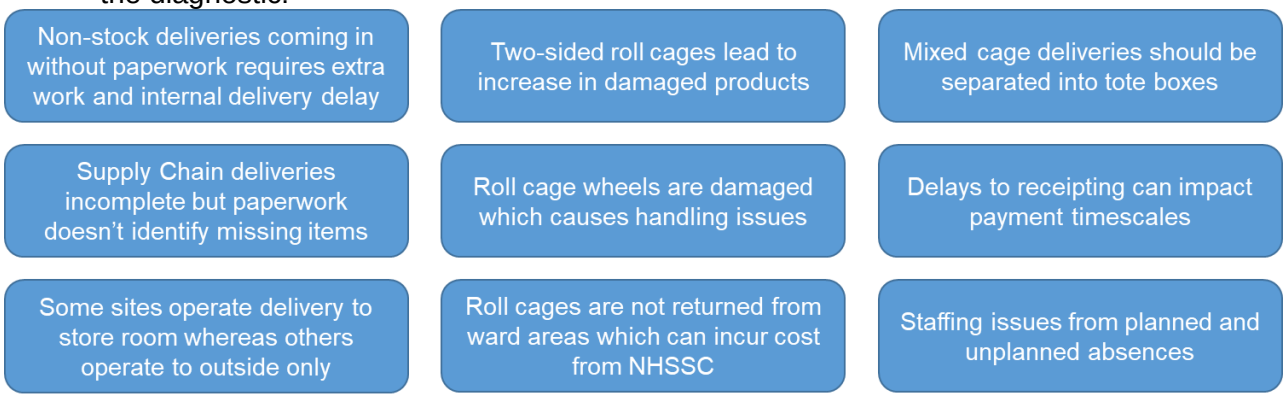

Figure 82 – Receipt & Distribution Findings

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:

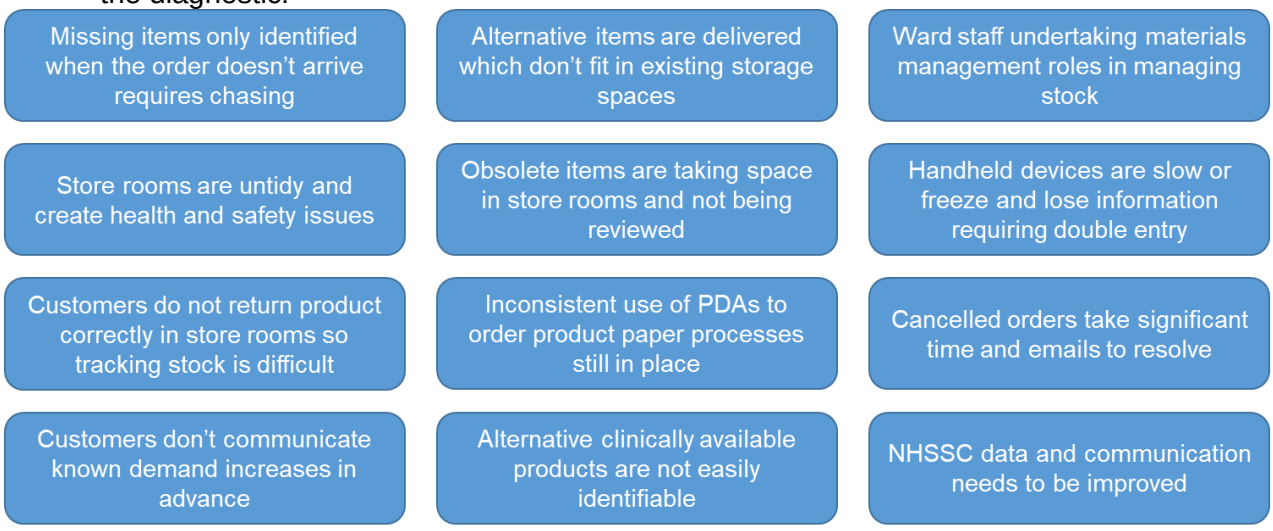

Figure 84 – Materials Management Findings

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:

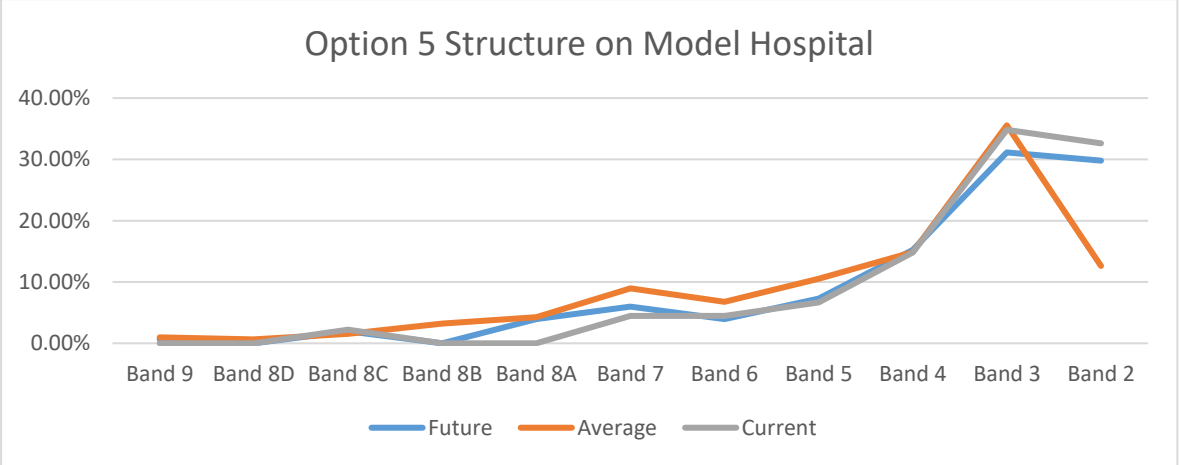

Figure 85 – Option 5 Structure on Model Hospital

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 v1.2)

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.

C. Collaborative of Acute Providers 16th January 2023 (business case updated to v1.3)

Q.	Question	Response
C1	Completely supportive of the case having invested in Procurement previously, can endorse this pays back many times over if you do it correctly and at scale. How will savings from clinical spend and engagement be delivered – do the Clinical Procurement Specialists become the gateway to the clinicians.	Yes the Clinical Procurement Specialists will become the gateway to the clinicians. There is also a governance structure in place which allows escalation of issues to a Procurement Board which has clinical representation from each of the trusts and then further escalation into the Trust Boards if required.
C2	Engagement is the key to success and having visibility of value for money and resource availability.	It is important that Procurement are measured on more than just savings and we start talking about value. If we spend more on a product which reduces length of stay or theatre throughput then these should be explored.
C3	What regular reporting is required to the Collaborative of Acute Providers to update on progress?	A monthly reporting template can be shared.

D. NLAG Trust Management Board 23/01/2023 (business case updated to v1.4)

Q.	Question	Response
D1	Will specialist support be offered to the Estates & Facilities team and is receipt & distribution included within the scope of the future procurement structure?	Yes, specialist support will be provided to Estates & Facilities colleagues through a dedicated Procurement Business Partner. Receipt and distribution colleagues are in scope of the future procurement structure although the nature of their role will mean very little change to the way they currently work.
D2	Will the future approach take learning from current organisations and roll it out further, for example taking the benefits from GIRFT and implementing locally?	Many of the quick wins will come from taking best practice from one organisation and rolling it out across the other two, this is the reason why Procurement Business Partners have been aligned to care groups across the three trusts rather than working Trust specific.
D3	Engagement with the clinical teams is imperative to delivering the proposed benefits, how will this be managed?	This will be managed through dedicated Procurement Business Partners who will engage at a care group level but also through the Clinical Procurement Specialists who will be Trust based to ensure strong local engagement and who will be able to understand local working practices.
D4	How are the staff currently feeling based on the proposed future structure?	The main concern from staff has been what this means to their current role and what they will be doing in the future. All staff have been engaged through newsletters and regular face-to-face visits. Many staff are excited by the proposed changes and see an opportunity for them in terms of career progression through the collaborative.

E. HUTH Productivity & Efficiency Board 25/01/2023 (business case updated to v1.5)

Q.	Question	Response
E1	Is it possible to identify at a granular level the savings opportunities for each Trust?	At this stage it is not possible. Work is underway reviewing the data but the ability to deliver the savings is linked to the appointment of the additional staff to further scope the projects and deliver the financial benefit. The detail behind the savings within the business case can be shared with the group.
E2	Is funding agreed yet and when do savings start	Funding is not yet available but would follow approval of the business case from the three Trust Boards. We will try to deliver some of the savings as early as possible e.g. buying as one rather than three, but the more complex change programmes will take longer, especially as staff to deliver these projects are unlikely to be in post until September/October 2023.
E3	What regular reporting is required to the Productivity & Efficiency Board to update on progress?	Report back every 3 months.

F. YSTH Executive Committee 01/02/2023 (business case updated to v1.6)

Q.	Question	Response
F1	Are the benefits of the case eroded if Scan for Safety is not rolled out within the Trust – is this the platform to do so?	The case future proofs the Trust if it were to decide to implement Scan for Safety. The stock management system would be compatible with Scan for Safety and will still deliver the benefits of a good inventory management system.
F2	The current procurement process at Scarborough feels clunky and there are some benefits from working smarter which are set out within the case.	EJ to meet with David Thomas to discuss in more detail.
F3	Are the savings within the case realistic as there are some big numbers in there, who have they been sense checked with?	The savings figures have been sense checked with colleagues at NHS England, NHS Supply Chain, North of England Commercial Procurement Collaborative and other ICS procurement functions. Where a savings range has been provided the lower figure has been used e.g. other ICS function have delivered 1-3% efficiency so this business case has used 1%.
F4	The medicines collaborative works well and has delivered efficiencies both financial and no-financial. There is a need to digitise more and provide visibility of stock dates and stop people running around the hospital to steal from others.	The business case aims to ensure that procurement is simplified and maximises the use of data to ensure we have visibility of our stock holding and to maximise the efficiency of clinical staff.
F5	Will the board be asked to run through the recommendations at the start of the paper?	Yes the Board will be asked to approve the recommendations.

Report to the Board in Public
Charitable Funds Committee November 2022

Item: Financial Report including Fund Balances	Level of assurance gained: Reasonable

The Committee agreed reasonable assurance. The committee received a comprehensive update on the charities funds including the balance sheet.

The committee discussed the expected payment from Dr Allam in relation to the Endoscopy building and the total expenditure to the 31st October 2022.

There was a proposal scheduled for discussion regarding the transfer of remaining balances.

Item: General Purpose Funds	Level of assurance gained: Reasonable

The Committee agreed reasonable assurance.

A proposal was shared with the committee that action be taken to close-down fund balances held within the Trust's General Purposes Charity and transfer such funds to the Hull and East Yorkshire Hospitals Health Charity (WISHH charity).

The committee highlighted it was essential to ensure the appropriate governance and assurance is in place with WISHH prior to the 31st March 2023.

Following transfer of funds by the 31st March, the committee would need to alter to reflect the changes and it was proposed to move the meetings to bi-annual for review of performance and deal with extra-ordinary payments and become the Charity Liaison Committee.

Item: Project Director's Report	Level of assurance gained: Reasonable

The Committee agreed reasonable assurance.

The committee received a comprehensive overview of the fundraising and the projects that it is supporting.
The Project Director of Fundraising also provided an update on existing benefactor funded developments.

Item: Annual Report and Accounts	Level of assurance gained: Reasonable

An extra-ordinary meeting was held in January 2023 to approve the annual report and accounts.

The Audit Completion Report identifies no significant findings and has identified no significant internal control deficiencies.

The audit identified one material misstatement in the testing of investments. Testing identified £271,000 of investments held in deposit funds which meet the criteria of cash equivalents. This has been adjusted in the balance sheet to increase cash balance by £271,000 and reduce investments by £271,000. (Prior year adjustment was also made for comparison purposes of £224,000). There were no unadjusted misstatements.

The committee agreed to approve the accounts and are happy to sign of letter of representation, Mr Robson agreed to sign on behalf of the committee.

The report is substantially complete, and will be fully signed off once the letter of representation is received. On satisfactory receipt the final audit statement received we will submit to The Charity Commission.

Report to the Board in Public
Performance and Finance Committee
December 2022

Item: Procurement Business Case	Level of assurance gained: Good

The Procurement business case was presented to the Committee. The case is for the consolidation of the three procurement functions, (HUTH, NLAG and YSTH) into a single shared service.

Investment was required but there should be a quick return and additional cost savings without impacting on front line services.

The Committee endorsed the business case for approval at the Board.

Item: Emergency Medicine Update	Level of assurance gained: Limited

The service presented to the Committee and highlighted the concerns regarding increasing waiting times and the work being undertaken to address this and improve patient care.

A RAT model at the front door, updated triage process and nurse to support escalation of patients had been introduced into Emergency Care. An action plan had also been drawn up following concerns raised by the CQC.

Item: Outstanding October - Outpatients	Level of assurance gained: Good

The Committee received a presentation outlining the Super September and Outstanding October national initiatives. These enabled focus on elements of the elective recovery which included Patient Initiated Follow Ups and Did Not Attend rates.

Item: Safe Start September - Theatres	Level of assurance gained: Reasonable

The Committee received a presentation highlighting the work relating to theatre improvement. The aims are to;

- Strengthen and improve our in session theatre utilisation
- Ensure theatre data is accessible and accurate
- Reintroduce a more robust 6:4:2 process
- Review patient pathways through theatres
- Reduce 'on the day' cancellations

Despite the focussed effort there was more work to do and it was decided that theatre performance should be presented quarterly to the Committee

Item: Performance Report	Level of assurance gained: Limited

The Committee received a cancer performance update. There is good progress on the +62 day standard and confidence in achieving the March 2023 trajectory.

The number of 104+ days remains challenging and some of the issue is due to late transfers from other providers.

Item: Financial Report & CRES Delivery 2022/23	Level of assurance gained: Reasonable

The Trust is currently reporting that it will deliver its financial plan for 22/23. This includes two major risks;

- £1.9m of uncovered risk within Health Group expenditure plans.
- ERF target of 104% activity value is delivered or funding is not clawed back in second half of the year.

The following reports were also shared:

- CRES Planning 23/24 – The Trust is still waiting for the finance guidance 2023/24 but it was anticipated that Trusts will be tasked to deliver a minimum of 3% productivity improvement.
- Screening Programme Update – Including Breast, AAA, Bowel, Lung and Diabetic Eye
- Board Assurance Framework – Q3 risk ratings were discussed. There were no changes proposed to the current risk ratings although the Finance risk was on target and should achieve its target risk rating.
- Capital Resource Allocation Committee Minutes

The following contracts were approved;

- Contract recommendation paper – The provision of insourced clinical services (Pioneer)
- Contract recommendation paper – The provision of Total Healthcare Waste Management Services