Harrogate and District NHS
NHS Foundation Trust

The next public meeting of the Board of Directors of Harrogate and District NHS Foundation Trust will take place:

On: Wednesday 23 September 2015

Start: 0900 Finish: 1230

In: The Boardroom, Harrogate District Hospital, Lancaster Park Road,

	AGENDA		
Item No	**Item**	**Lead**	**Paper Number**
0845	**Update from DIPC**		
0900 – 0930	**General Business**		
1.0	**Welcome and Apologies for absence:** *To receive any apologies for absence;*	Chairman – Mrs Sandra Dodson	
2.0	**Declarations of Interest and Board of Directors Register of Interests** *To declare any interests relevant to the agenda for the meeting and to receive any changes to the register of interests pursuant to section 6 of the Board Standing Orders*	Chairman – Mrs Sandra Dodson	2.0
3.0	**Minutes of Board of Directors meeting held on 22 July 2015** *To review and approve the Minutes*	Chairman – Mrs Sandra Dodson	3.0
4.0 *0930*	**Review of Actions schedule and Matters Arising** *To review the actions schedule and provide updates on progress of actions to the Board of Directors.*	Chairman – Mrs Sandra Dodson	4.0
0930 - 1030	**Implementing the Strategic Plan**		
5.0	**Report by the Chief Executive** *To be noted*	Chief Executive – Dr Ros Tolcher	5.0
5.1	**Briefing on Trust Strategic Objectives** *To be noted*	Chief Executive – Dr Ros Tolcher	5.1
6.0	**Integrated Board Report** *To be noted*	Chief Executive – Dr Ros Tolcher	6.0
1030 – 1045	**Break**		
1045 – 1115	**Putting Patients First**		
7.0	**Report by the Medical Director** *To be noted*	Medical Director – Dr David Scullion	7.0
7.1	**NCEPOD Interim Report** *To be noted*	Mr David Lavalette – NCEPOD Ambassador	7.1
8.0	**Report by the Chief Nurse** *To be noted*	Chief Nurse – Mrs Jill Foster	8.0
9.0	**Report by the Chief Operating Officer** *To be noted*	Chief Operating Officer – Mr Robert Harrison	9.0
9.1	**Emergency Preparedness; Resilience and Response Assurance report 2015** *To be noted*	Chief Operating Officer – Mr Robert Harrison	9.1

1115 – 1125	**Managing Resources Efficiently**		
10.0	**Report by the Director of Finance** **Including financial recovery plans** *To be noted*	Director of Finance – Mr Jonathan Coulter	10.0
1125 – 1135	**Valuing and Rewarding Staff**		
11.0	**Report by the Director of Workforce and Organisational Development** *To be noted*	Director of Workforce and Organisational Development – Mr Phillip Marshall	11.0
1135 – 1220	**Governance**		
12.0	**Reports from Directorates** *i. Urgent, Community and Cancer Care* *ii Elective Care* *iii Integrated Care*	Clinical Director - Mr Andy Alldred Clinical Director - Dr Kat Johnson Clinical Director - Dr Natalie Lyth	
13.0	**Report on Assurance Issues by the Chief Executive**	Chief Executive – Dr Ros Tolcher	
14.0	**Reports:** *To receive the Minutes of, and/or oral reports from, Board Committees:* *i. Finance Committee* *ii. Quality Committee – 5 August 2015* *iii. Audit Committee – 21 May 2015*	Committee Chairman - Mrs Maureen Taylor (Non-Executive Director) Committee Chairman - Mrs Lesley Webster (Non-Executive Director) Committee Chairman – Mr Christopher Thompson (Non-Executive Director)	14.1 14.2
15.0	**Serious Complaints / Incidents/matters relating to compliance with the Trust's Licence or other exceptional items to report or that have been reported to Monitor and/or the Care Quality Commission** *To receive an update on any matters reported to regulators.*	Chairman – Mrs Sandra Dodson	
1220 – 1230			
16.0	**Any Other Relevant Business** *By permission of the Chairman*	Chairman – Mrs Sandra Dodson	
17.0	**Board Evaluation**	Chairman – Mrs Sandra Dodson	
18.0	**Confidential Motion** **The Chairman to move:** *'That members of the public and representatives of the press be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest'.*		

Harrogate and District NHS
NHS Foundation Trust

BOARD OF DIRECTORS – REGISTERED DECLARED INTERESTS

This is the current register of the Board of Directors of Harrogate and District Foundation Trust and their declared interests.

The register is maintained by the Foundation Trust Office.

Name	Position	Interests Declared
Mrs Sandra Dodson	Chairman	1. Partner in Oakgate Consultants 2. Trustee of Masiphumelele Trust Ltd (A charity raising funds for a South African Township.) 3. Trustee of Yorkshire Cancer Research 4. Chair (elect) of Red Kite Learning Trust – multi-academy trust
Dr Ros Tolcher	Chief Executive	Specialist Adviser to the Care Quality Commission
Mr Jonathan Coulter	Finance Director/Deputy Chief Executive	None
Mrs Jill Foster	Chief Nurse	None
Mr Robert Harrison	Chief Operating Officer	1. Appointed Voluntary Member of the Strategy and Resources Committee of the Methodist Church
Mr Phillip Marshall	Director of Workforce and Organisational Development	None
Mr Neil McLean	Non-Executive Director	Director of: 1. Northern Consortium UK Limited (Chairman) 2. Ahead Partnership (Holdings) Limited 3. Ahead Partnership Limited 4. White Rose Academies Trust 5. White Rose Resourcing Limited 6. Swinsty Fold Management Company Limited 7. Acumen for Enterprise Limited 8. Leeds Apprenticeship Training Agency Limited 9. Yorkshire Campaign Board Chair Maggie's Cancer Caring Centres Limited
Professor Sue Proctor	Non-Executive Director	1. Director and owner of SR Proctor Consulting Ltd 2. Chair of LEAF Multi Academy Trust (Leeds) 3. Member – Council of University of Leeds 4. Member – Council of NHS Staff College (UCLH) 5. Associate – Good Governance Institute 6. Associate - Capsticks
Dr David Scullion	Medical Director	None
Mrs Maureen Taylor	Non-Executive Director	1. Independent Non Executive Member (Audit Group) – British Showjumping
Mr Christopher Thompson	Non Executive Director	1. Director/Trustee of Community Integrated Care Limited and Chair of the Audit Committee

Mr Ian Ward	Non-Executive Director	1. Vice Chairman and Senior Independent Director of Charter Court Financial Services Limited, Charter Court Financial Services Group Limited, Exact Mortgage Experts Limited, Broadlands Financial Limited and Charter Mortgages Limited 2. Chairman of the Board Risk Committee and a member of the Remuneration and Nominations Committee, the Audit Committee and the Funding Contingent Committee for the organisations shown at 1. above 3. Director of Newcastle Building Society, and of its wholly owned subsidiary IT company – Newcastle Systems Management Limited 4. Member, Leeds Kirkgate Market Management Board
Mrs Lesley Webster	Non-Executive Director	None.

September 2015

Harrogate and District NHS
NHS Foundation Trust

Report Status: Open

BOARD OF DIRECTORS

Minutes of the Board of Directors meeting held on Wednesday 22 July 2015 at 8.45am in the Board Room, Harrogate District Hospital.

Present:
Mrs S Dodson, Chairman
Mr J Coulter, Director of Finance and Deputy Chief Executive
Mrs J Foster, Chief Nurse
Mr R Harrison, Chief Operating Officer
Mr N McLean, Non-Executive Director
Mr P Marshall, Director of Workforce and Organisational Development
Professor S Proctor, Non-Executive Director
Dr D Scullion, Medical Director
Mrs M Taylor, Non-Executive Director
Mr C Thompson, Non-Executive Director
Dr R Tolcher, Chief Executive
Mr I Ward, Non-Executive Director
Mrs L Webster, Non-Executive Director

In attendance:
Mr A Alldred, Clinical Director, Acute and Cancer Care Directorate
Ms K Barnett, Operational Director, Integrated Care Directorate
Mrs B Barron, Operational Director, Elective Care Directorate
Dr D Earl, Joint Deputy Medical Director
Dr C Sri-Chandana, Deputy Clinical Director, Elective Care

Mr A Forsyth, Interim Head of Corporate Affairs (Minutes)

Two Governors of the Trust, three members of staff

Rapid Process Improvement Workshops Update

Mr D Plews, Deputy Director for Partnerships and Innovation, and Ms Michelle Page gave the Board members a short update on progress.

Improvement Projects Next Steps

A longlist of 44 potential improvement projects had been discussed at Clinical Transformation Board and discussions were in train to shorten and prioritise this list with Programme and Project leads. It had been agreed that 80% of future improvement capacity should be used to support the priorities of the Clinical Transformation Board, with the remaining 20% supporting “business as usual” activity.

Emerging priorities for potential improvement work included:

- Process design blueprinting for New Models of Care

- Reducing day surgery cancellations and improving flow in outpatients
- Transforming staff engagement

Work was about to start on a project to improve Patient Safety in two or three key wards by improving processes, changing behaviour and further developing patient safety culture. Research was taking place to determine the wards where the work might yield the best effect. Clinicians would be engaged from the outset.

1. Welcome and Apologies for Absence

Mrs Dodson welcomed the Governors to the meeting.

There were apologies for absence from Dr P Hammond, who was represented by Ms Barnett and Dr K Johnson, who was represented by Dr Sri-Chandana and Mrs Barron. Mrs Dodson welcomed them and Dr Earl to the meeting. She said that this was an auspicious meeting since it would be the first to use the Boardpad application, without papers, and she was confident that it would go well. She thanked the three members of staff for attending to provide any necessary technical support.

2. Declarations of Interest

There were no declarations of interest relevant to items on the agenda for the meeting or the Register of Interests.

3. Minutes of the meeting of the Board of Directors on 24 June 2015

3.1 The draft Minutes of the meeting were accepted as a true record, subject to the following amendments:

Pages to be numbered

Mr I Ward, Non-Executive Director, had been present at the meeting.

Minute 6.6 line 8	**Delete:** 'Bards' **Insert:** 'Boards'
Minute 6.13 line 9	**Delete:** 'the worse the condition can be' **Insert:** 'the harder it is for them to return to work.'
Minute 6.17 line 8	**Delete:** 'was not counted in the Leeds model' **Insert:** 'was treated differently by the Leeds CCG*'*
Minute 6.18 line 5	**Delete:** 'whereas Leeds CCG excludes all CAT attendances' **Insert:** 'and work was continuing to review whether or not this model could be more appropriate for HaRD CCG*'*
Minute 6.21 line 5	**Delete:** 'need to agree a conditions register with primary care' **Insert:** 'conditions register, agreed with primary care,'
Minute 6.30 line 5	**Delete:** 'nurse endoscopists……..follow ups'

Insert: 'the Trust was recruiting for a permanent Gastroenterologist and would review the training of further nurse endoscopists.'

Minute 6.31 line 2 **Delete:** 'Mrs Dodson…..reduce costs.'
Insert: 'Mrs Dodson asked about increased cancer screening referrals and Mr Harrison stated that the Trust would be working with the CCG to review access criteria and ensure all referrals were clinically appropriate to support reducing demand.'

4. Review of Actions Schedule and Matters Arising

Action 1 - Board action complete.

Action 2 – Ms Barnett gave an update, in the absence of Dr Hammond. Work to review the number of readmissions had started, using May data. There had been 137 readmissions within 30 days of discharge during that month. As the Board had discussed previously, this figure included patients who had only visited the Clinical Assessment team (CAT) on first admission, some who had only attended CAT on their readmission and some who had only attended CAT on both occasions. It therefore included patients whose care was entirely clinically appropriate. The length of stay for readmissions varied between zero and 4 days (with 40% of them being zero). There would be more work on the details before a casenote review to establish how many of the readmissions were classed as 'avoidable'. Ms Barnett said that the analysis would also take account of primary and social care issues. In view of the work involved, and the forthcoming change of Clinical Director in Integrated Care, it was **agreed** that the paper would be brought to Board in October.

Action: Dr Lyth

Professor Proctor welcomed the update and wondered whether the next report could include some informal benchmarking with other Trusts. Dr Scullion pointed out that only medical cases were being reviewed – they constituted the biggest percentage of readmissions. Dr Tolcher observed that the CAT-only admission and readmission could be the result of first class care, avoiding admission as an inpatient. Dr Scullion agreed and said the fundamental point was that the Trust was potentially being penalised for what could be good care and Dr Tolcher said that it would be wrong to assume that a readmission within 30 days was the result of a failed discharge. Mrs Dodson hoped that a parallel piece of work would be put in hand in the Elective Care Directorate, examining the position on surgical readmissions.

Action 3 – the Board had been briefed on emerging models. Board action complete.

Action 4 – Mrs Foster said that the report on the Action Plan following the Morecambe Bay Inquiry was included in her report at Item 8 of the Agenda.
Board action complete.

Action 5 – the letter had been circulated. Board action complete.

Action 6 – the Harrogate Health Transformation Board Vision and Principles paper was included as an Annex to Dr Tolcher's report at Item 5 of the Agenda.
Board action complete.

Action 7 – the theatre utilisation data covered only elective procedures, and was included in the Integrated Board Report at Item 6 of the Agenda. Board action complete.

Action 8 – the Board Agenda included an Item for Committee reports and Minutes. Board action complete.

Action 9 – comments had been received. Board action complete.

Action 10 – Dr Scullion said that robust data on deaths within 24 or 48 hours of admission, allied to the day of admission, was not yet available. Mr Coulter was keen to know whether there was variation across the week It was **agreed** to defer this action until the September Board meeting.

Action: Dr Scullion

Action 11 – Dr Scullion said that the staff were on a journey. Information had been circulated via leaflets in payslips, and he had spoken at the Consultants' Forum. His impression was that the Duty of Candour was consistently in the forefront of clinicians' minds. He felt that they had always been aware of a Duty of Candour, the difference being that it was now enshrined in legislation. There were grey areas – Duty of Candour and complaints were not the same thing, for example. Those in any doubt were being urged to consult the Risk Management team. Mrs Dodson said this would be picked up through the assurance process. Board action complete.

Action 12 – Mrs Foster said that this would be brought to the Board in September.

Action: Mrs Foster

Action 13 – Dr Tolcher said that she expected to bring this to Board in October.

Action: Dr Tolcher

Action 18 – Mrs Dodson reported that the Non-Executive Directors had discussed the membership of the Remuneration Committee and had concluded that no change was necessary. Board action complete.

There were no other Matters Arising.

Implementing the Strategic Plan

5. Report from the Chief Executive

5.1 Dr Tolcher's report had been circulated in advance of the meeting and was taken as read.

5.2 Dr Tolcher was pleased to report that, following a selection board on 21 July, Dr Natalie Lyth had been appointed as the Clinical Director for the Integrated Care Directorate. She is a community paediatrician who is currently the Designated Doctor for safeguarding children for North Yorkshire and York and has previously been an Associate Medical Director in two PCTs. Dr Lyth will replace Dr Peter Hammond who has been appointed as the Dean of the postgraduate school of medicine

5.3 Mrs Dodson lamented that, in his absence and without a Board meeting in August, there was no vehicle for the Board to bid a formal farewell to Dr Hammond. He had been a longstanding member of the Board and had driven change in his Directorate. On behalf of the Board she thanked him for his contribution and his passion as a Clinical Director. She looked forward to working with him in his new role

where he would continue to have strategic involvement and impact for the Trust. Dr Lyth would be invited to the September Board meeting and would be undergoing an induction into her new role.

5.4 Moving on, Dr Tolcher noted that her report would in future include details of Director Visits as well as Patient Safety Visits. Mrs Foster said that there had been four Director Visits this year to date, to Farndale, Wensleydale, Littondale and Nidderdale wards. All the visits had been positive although 'Red' reports had been issued for the first two wards. The issues had been around cannula insertion and subsequent visits had resulted in 'Green' reports in Farndale and Wensleydale wards.

5.5 Mr McLean said that he had been very impressed with Nidderdale and Wensleydale wards whilst Mr Harrison said that there had been fantastic feedback from patients and staff, who had been really positive about the wards. The 'Red' reports had been unfortunate but necessary. Mrs Dodson said that the cannula issue had largely been around documentation and she expected the Quality Committee to pick this issue up in the course of their work.

5.6 Mr McLean said that he had one concern regarding delays in action which rang alarm bells for him, and this was reflected more generally elsewhere. This had been a leaking shower which had been reported in January and was still not repaired –. Mrs Foster said that delays in rectifying issues concerning the fabric of the Trust were being noticed more widely; she wondered whether the agreed risk assessment process needed to be revisited. Mr Harrison reminded Board members that there had been staffing issues in the Estates Department, as well as a high level of sickness absence. The situation was beginning to improve and he was hopeful that delays in taking action would reduce.

5.7 Mrs Webster was pleased that there had been four Director Visits but disappointed that her visit had been cancelled because of the lack of an Infection Prevention and Control nurse. Mrs Dodson said that it was important that the Infection Prevention and Control nurse from the ward led the visit but asked Mrs Foster to examine the possibility of seconding a suitable substitute to prevent visits being cancelled. **Action: Mrs Foster**
Mr Marshall said that on a recent visit it had been a joy to hear the positive views of patients on Nidderdale ward.

5.8 Turning to the contract position, Dr Tolcher said that there was still no agreement with the Harrogate and Rural District Clinical Commissioning Group (HaRD CCG). There was a need to increase funding in the community contract to cover the current costs of delivery which exceed the contract value.

5.9 Mr Coulter said that there had been an exchange of proposals with the CCG. The CCG recognised that more funding was need for the community contract but they had a finite resource available, the greater part of which is required to cover the acute contract. Potential schemes to identify resources for the community contract were under discussion. The CCG had recognised that HDFT's modelling was historically accurate but an affordability gap remained. Demand management schemes would reduce costs for the CCG but had either not gained traction or had not yet commenced. Mr Coulter was keen to agree the contract as soon as possible.

5.10 Dr Tolcher said that the Trust's proposals shared the risk with the CCG and that successful delivery would benefit both the CCG and the provider. She was

seeking to reconcile views and finalise the contract and the Trust was acting with goodwill and the best of intentions.

5.11 Mr Thompson was increasingly nervous that it was now month four of the financial year without an agreed position and finances were tight. Was the Trust 'building on sand' he wondered. He noted the rigidity of the CCG holding on to a requirement to generate a surplus at year-end, to the detriment of the health economy as a whole. He was encouraged by the idea of a risk share with the CCG.

5.12 Mr Coulter noted that, of the income assumptions made by the Trust, in the acute contract 85% were activity-based. There were no disputes with the Leeds CCGs. In terms of the community contract the discussion was about funding of current activity which has increased 12% in the last 12 months, as well as forecast growth. If funds were not committed then some services potentially could be at risk. He considered that the plan was on a firm foundation.

5.13 Dr Tolcher suggested that sharing the risk with the CCG would provide motivation for both it and the Trust to successfully deliver their plans and support a health system which would be clinically and financially sustainable. Risk sharing would allow a pass back or write off if one or other did not achieve its plan. Mr Coulter reminded Board members that this was not about a break even approach – the plan would deliver a surplus – the CCG's published plan showed that it was also planning for a £1.8m - £2m surplus.

5.14 Mr Ward was pleased to hear about a possible cash payment in September and asked about any cashflow issues. Mr Coulter said that there were no immediate cashflow issues, although managing the cash position was creating extra work for the finance team. The CCG payment would be made on 1 September rather than at the end of that month. Currently 14% of payments were made within 30 days (the target was 90%). Payments were batched with small local payments being made first. 91% of payments were made within 45 days so the Trust was about two weeks behind the ideal process. He reminded Board members that the September cash payment would need to last through until February. He confirmed that there was no damage to the reputation of the Trust by delaying payments. Mr Coulter noted that last year (2014-15) the CCGs nationally had made a surplus of c£700m, of which c£400m had been from those in the north of England. This had been held against the deficits of providers, which this year were forecast to be in the order of £2bn.

5.15 Mr McLean welcomed the idea of agreeing the profile and then reconciling. He wondered how hard the Trust was driving to pull in the arrears from 2014-15, which would relieve some of the pressure. Mr Coulter said that the Trust was constantly pushing for payment.

5.16 Dr Tolcher said that the Trust had achieved a modest surplus in June but remained £200,000 short of the Monitor plan and c£500,000 adverse against the Trust stretch target. She said that robust controls remained in place. Activity and income were higher than the planned levels but medical staffing and ward staffing costs in particular meant that expenditure was also higher – the recent SMT had discussed this at length. The Cost Improvement Programme (CIP) was also running behind plan. Work was continuing to improve rostering and tighten the Return to Work process, especially with junior and Middle Grade doctors. Dr Tolcher said that she had directed that forward planning for the 2016-17 CIP and beyond should now be put in hand, with the aim of having Project Initiation Documents and Quality Impact Assessments for proposed measures in place by September. There was a

need to be proactive so that the agreed savings requirements would start to contribute from 1 April 2016.

5.17 Professor Proctor asked how confident Dr Tolcher was that the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) represented accurately the financial risks to the Trust. Mr Coulter said that the risk was currently scored with Consequences of 4 and a Likelihood of 3 (possible) and he felt this to be reasonable. They were objective measures and these were reviewed monthly by the Executive team, and this included looking at the impact of the New Models of Care (NMC) work. Professor Proctor probed the pace and activity around NMC - were the risks in the system explicit? Mr Coulter said that any double-running funding would be time-limited and a reversion to single running would be needed in all areas. It was going to be challenging to work through.

5.18 Professor Proctor then asked for the views of the Directorates, particularly about their contributions to the CIP. Mr Alldred said that 75% of his CIP had been delivered and actioned. Most of these measures were low and medium risk. Of the remaining 25% he estimated that £250,000 was of high risk and may not be delivered so that his Directorate was looking for alternative, low and medium risk, measures which would be delivered. He was aiming for a 95% delivery and he had already delivered more at this stage than in previous years.

5.19 Mrs Barron said that her Directorate had delivered 74% of its CIP to date. 14% of the remainder was high risk and these were being progressed where possible to reduce the risk and deliver. Progress had been made on out of hours payments including annualised Programmed Activity job planning and the inclusion of Saturday and evening sessions in job plans. A Task and Finish Group to examine Best Practice Tariff was making good progress. Mrs Barron also noted that new alliance work with Leeds and York, to provide paediatric trauma and orthopaedics, and plastics, had not been factored into her position.

5.20 Ms Barnett said that 77% of her Directorate' CIP had been achieved to date and that 93% was achievable without high risk measures. She noted the inpatient project to reduce summer bed days which had achieved a reduction of eight beds continuously over 25 days. There had also been success in public health and she had arranged a Directorate meeting on 5 August to discuss the 2016-17 CIP.

5.21 Mr Coulter said that he had been attending the Directorate finance review meetings and confirmed that work on the CIP had been most positive; it had momentum and was improving month by month. Medical and nurse staffing, however, was proving more challenging. Mr Ward asked how the position this year compared with the same four months last year. Mr Coulter said that it was better than the position in each of the last two years, not only with performance against plan but also with the level of engagement, even with a more challenging external environment. The Trust was delivering activity and striving to achieve the CIP, although operational issues (eg rostering and locums) persisted.

5.22 Moving to the NMC, Dr Tolcher said that the picture was mixed. She reminded Board members that an application for transitional funding had been deferred and that this still needs to be concluded and submitted. There was a Harrogate Health Transformation Board Meeting on 23 July to which various Task and Finish groups were due to report. The goal remained to write a credible value proposition by August for submission to NHS England. The Project Director post had not yet been filled.

5.23 Mr Thompson said that, as a Director of a social care charity, he was aware that the introduction of the National Living Wage in the recent Budget would introduce a cost pressure of 7% each year. Would that put pressure on financial assumptions which had been made? Dr Tolcher said that because of North Yorkshire County Council's (NYCC) sub contracts this has been foreseen as a potential problem. Mr Coulter said that it would have no impact on HDFT modelling because all staff were already paid at this level or above.

5.24 Mrs Taylor wondered whether there would be any capacity implications for HDFT from the potential involvement in the West Yorkshire Acute Trust Vanguard application. Dr Tolcher said that there was more to gain from being part of it than not but the Trust would need to take stock as the telemedicine scheme was rolled out. Mr Harrison noted that the acute providers scheme had not yet been submitted whilst an additional urgent and emergency care scheme, which the Trust was also party to, had been submitted.

5.25 Moving to the CRR, Professor Proctor was concerned that there were two new risks and two risks where progress was behind plan. Dr Tolcher said that a well-run risk register will reflect changes in risk and that the system of rating progress was designed to encourage this type of challenge. The timed Action Plans ensured focus on areas where progress was falling behind. In respect of CR3 it would be necessary to revisit the BAF to ensure that any strategic risk to the Trust was captured appropriately. Mr Harrison said that because there were gaps in assurance, the Deputy Director of Estates had written formally to NHS Property Services (NHSPS) seeking assurance but had received no response to date. The Trust could undertake surveys if the buildings were maintained by it but only if commissioned to do so. The risk level had been raised because the Trust now believed that the work had not been completed rather than carried out and not documented. Dr Tolcher said that she was not confident that NHSPS had robust arrangements in place and there may come a point where, on the grounds of the safety of patients and staff, the Trust would do the work and seek to reclaim the costs from NHSPS.

5.26 On the subject of CR4 Mr Alldred explained that the Trust had two sterile units which allowed it to make up some chemotherapy drugs. These were both for the protection of the operator and to guarantee the integrity of the drug. One of the two units had been decommissioned as not fit for purpose. If the other failed then there was a risk that the Trust would not be able to manufacture chemotherapy drugs. The Trust was working with the manufacturer of the units to lease a unit as a contingency. Development and approval of a Business Case for replacement was in progress.

5.27 Mrs Dodson reminded Board members that the BAF was used to capture the risk to the Trust's strategic objectives and asked whether they considered it was addressing these risks. Dr Tolcher said that the BAF should be driving the Board agenda, both formal and informal. In future there would be 'deep dives' on a regular basis to examine the risks, the assurance, the gaps and the realism of the plans in place to address them.

5.28 Dr Scullion, as the mental health lead for the Trust, picked up CR63. He had regular, quarterly meetings with Tees, Esk and Wear Valley Trust (TEWV) and an educational programme for both mental health and mental capacity training was in place. Mental health act training was provided contractually by TEWV and two sessions had already taken place. Mental capacity training was being provided by the Trust solicitors (DAC Beachcroft) with a session scheduled for 24 July – this would include training on learning difficulties. He said there had been some slippage

in the programme but it was not a one-off process – there would be a programme of continuing education for key members of the organisation and knowledge would be cascaded, particularly around the changing regulatory framework on capacity and Deprivation of Liberty. It would be a rolling programme which, following a question from Mr Ward, he considered to be realistic. Although it came with a cost, more capacity training would be provided if necessary. Mr McLean emphasised the huge importance of this training, especially about learning difficulties.

5.29 Mr Coulter said that he would arrange a session for Non-Executive Directors about risk assessment. **Action: Mr Coulter**

5.30 Finally Dr Tolcher noted that the Continuity of Service Risk Rating for the quarter would be 4 and not 3 as shown in her report but pointed out that, under the proposed new Risk assessment Framework from Monitor it would have been scored as a 3.

6. Integrated Board Report

6.1 The report had been circulated in advance of the meeting and was taken as read.

6.2 Dr Tolcher said that the Red/Amber/Green ratings were not perfect but were evolving and she proposed moving through the report page by page for questions and comments.

6.3 Professor Proctor noted that, on the subject of pressure ulcers, at the recent Patient Safety Conference which she had attended, Leeds University had indicated that it was running a research project and wondered whether the Trust had any relationship with the project. Mrs Foster said that there was currently no relationship but that she would seek to tap into it and Dr Tolcher added that a research nurse from the Trust was contributing to it. **Action: Mrs Foster**

6.4 Mrs Dodson said that the pressure ulcer measure was colour-coded 'green' despite an increase and what were the tolerance levels. Mrs Foster replied that the figure showed the totality of year to date. The Root Cause Analysis which was carried out for each Category 3 or 4 pressure ulcer indicated whether or not it was avoidable – in the five reports completed so far it had been decided that three were unavoidable. This meant that the right risk assessment, implementation and care management had taken place and this had reduced the severity of the skin damage. In the remaining two cases there had been deficits in care and/or documentation issues.

6.5 Mr McLean said that he had concerns about the quality of the 'Narrative'. It just repeated what was on the chart – it should add to the detail and ask the question 'what's next? 'Dr Tolcher said that the 'Narrative' should be changed to 'Interpretation'.

6.6 Mrs Foster said that although there had been six cases of *Clostridium difficile* against a threshold of 12 for the year, the Root Cause Analyses had not revealed any evidence of patient to patient transmission whilst in HDFT care. This strongly suggested that the Trust Infection Prevention and Control measures were effective. Mr Alldred said that three cases had been on the same ward, which had been deep-cleaned, and an action plan was in place as a result. Mrs Foster said that the Director of Infection Prevention and Control would make a periodic and timely presentation to the Board in September. Many local Trusts were above their

trajectory and she wondered if there was a wider issue. Mrs Webster asked about the proposed CIP scheme relating to deep-cleaning and both Dr Scullion and Mr Harrison confirmed that this had not been taken forward following Quality Impact Assessment as it was determined to be of too high a risk. Mr Alldred said that in respect of hand hygiene recent audits had shown an improved position.

6.7 Moving to the Patient Friends and Family Test (FFT) Dr Tolcher said that she would wish to see a benchmark of the responses and outcomes against other Trusts to see how HDFT figures compared. The spend on temporary staffing remained high, at 6.6%, and efforts were being made to reduce this. In terms of financial efficiency, at the start of the year the Trust had waived the right to charge the NYCC for reimbursable delayed transfers of care. Ms Barnett said that there was a daily Multi-Disciplinary Team (MDT) meeting on this issue and the Discharge Planning group met weekly. Mr Harrison said that not charging NYCC freed the resource to work differently.

6.8 Mr Thompson was disappointed that there was no measure in the Integrated Board Report which referred explicitly to work in the community. Under the previous system there had been concerns about compliance with new-born and 12 month visits by Health Visitors – what was the current position? Ms Barnett said that significant work had been undertaken – in the first quarter 77% of new-born visits had taken place within the required timescale as against 31.2% for the same quarter last year, and this included 80% in June. This was an improvement but had not yet reached the internal target of 95%. The position on 12 month visits was more challenging to measure since these could take place between 10 and 15 months (with figures for 10 -12 and 12-15 being measure separately and then aggregated). NHS England had now agreed that the measure should be at 15 months and the Trust figure for the quarter was 61.4% although this should improve in future periods.

6.9 Mr Marshall noted that at the recent Local Education and Training Board (LETB) meeting it had been agreed that it would make 50% of the funding available to Trusts for unfilled posts, which were running at 10% for the next rotation. Health Education England had widened its remit to cover the current workforce as well as the future workforce. On the matter of temporary staffing, an internal review of locum rates was underway to make this more attractive, with the aim of reducing additional medical staffing costs. Mr Marshall informed the Board members that a Business Case for further international nursing staff recruitment was in development. Many other Trusts were taking this route; it was intended to run the process in Spain for staff to start in January. Following a question from Mrs Dodson, Mrs Foster said that 21 of the original 24 nursing staff recruited in the first tranche remained in Trust employment and Dr Scullion said that the Trust should take advantage of the experiences of this cohort in the next round.

6.10 Mrs Webster wondered about the impact of the requirement for cancer patients to receive results of diagnosis tests within four weeks, as recently announced in the press. Mr Harrison said that the Trust was in the top 10% of Trusts nationally on the current 14-day measure. This change implied a further two weeks for diagnostic results, which could often be from a number of sources, not all within the Trust. Additionally, part of the process is discussing results and options with patients, following an MDT meeting. The Trust was reviewing how it might meet a new four week target. Dr Scullion said that forcing this pathway could be detrimental to patients, especially where the Trust was reliant on other organisations. Mrs Webster wondered what the consequences of pushing back on the measure might be. Mr Harrison said it was important to understand the context and the detail – could there be cost reductions further down the patient journey, for example. There may be

a need to increase diagnostic involvement and there may be cases where meeting a four week target was not appropriate. Mr Alldred commented that there had been no consultation and it could well require additional diagnostic capacity. There was a need to look at the implementation and consequences of the change.

Putting Patients First

7. Report by the Medical Director

7.1 Dr Scullion's written report had been circulated in advance of the meeting and was taken as read.

7.2 Dr Scullion informed Board members that he and Mr Mahon had carried out a review of the 10 cases of abdominal pain identified using the Cumulative Sum (CUSUM) model to flag excessive deviation from the normal deviation for mortality. There had been no failings of care in any of those reviewed. Three patients had been medical patients and there were no concerns. Seven of the cases had been very ill surgical patients and the care they had received had been appropriate. Mr Harrison commented that the coding rules under which these cases had been identified were international and utilise the original diagnosis.

7.3 Moving to the National Emergency Laparotomy audit Dr Scullion picked out two particular themes – early input by senior clinicians and medical geriatric support. He would be convening a meeting of the Directorates, including the Emergency Department, to discuss the outcomes of the audit and their applicability within the Trust, and would report back to the October meeting of the Board. Dr Tolcher said this was helpful third party endorsement for the approach already being adopted by the Trust.

Action: Dr Scullion

7.4 Turning to support to gynaecological oncology, Dr Scullion said that the MDT was crucial in the decision-making process. Attendance could be either by image link or in person. A surgeon in Leeds was retiring and thus there was additional pressure on that Trust. There are two appointments due to be made in September but this meant that the *status quo ante* would not be restored for six months. Mr Alldred wondered about the peer review and Mr Harrison said that it was about the cost-effectiveness of the approach taken. The use of video link was very good – the cost of a personal visit was about double, although as Dr Scullion pointed out, the consultant could undertake a clinic for those patients going on to be treated at Leeds, as well as attending the MDT. The use of technology was a good interim solution. Mrs Webster recalled the question at the Council of Governors meeting on this subject – Mr Harrison said that the position had not changed. The Trust had advertised the post but received no applications.

7.5 Regarding the Harrogate/York Haemato-oncology Peer Review Visit, Dr Scullion said that there had been some concerns about specialist nurse support to the joint (HDFT and York) haematology MDT but he said that these had related to Scarborough and that there were no concerns about HDFT input. Mr Harrison said that there was an oncologist presence on the MDT but she had to alternate MDT meetings and her attendance was therefore 67% independently, which fell below the threshold. Dr Scullion said that it was unfortunate that the Trust was being penalised for being flexible – a cumulative approach is not allowed. Mr Harrison said that the Trust was examining options and actions which might be taken to provide cover and would discuss any proposals with the peer review team.

8. Report by the Chief Nurse

8.1 Mrs Foster's written report had been circulated in advance of the meeting and was taken as read.

8.2 Mrs Foster drew Board members' attention to the summarised outcomes of the report on the Morecambe Bay incidents and the Trust's response to them. These would be translated into an Action Plan by the Elective Care Directorate, progress against which would be reported to the Patient Safety Group. She did not believe that there was a risk of this nature, which had arisen at Morecambe Bay, within HDFT. Serious incidents were investigated thoroughly and the governance systems in place were robust. Serious Incidents Requiring Investigation (SIRI) were always investigated.

8.3 Dr Tolcher said that there had been an increase in incidents in the maternity service and also feedback from the Deanery about relationships in the Department. She wondered about the quality of the MDT meetings?

8.4 Mrs Barron said that there were robust systems in place and a number of groups reviewed each incident. There was work underway on relationships and communication and she had been looking at the structure – a Business Case was due to be presented to the Executive team the following day. There were robust internal governance processes in place. Dr Tolcher said that there was an opportunity for joint development and new systems to be developed. Dr Scullion said that Dr Johnson, the Clinical Director for Elective Care, was considering the completed reports on the recent serious incidents and would bring an overarching report to the Board in September to answer specific and general questions about them. He said that the team was cohesive, conscientious, reported proactively and was keen to understand and absorb learning; it also realised that there was still some learning to achieve. Dr Sri-Chandana endorsed this view. Dr Earl said that it was intended to use the Manchester Framework with the Obstetrics team as part of the Sign Up to Safety programme. Mrs Baron said that there was to date one candidate for Clinical Lead of the Department. **Action: Dr Johnson**

8.5 Professor Proctor was worried about midwifery supervision which, as the result of changes announced recently, seemed to rely on faith as a concept. What was the future for these arrangements? Mrs Foster said that she understood that the current arrangements would be replaced but possibly not for some 18 months. There was as yet no indication as to what would be the replacement statutory system. Professor Proctor suggested writing to the Nursing and Midwifery Council expressing the Trust's concern. **Action: Mrs Foster**

Mrs Foster highlighted progress from the previous supervisory maternity office audit and said that there were very few areas for improvement – the Trust had been described as a model example.

8.6 Ms Barnett noted that the high staffing figures for Bolton ward reflected a change in establishment and the filling of new posts and the numbers would reduce next month. Mrs Webster wondered whether the Quality Assurance visit report should be linked in to the Quality Committee and Mrs Foster confirmed that this would be taken forward through Directorate reports to the Quality Committee.

9. Report by the Chief Operating Officer

9.1 Mr Harrison's report had been circulated in advance of the meeting and was taken as read.

9.2 Mr Harrison drew attention to significant issues with junior doctors and consultant cover. The position would improve from August onwards. The cover by consultants, including a number prepared to 'act down' had been very impressive. There were plans to improve the situation through, for example, the CESR rotation post in the Emergency Department and moving Middle Grade doctors into the Integrated Care Directorate. Everyone was working hard for patient safety.

9.3 Moving to the College of Emergency Medicine audits the reports had highlighted areas which had previously been identified as challenging. Work was in hand to improve the pathways for mental health patients so that they would avoid the Emergency Department as appropriate.

9.4 The Operational Delivery Group had considered the position with community services activity. There was no capacity for further work to be accepted. He expected improved recording to be achieved through the use of mobile working. There was concern, however, about staff at Band 5 being offered the same work at Band 6 by another Trust locally. Mrs Dodson asked how this could be achieved under Agenda for Change terms and conditions and Mr Marshall said this could be by changing the Job Description. He was working with colleagues to see how this had been changed – the salary differential was of the order of £4,000 pa. Mr Alldred confirmed that the Trust had lost four or five staff this way – Mr Ward asked whether we could regrade the Trust staff. Mr Marshall said that this would be an issue of competence and quality. Dr Sri-Chandana wondered if this was an issue for the regulator body but Professor Proctor suggested that it could be discussed at the West Yorkshire Alliance of Acute Trusts; Dr Tolcher agreed saying that members should not break the pack.

9.5 Dr Tolcher sought clarification on the statement on the front cover of the report referring to staffing levels being concerning. Mr Harrison confirmed that this comment related to the *cost* of providing a safe level of staffing and did reflect unsafe levels of staffing. He agreed to amend this accordingly.

9.6 Mrs Webster asked about the discussions with the Yorkshire and Humber Commissioning Support Unit (CSU) and whether any costs would be involved. Mr Harrison said that the CSU would cease to exist from April 2016 and that the HaRD CCG was seeking to reprocure the service but HDFT was not eligible to bid. The Trust was trying to agree the costs to mitigate the capital and revenue risks, which had potential financial consequences.

9.7 Moving to Patientrack Mr Harrison said that this had now been rolled out to all adult medical and surgical wards and all escalation areas – the roll-out had gone well. There were some operational issues being thrown up, including access from home for Middle Grade doctors and adjustments were being made – the Patientrack team had been very helpful. The Trust now knew precisely where the sickest patients were located. The next areas for roll-out were ITU, the Emergency Department, paediatrics and maternity. Assessments had been put on to Patientrack, prioritised to support CQUINN schemes.

9.8 Mr Harrison asked Board members to note that the Information Governance Baseline Submission showed a reduction in Information Governance issues but that

because the standard had been increased, HDFT's reported performance had reduced, although it remained above the required new standard. Work was continuing to address issues which affected performance. Mr Harrison sought approval of the baseline submission and the Board **approved** the submission for quarter 1.

9.9 The Board **approved** the submission of a Green governance rating for the end of quarter 1.

Managing Resources Efficiently

10. Report by the Director of Finance

10.1 Mr Coulter's report had been circulated in advance of the meeting and was taken as read.

10.2 Mr Coulter drew attention to the report on the Cost Improvement Programme. He said that the Trust was ahead of the minimum required to deliver the plan which had been delivered to Monitor and momentum was carrying through. He was more concerned about measures for 2016-17 being ready to start on 1 April 2016. At this stage 75% of the measures were recurrent, which was much better than in the previous year, although he appreciated that a number of non-recurrent measures would arise in-year. Whilst a reduction in Whole Time Equivalents had been achieved the measure had not yet been realised in full. He would have a better overall picture after the sessions with Directorates on 27 July.

10.3 The Board **approved** the submission of a Continuity of Service Risk Rating of 4.

10.4 Turning to the Reference Costs for 2014-15 Mr Coulter said that the Internal Audit team had carried out an audit of the process and issued an opinion of Significant Assurance. The next Audit Committee was not until September so that the submission was brought to the Board for approval prior to submission. The report would be considered by the Audit Committee at its next meeting, along with a review of comments on the Monitor review of costings. The Board **approved** the Reference Costs submission.

Valuing and Rewarding Staff

11. Report by the Director of Workforce and Organisational Development

11.1 Mr Marshall's report had been circulated prior to the Board and was taken as read.

11.2 Mr Marshall pointed out that this was a new, more concise report and he would supply Board members with a link if they wished to examine more closely the data on which it was based. **Action: Mr Marshall**

He said that because the LETB regarded the Trust as a high quality training provider, he had been able to secure more non-recurrent funding which would be used to address some of the issues around handover of patients.

11.3 Moving on to the work on Job Plan compliance for medical staff, Mr Marshall said that whilst the process was sound, there were shortcomings in completing and agreeing the Job Plans themselves. He hoped to drive up standards by including them in the Pay Progression policy in due course.

11.4 He had been very pleased with the 88% assessment awarded to the Library. Mr Marshall reported that Dr Will Peat had been appointed as the new lead for simulation. He was encouraging Directorates to find candidates for the Regional Leadership Awards.

11.5 Mr Ward asked about the replacement of Polly McMeekin, when she left at the end of August to take up a similar role at York Hospitals NHS Foundation Trust. Mr Marshall said that there had been 35 applications and seven had been selected for interview on 30 July. The calibre of applicants had been high.

11.6 Mrs Dodson said that she was sure she had the support of the Board in wishing Ms McMeekin well in her new post and thanking her for all that she had done for the Trust. There was always a risk that high quality staff would leave – but hopefully also return at some point.

Governance

12. Reports from Directorates

12.1 Acute and Cancer Care

12.1.1 Mr Alldred said that he had received the Healthwatch North Yorkshire report on the York Wheelchair Service and that it made sober reading. He had made comment on the first draft and the subsequent version was more balanced. Staff were said by service users to be 'doing their best in difficult circumstances' but there were also comments about long waits for chairs to be allocated and for repairs. Communications with patients also drew adverse comments. He was concerned to ensure that the best decisions were being made about the use of the budget and was also pushing to re-examine the commissioning requirement. The situation was complex – an action plan had been produced after a Patient Safety Visit and the York Overview and Scrutiny Committee had also been negative about the service. It was disappointing to be unable to provide a service for wheelchair users which meets our ambition for quality and it is also a reputational issue for the Trust. Mr Alldred said that he would pick up some issues with the Commissioners whilst supporting the staff involved. He would send the report to Board members.

Action: Mr Alldred

12.1.2 Mr Thompson said that he had taken part in the Patient Safety Visit and said that whilst the staff were committed they were frustrated. Some of the issues that had been found were not difficult to put right – he was surprised that there was no HDFT signage at the centre, for example, it was all from the pre-existing organisation. Mr Alldred said that the simple things had been done but that there was more to do.

12.1.3 Dr Tolcher said that there was a need to reinforce messages. The Overview and Scrutiny Committee had given an honest hearing to the report. There were underlying issues but some were within the Trust's ability to rectify. She wondered how much was previously known about the situation. Mr Alldred replied that some things were known about whilst others had been picked up at the Patient Safety Visit. There was more work to do around the structure of the service.

12.1.4 Dr Tolcher asked how easy it had been to tell that some things were not operating effectively. How effectively does the Trust respond to issues – the service would never be resourced to the level desired by users and she wondered how easy it was for users to have a voice. In Mr Ward's view the Trust did not rectify easy things in a timely manner, which led to greater problems developing. Mrs Foster pointed out that there was a national campaign currently around wheelchair services.

12.2 Elective Care

12.2.1 Mrs Barron said that there had been use of Facebook and media around the physical improvements in the Maternity services and the feedback had been good. The work was due to be completed on 7 August and might result in a slight increase in activity through the unit.

12.2.2 She reported that two new services would be starting – in October a new plastics services would start, in alliance with York FT, whilst in February a paediatric orthopaedic/trauma service would start. Mrs Barron noted that there had been issues about safety and quality because of the turnover of staff in theatres and ITU and the need to reallocate staff to ensure safe staffing levels. Those who were moved were sometimes exposed to unfamiliar equipment and tasks. This was affecting morale.

12.2.3 Mrs Dodson said that it was important the Board members understood this difficult issue. Dr Tolcher expressed her thanks to those staff who had shown flexibility, for whom there were no tangible rewards. Mr Harrison said that it was necessary to form a judgement on quality and safety – all other options for this staffing re-allocation, including Bank and agency, had been exhausted. Mr Marshall said he was aware of the issue and was examining the potential for recruiting to a pool of appropriate staff.

12.3 Integrated Care

12.3.1 Ms Barnett said that junior doctor staffing would be very challenging over the next three months; the Trust had planned for stronger support from the August rotation – the intention was to use Trust staff and the Middle Grade rota was now more flexible.

12.3.2 The new Integrated Care management team was now in place and bedding in – the move had been seen as a positive one.

12.3.3 In the community the new 5 – 19 service had mobilised well and would be subject to review in the next few weeks. Staff were in the right places and were achieving good outcomes.

12.3.4 A decision on the award of the contract for smoking cessation from 1 January would be made during September.

13. Report on Assurance by the Chief Executive

13.1 Dr Tolcher had nothing further to report at this meeting.

14. Reports from Committees

14.1 Finance Committee

14.1.1 Mrs Taylor presented the Minutes of the meeting of the Finance Committee on 21 April. The subsequent meeting on 10 July had been looking forward whilst a meeting that taken place on 20 July had been reviewing quarter 1.

14.1.2 She noted that work under the contract with Imtech and the Carbon Energy Fund was now underway. There had been discussion about generating the 2016-17 Cost Improvement Programme and the search for initiatives to produce appropriate measures and some concern had been expressed about the reputational aspects of cashflow.

14.2 Quality Committee

14.2.1 Mrs Webster reported that the Quality Committee had met for the first time on 1 July and all but one full member of the Committee had attended. The development of the Committee's work and agenda was an evolutionary process, she said, but as part of providing assurance the Committee had looked at the closing Minutes of each of the four 'closed' groups to ensure that no issues had been missed in the transition.

14.2.2 The Committee had discussed an annual programme of work, and the development of achievable objectives. The issues of the GP Out Hours service and recent focus on mortality were two issues which had been brought to the Board and would now be covered by her Committee. The Committee had developed a draft set of Terms of Reference, which she presented to the Board for approval.

14.2.3 Three minor changes to the draft as presented were proposed:

a. Delete paragraph 1 in its entirety and substitute:
'The Quality Committee is a committee of the Board of Directors. As such it will, on behalf of the Board, contribute to setting strategy as this relates to quality; oversee arrangements for quality governance and seek assurances on the delivery of high quality care and regulatory compliance.'

b. In paragraph 2 final sentence delete 'and Risk' and

c. Deputy Director of Performance and Informatics to be added as deputy for Chief Operating Officer.

14.2.4 The Board of Directors **approved** the Terms of Reference for the Quality Committee subject to the inclusion of the amendments at 14.2.3 above.

15. Serious Complaints/Incidents/matters that have been reported to Monitor and/or the Care Quality Commission

15.1 Mrs Dodson confirmed that the governance rating of green and the Continuity of Service Risk Report of 4 would be reported to Monitor as required.

16. Any Other Business

16.1 There was no other business.

17. Board Evaluation

17.1 Mrs Dodson said that she thought that the first meeting using Boardpad had been good and the system had performed satisfactorily.

17.2 Mrs Foster wondered there was very much content in her separate Chief Nurse report which Board members needed – if not then apart from reporting by exception (for example, the Morecambe Bay report or an update on revalidation) she would ensure that everything was included in the Integrated Board Report. Mrs Taylor mentioned the quality dashboard and Dr Tolcher said that the detail of that was not for the Board as it would be discussed elsewhere.

17.3 Mrs Dodson said that the reports from the Directorates had served to supplement the Integrated Board Report where they had an impact on delivering the strategic direction of the Trust. Dr Tolcher said that exception reports would usually be about a subject eg Morecambe Bay response, rather than generic. Mrs Webster said that exception reports should be about non-recurrent subjects, a view echoed by Mrs Dodson, who added that reports should normally be under their own headings.

17.4 Mr Ward wished the comments in the Integrated Board Report to follow a consistent format and seek to interpret the data.

17.5 In responding to a question from Mrs Dodson, Dr Tolcher said that in her view the debates at the meeting had not been too long but had been appropriately searching, especially around the finance and contract positions.

17.6 Mrs Dodson thanked Board members for their comments. She moved on to thank the two Governors for attending and the staff members for providing contingent technical support which, in the event, had been used minimally.

18. Confidential Motion

The Chairman moved ‘that members of the public and representatives of the press be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest’

The Board agreed the motion unanimously.

The meeting closed at 12.50pm.

Harrogate and District NHS
NHS Foundation Trust

HDFT Board of Directors Actions Schedule – September 2015

Completed Actions

This document logs actions Completed items agreed for action at Board of Director meetings. Completed items will remain on the schedule for three months and then be removed.

Outstanding items for action are recorded on the 'outstanding actions' document.

Item Description	Director/ Manager Responsible	Date of completion/progress update	Confirm action Complete
Revise Board Terms of Reference iaw comments and new template	Mr Forsyth, Interim Head of Corporate Affairs	June 2015	Complete
Circulate to NEDs dates of medico-legal lectures by Professor Marks	Dr Scullion, Medical Director	June 2015	Complete
Report on communications campaign around nurse and midwife revalidation	Mrs Foster, Chief Nurse	June 2015	Complete
Include role as Board focus for 'whistleblowing' in TsofR for post	Mrs Sandra Dodson - Chairman	June 2015	Complete
Show trajectory of progress with pressure ulcers and falls with fractures	Mrs Foster, Chief Nurse	June 2015 *etc seq*	Complete
Meet with Professor Proctor to consider response to Lampard Review	Mrs Foster, Chief Nurse	June 2015	Complete
Discuss Wi-Fi provision in the.hospital with NHS Providers and other partnerships	Mrs Foster, Chief Nurse	June 2015	Complete
Complete response to Lampard Report and submit after approval from Mrs Dodson and Dr Tolcher	Mrs Foster, Chief Nurse	June 2015	Complete
Discuss impact of changes to admission arrangements with Mr Ward	Mr Harrison (Mr Nicholas), Chief Operating Officer	June 2015	Complete
Forward details of other providers' plans to Mr Ward	Mrs Dodson, Chairman	June 2015	Complete
Report results of Remuneration Committee	Mrs Dodson, Chairman	June 2015	Complete
Report any future complaints about the LCP to the Board via the Chief Nurse report	Mrs Foster, Chief Nurse	July 2013	Complete
Report on Action Plan following Morecambe Bay Inquiry	Mrs Foster, Chief Nurse	July 2015	Complete

Circulate to Board members agreed HHTB Principles document	Dr Tolcher, Chief Executive	July 2015	Complete
Board Agenda to include monthly reports from, and Minutes of, Committees of the Board	Mr Forsyth, Interim Head of Corporate Affairs	July 2015	Complete
Invite comments on draft Integrated Board Report for final version at September Board meeting	Mr Forsyth, Interim Head of Corporate Affairs	July 2015	Complete
Report to Board on how changes resulting from implementation of Duty of Candour are being prioritised	Dr Scullion, Medical Director	July 2015	Complete
Possible changes to the Remuneration Committee to be discussed by NEDs	Mrs Dodson, Chairman	*July 2015*	Complete

Harrogate and District NHS
NHS Foundation Trust

HDFT Board of Directors Actions Schedule – Outstanding Actions

September 2015

This document logs items agreed at Board meetings that require action following the meeting. Where necessary, items will be carried forward onto the Board agenda in the relevant agreed month. Board members will be asked to confirm completion of actions or give a progress update at the following Board meeting when they do not appear on a future agenda.

When items have been completed they will be marked as such and transferred to the completed actions schedule as evidence.

Ref	Meeting Date	Item Description	Director/Manager Responsible	Date due to go to Board or when a confirmation of completion/ progress update is required	Detail progress and when item to return to Board if required
1	July 2015 (June 2015)	Investigate the incidence of deaths which took place within 24 or 48 hours of admission on Thursdays or Fridays (4.0)	Dr Scullion, Medical Director	**September 2015** (July 2015)	
2	June 2015	Investigate potential for HDFT to instigate Beacon Wards scheme (4.0)	Mrs Foster, Chief Nurse	**September 2015**	
3	June 2015	Report on overarching review of growth charts and associated issues in (6.9)	Dr Johnson, Clinical Director, Elective Care	**September 2015**	
4	June 2015	Mr Lavalette, NCEPOD Ambassador, to report biannually (Mar/Sep) on progress of NCEPOD work (4)	Dr Scullion, Medical Director	**September 2015**	
5	June 2015	Report progress on GPOOH service (4)	Mr Alldred, Clinical Director, Acute and Cancer Care	**September 2015**	
6	March 2015	Update on immunisation screening of staff (11.9)	Mr Marshall, Director of Workforce and Organisational Development	**September 2015**	
7	July 2015	Examine the possibility of seconding a substitute IPC nurse to Director Team visits when required (5.7)	Mrs Foster, Chief Nurse	**September 2015**	
8	July 2015	Arrange a session on risk assessment for	Mr Coulter, Director of Finance/Deputy Chief	**September 2015**	

		Non-Executive Directors (5.29)	Executive		
9	July 2015	Investigate linkage between HDF research nurse and Leeds University project on pressure ulcers (6.3)	Mrs Foster – Chief Nurse	**September 2015**	
10	July 2015	Report on outcome of Clinical Lead discussions ((84.)	Dr Johnson, Clinical Director, Elective Care	**September 2015**	
11	July 2015	Write to Nursing and Midwifery Council re concern about lack of statutory replacement (8.5)	Mrs Foster, Chief Nurse	**September 2015**	
12	July 2015	Provide Board members with link to data underlying report (11.2)	Mr Marshall, Director of Workforce and Organisational Development	**September 2015**	
13	July 2015	Circulate Healthwatch report on York Wheelchair service to Board members (12.1.1)	Mr Alldred, Clinical Director, Acute and Cancer Care	**September 2015**	
14	July 2015 (June 2015)	Develop and circulate a consistent narrative and direction of travel for the Trust (4.1.2)	Dr Tolcher, Chief Executive	October 2015	
15	July 2015 (April 2015)	Board Paper on Admissions (including readmissions) (10.5)	Dr Lyth, Clinical Director, Integrated Care Directorate	October 2015 (July 2015)	
16	July 2015	Report to the Board on outcomes of National Emergency Laparotomy audit (7.3)	Dr Scullion, Medical Director	October 2015	

Report to the Trust Board of Directors: 24 June 2015	Paper number: **5.0**

Title	Report from the Chief Executive
Sponsoring Director	Chief Executive – Dr Ros Tolcher
Author(s)	Chief Executive
Report Purpose	To receive and note the contents of the report.
Previously considered by	N/A

Key Issues:
The Trust's financial performance remains challenging with adverse variance in both income and expenditure year to date. Directorates are developing financial recovery plans.

The Trusts Monitor governance rating has been confirmed as 'green' and Continuity of Services Risk Rating (CoSRR) confirmed as 4.

The Trust will be inspected by the Care Quality Commission (CQC) in February 2016 as part of the CQC's routine programme of inspections.

An internal audit of the WHO Checklist compliance has given limited assurance. Robust action has been taken to address this.

Related Trust Vision	
1. Driving up quality	Yes
2. Working with partners	Yes
3. Integrating care	Yes
4. Growing our business	Yes

Risk and Assurance	
Legal implications/ Regulatory Requirements	No additional risks

Action Required by the Board of Directors
The Board of Directors is asked to:

- Note actions being taken to improve delivery of the financial plan.
- Note the planned CQC inspection

1.0 MATTERS RELATING TO QUALITY AND PATIENT EXPERIENCE

1.1 Patient Safety Visits

Reports on Patient Safety Visits and Directors Inspections are now covered in the Chief Nurse report to the Quality Committee.

1.2 Care Quality Commission (CQC) Inspection

We have been notified that the CQC will conduct an inspection of trust services in February 2016. All acute and community core service will be inspected. A CQC Inspection planning group has been convened and detail planning to support a successful inspection is underway.

2.0 STRATEGIC UPDATE

2.1 2015/16 Contracts

A contract with Harrogate and Rural District CCG has been agreed and we anticipate formal signing of contracts imminently.

2.2 Change of Directorate name:

The Acute and Cancer Care Directorate has changed its name to Urgent, Community and Cancer Care, which more accurately reflects the services it is now responsible for.

2.3 Annual Members Meeting

The Annual Members Meeting took place on 3rd September at the Harrogate Pavilions. It was attended by more than 70 members, staff and stakeholders, and included an interactive session relating to New Models of Care. The Trust was pleased to welcome the contribution of Dr Bruce Willoughby from the CCG on the discussion panel.

2.4 Monitor Q1 Performance

Monitor has confirmed a green rating for Governance, and a CoSRR of 4 for Q1.

3.0 WORKING IN PARTNERSHIP

3.1 New Models of Care (Vanguard Programme) and Harrogate Health Transformation Board

The Value Proposition has been signed off by the HHTB (Harrogate Health Transformation Board) partners and submitted to NHS England for review. Our New Care Model requires an investment of £2,833,739 in 2015/16, £8,701,207 in 2016/17 and £7,046,624 in 2017/18. We expect to release savings to entirely cover recurring costs by the end of 2017/18 whilst significantly improving quality and outcomes for our population. The new model will not however fully close the emerging funding gap.

HHTB agreed to go at risk on early implementation of key posts for the Boroughbridge and Knaresborough Integrated Locality Teams. Recruitment is underway. The New Models of Care Task and Finish groups will now be re-defined as delivery groups and the membership will be reviewed on this basis. A programme manager has been appointed.

3.2 Report from the West Yorkshire Association of Acute Trusts (WYAAT)

A briefing note dated 3 August as appended to this report.

The WYAAT group has submitted a Vanguard application in the Acute Care Collaboration (ACC) cohort. The ambition is to use technology to enable a radical shift in clinical resource deployment. Adopting a 'model clinical network' approach, we will aim to deliver improved outcomes for patients and use technology to support up to 30% of consultations operating via a virtual platform over the next 5 years. Developing this approach across networks at scale rather than in individual institutions will improve clinical productivity and support the delivery of 7/7 working across a larger population. Four members of the partnership attended the bidding event in London on 7 and 8 September. The outcome is awaited.

4.0 FINANCIAL POSITION

The financial position in August was an adverse variance against plan of £123k, resulting in a year to date variance of £1,049k. The income in August was in line with our reduced plan, but costs were above plan. This represents an improved performance compared to July which recorded an in-month adverse variance of £372k. the underlying position however remains very challenging.

The last 4 weeks have seen the Directorates pulling together recovery plans. Engagement has been good and significant focus is on resolving the current under performance. The plans were discussed at SMT and further detail is contained within the report of the Finance Director.

5.0 SENIOR MANAGEMENT TEAM (SMT) MEETING

Key issues from the SMT meeting held on 19 August:

- Numbers of C. Difficile cases of concern. Reassuring that there is no evidence of patient to patient transmission or lapses in care leading to infection. Director of Infection Prevention and Control (DIPC) meeting with commissioners to agree contractual implications if the number of cases recorded exceeds to maximum allowable for 2015/16 which is 12 cases.
- Finances: review and challenge of CIP delivery and financial controls. Income and expenditure both adverse in M4 for the first time in 15/16. Pay costs in excess of plan are the main driver. All Directorates asked to work up financial recovery plans for September SMT. Use of additional staffing to be the subject of particular focus. Directorate were asked to provide assurance on the robustness of vacancy controls arrangements.
- CIP governance: SMT members were reminded of the agreed process for CIP identification, sign off and Quality Impact Assessment
- Operational performance:
    - GP OOHs NQR Performance – It was noted performance had marginally improved but was still 'red'
    - CQUINs – AKI (acute kidney injury) and Sepsis – the difficulty in demonstrating delivery of good practice was noted and a more detailed briefing requested.
- Two new risks on the Corporate Risk Register noted and actions required to mitigate these discussed: (1) a risk in relation to failure to renew/maintain equipment and (2) a risk in relation to the commissioned breast cancer care pathway which is non-compliant with NICE guidance.
- A review of Trust Policies on the intranet has identified large numbers of expired, duplicate and obsolete policies presenting risks to safe care and compliance. Actions were agreed to recover this position.
- The Internal Audit report on the WHO Checklist compliance was discussed. The Audit was rated as offering Limited Assurance with 12 high risk actions. All actions

to be completed by October 2015. Decision to undertake a further audit in 6 months, prior to formal re-audit by our Internal Auditors in 12 months.

- The current state of CCG contract negotiations was discussed. The CCG would like to implement a Clinical Board spanning commissioners and providers, to support an affordable system.
- Changes to use of charitable funds and consolidation of Charitable Funds noted.
- Communications from Leeds Teaching Hospital NHST relating to 62 day cancer pathway discussed.
- PLACE report- low scores for privacy and dignity, and dementia discussed. Further work underway to identify remedies where feasible.
- Effective Rostering – an Internal Audit report had highlighted rostering being suboptimal. A business case has been agreed to implement the Oceans Blue system with effect from September to maximise reporting from RosterPro, ESR and NHSP.
- The Corporate Risk Register was scrutinised and challenged.

6.0 COMMUNICATIONS RECEIVED AND ACTED UPON

6.1 **Monitor CEO letter to all FT CEO's regarding Annual Plans (3 August)**. David Bennett wrote to all Trusts urging executives to review their annual plans and seek further cost savings.

6.2 **2014/15 Q4 monitoring and 2015/16 Annual Plan Review (APR) (3 August).** HDFT governance rating is confirmed as green. Monitor has flagged some minor concerns relating to finances and we will continue with quarterly calls as previously.

6.3 **2015/16 Q1 monitoring (15 September)**HDFT governance rating is confirmed as green and the Continuity of Service rating as 4.

6.4 **National Safety Standards for Invasive Procedures (NatSSIPs) (7 September)** Dr Mike Durkin, Director of Patient Safety, NHS England has introduced some National Safety Standards for Invasive Procedures (NatSSIPs).

6.5 **Monitor communication re Agency use for Registered Nurses.** An annual ceiling for nursing agency spend for each trust and a mandatory requirement to use approved frameworks for procuring agency staff is required. HDFT is in the lowest risk category. And current agency expenditure on registered nurses is well below the advisory ceiling.

7.0 BOARD ASSURANCE AND CORPORATE RISK

The summary current position of the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) is presented below.

7.1 <u>Board Assurance Framework (BAF)</u>

The BAF has been fully reviewed and updated. It is also the subject of a quarterly update this month in the closed section of the Board meeting, due to the commercially sensitive content.

There are 16 Risks recorded on the BAF.

Four new risks have been added to the BAF since last month. Three of these have been added to provide a more comprehensive picture and do not represent novel risks. The fourth is a risk which has been escalated from the Corporate Risk Register.

All the existing BAF entries have action plan progress scores of 1 or 2 which provides assurance that actions are being progressed. One of the new risks has a progress score of 2, two of them have progress scores of 3 (actions are defined – work started) and one has a progress score of 4 (actions defined but work not started/behind plan).

The strategic risks are as follows:

Ref	Description	Risk score	Movement since last month and progress score
BAF#1	Lack of Medical, Nursing and Clinical staff	*Amber 9*	*unchanged at 2*
BAF#2	High level of frailty in local population	*Red 12*	*unchanged at 2*
BAF#3	Failure to learn from feedback and Incidents	*Amber 9*	*unchanged at 2*
BAF#4	Lack of integrated IT structure	*Red 16*	*unchanged at 2*
BAF#5	Service Sustainability	*Red 12*	*unchanged at 2*
BAF#6	Understanding the market	*Red 12*	*unchanged at 2*
BAF#7	Lack of robust approach to new business	*Amber 8*	*unchanged at 2*
BAF#8	Visibility and reputation	*Red 12*	*unchanged at 2*
BAF#9	Failure to deliver the Operational Plan	*Red 12*	*unchanged at 2*
BAF#10	Loss of Monitor Licence to operate	*Amber 5*	*unchanged at 2*
BAF#11	Risk to current business	*Green 4*	*unchanged at 1*
BAF#12	External funding constraints	*Red 12*	*improved at 1*
BAF#13	Focus on Quality	*Amber 8*	*unchanged at 2*
BAF#14	Delivery of integrated models of care	*Red 12*	*unchanged at 3*
BAF#15	Alignment of strategic plans	*Red 16*	*unchanged at 3*
BAF#16	Assurance of building safety in non-HDFT owned premises	*Red 12*	*unchanged at 4*

Key to Progress Score on Actions:
1 Fully on plan across all actions
2 Actions defined - some progressing, where delays are occurring interventions are being taken
3 Actions defined - work started
4 Actions defined - but work not started/behind plan

7.2 Corporate Risk Register (CRR)

The CRR was most recently reviewed at the monthly meeting of the Corporate Risk Review Group on 11 September and SMT on 16 September.

One risk has been added to the CRR – CR6: Risks associated with failures of medical devices and equipment (risk to be fully defined).

The top-scoring risk remains CR49c: Risk to business objectives due to non-delivery of locality wide IT system – Risk Score 16 (Consequences 4 Likelihood 4)

Two risks have action plans which are behind plan and subject to additional work:

COR 64: Harm to ophthalmology patients
COR 74: Harm to ward-attending patients

There was one Risk from the Corporate Risk Register which has been escalated to the Board Assurance Framework (BAF#16 relating to buildings safety).

8.0 DOCUMENTS SIGNED AND SEALED

I am pleased to report that during the month the Chairman and I signed and sealed a Variation Agreement for the community services contract 2013/14.

Dr Ros Tolcher
Chief Executive

Harrogate and District NHS
NHS Foundation Trust

Report to the Trust Board of Directors: 23 September 2015	Paper No: 5.1

Title	Briefing on Trust Strategic Objectives
Sponsoring Director	Dr Ros Tolcher
Author(s)	Dr Ros Tolcher
Report Purpose	To seek formal adoption of revised Strategic Objectives

Key Issues for Board Focus:
Clearly defined strategic objectives direct the work of the Trust and will ensure that we achieve our Vision.
The HDFT Strategic Objectives have been updated to reflect National Drivers and discussions at the Board of Directors Time Out meeting.

Related Trust Objectives	
1. Driving up quality	Yes
2. Working with partners	Yes
3. Integrating care	Yes
4. Growing our business	yes

Risk and Assurance	
Legal implications/ Regulatory Requirements	none

Action Required by the Board of Directors

- To approve the revised Strategic Objectives
- To note further work on refining vision and mission statements

1. Proposed amendment to the Trust's Strategic Objectives

High performing organisations demonstrate a compelling vision and secure internal alignment to that vision by having clear objectives and values which staff buy in to. The Board of Directors has previously recognised the importance of updating its Vision and Mission statements and of ensuring that our organisational strategic objectives are the right ones to deliver our vision. Work is currently underway to review and refresh the vision and mission statements.

The Board of Directors discussed a proposed amendment to the Trust strategic objectives at its' Development Day in July. Further to that meeting it is now proposed that the Board formally adopts a revised set of three high level strategic objectives as follows:

Objective one: To deliver high quality care

Objective Two: To work with partners to deliver integrated care

Objective Three: To ensure clinical and financial sustainability

All of the Trust's strategic documents and the Board Assurance Framework will be constructed based on these strategic objectives.

Recommendation: the Board of Directors is requested to approve the three Strategic Objectives

Further work is underway to review the Trust's Vision and Mission statements. The Board of Directors has previously agreed a core set of Values which will support delivery of our objectives. At its meeting in February the Board of Directors also approved a set of Annual Goals which will help every member of staff agree purposeful actions in their individual roles. The Annual Goals build upon the strategic objectives. These four goals are now being used as the framework for annual objective setting.

A summary of our Strategic Objectives, Values and Goals is provided below.

Recommendation: the Board of Directors is asked to note progress on developing the Mission, Vision, Values, Objectives and Goals suite of documents.

2. Summary position: Mission, Vision, Values, Objectives and Goals.

Our Mission

Work is underway to review/revise a mission statement for HDFT.

Our Vision

The current vision statement is:

To be an integrated community and hospital provider, providing services across an expanded population, within a network of partners delivering high quality care to patients and users of our services.

Work is underway to review/revise a Vision statement for HDFT.

Our values

Respectful
We will treat people with respect. People using our services will be treated with dignity and compassion. We will listen to people and treat everyone equally.

Responsible
We will be responsible and accountable. We will be open and honest with people. We will ensure that we have the right skills for our work and that we keep up to date. We will take action when things go wrong. We will seek to learn and improve continuously.

Passionate
We will maintain an unwavering focus on the quality of what we do. We will go the extra mile to deliver great care, to support each other and to lead the way in innovation. We will do the things we commit to doing and do them well.

Our Strategic Objectives

1. **Deliver high quality care**

   This means that we will continuously strive to deliver the best possible outcomes and ensure that people using our services have a positive experience. We will make the safety of services our highest priority. We will listen to the views of people using our services and staff providing care and use this to make improvements. We will invest in supporting and developing our workforce and promote a positive and open culture of learning. We will make sure that HDFT is a great place to work.

2. **Work with partners to deliver integrated care**

   This means that we will work positively with other providers, Local Authorities and commissioners to ensure that the design of services offers the best possible, affordable care. We will design services based on the needs of local people and ensure that these are joined up where this makes sense.

3. **Ensure clinical and financial sustainability**

   This means that we will manage resources carefully and make sure that clinical models are robust and reliable. We will take a long term view of financial risk and strategic planning. We will look carefully at

trends in activity and align workforce and infrastructure capacity. We will seek to expand our services to a wider population where this provides greater clinical and financial benefits. We exercise robust financial stewardship to protect the continuity of services.

Our Annual Goals

1. **To place patients/people who use our services at the centre of decision making.**

This means that we will

- Plan and deliver care based on the needs of patients
- Listen to feedback and make improvements on this basis
- Treat each person as an individual
- Ensure that people in our care feel safe and are treated with dignity and respect

2. **To support and engage with staff**

This means that we will

- Live our values, valuing individuals and teams
- Invest in and develop people to enable them to thrive
- Promote staff health and wellbeing
- Respond to messages in the annual staff survey and staff FFT
- Promote an open and honest culture

3. **To use resources carefully**

This means that we will

- Exercise prudent cost control
- Do things on time, right first time
- Use our time effectively and respect the value of colleagues time
- Prepare well for meetings and be 'present'

4. **To plan for the future**

This means that we will

- Use information to drive resilience, model future demand and manage risk proactively
- Respond to and work with partner organisations for a shared future
- Follow through on action plans
- Understand our cost base and how we can improve it
- Use benchmarking information to drive efficiency

Harrogate and District NHS
NHS Foundation Trust

Report to the Trust Board of Directors: 23rd September 2015	**Paper No: 6.0**

Title	**Integrated Board Report**
Sponsoring Director	Dr. Ros Tolcher, Chief Executive
Author(s)	Rachel McDonald, Head of Performance & Analysis
Report Purpose	For information

Key Issues for Board Focus:

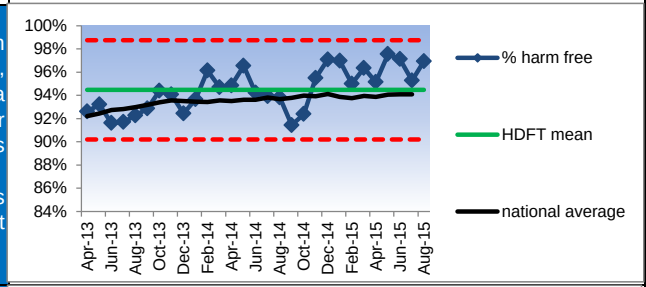
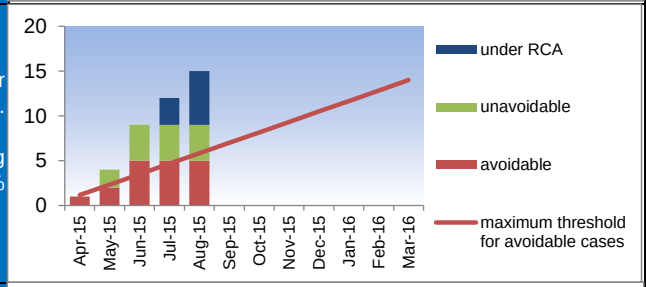
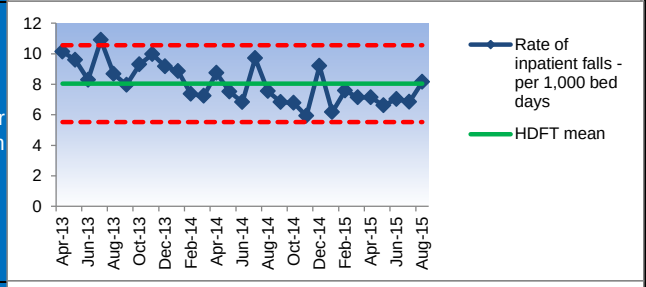
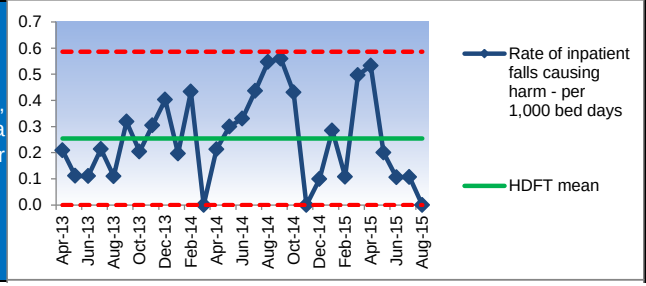
- The red rated indicators in this month's report are delayed transfers of care, cash balance, agency spend in relation to pay spend, GP OOH national quality standards 9 and 12 and health visiting new born visits. Please note that three of these are new indicators not included in last month's report.
- Work continues on defining appropriate RAG ratings for each indicator and new community metrics will be introduced from next month as detailed in the narrative report from the Chief Operating Officer.

Related Trust Objectives	
1. Driving up quality	Yes
2. Working with partners	Yes
3. Integrating care	Yes
4. Growing our business	Yes

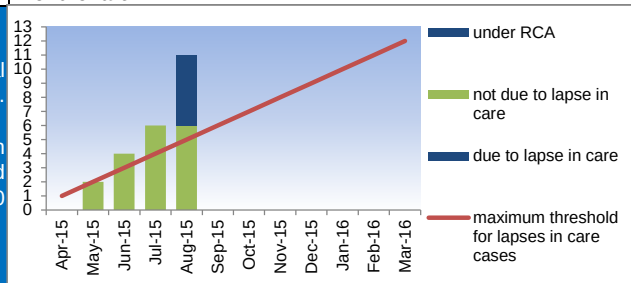
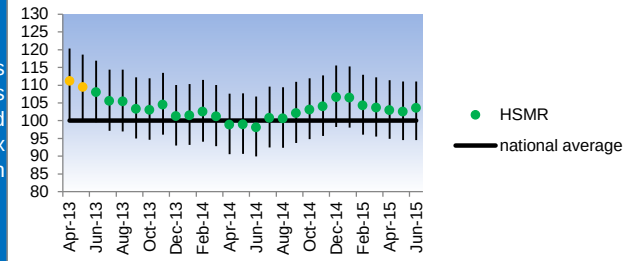
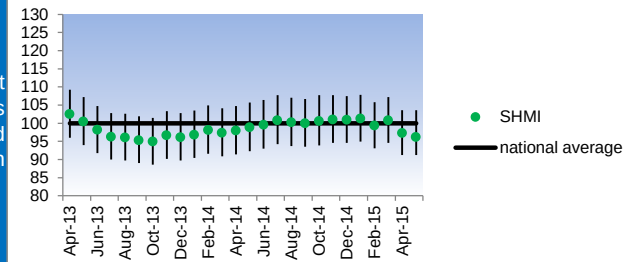
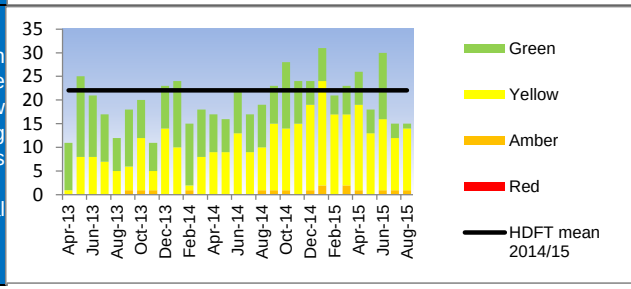
Risk and Assurance	The report triangulates key performance metrics covering quality, finance and efficiency and operational performance, presenting trends over time to enable identification of improvements and deteriorations.
Legal implications/ Regulatory Requirements	The Trust is required to report its operational performance against the Monitor Risk Assessment Framework on a quarterly basis and to routinely submit performance data to NHS England and Harrogate & Rural District CCG.

Action Required by the Board of Directors
To note current performance.

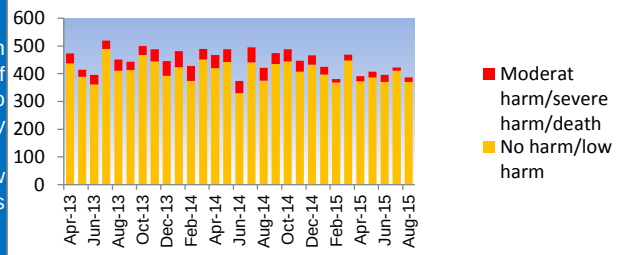
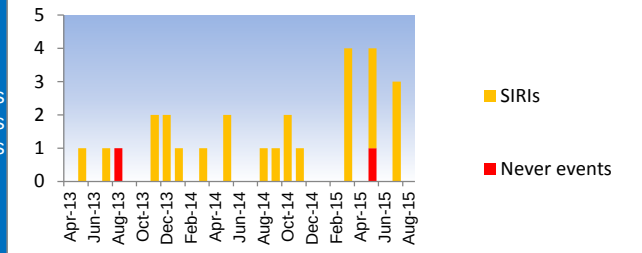
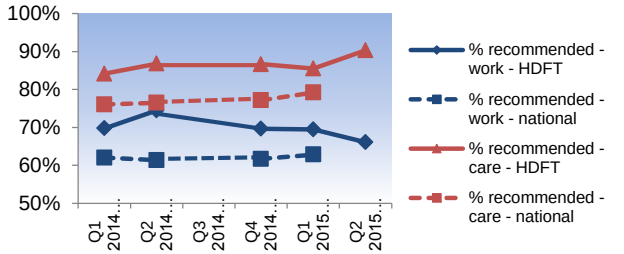
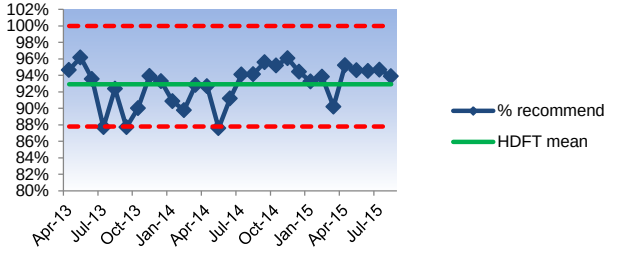
Quality - August 2015

Indicator	Description	Trend chart	Interpretation
Safety thermometer - harm free care	Measures the percentage of patients receiving harm free care (defined as the absence of pressure ulcers, harm from a fall, urine infection in patients with a catheter and new VTE) in the Safety Thermometer audits conducted once a month. The data includes hospital and community teams. A high score is good. Whilst there is no nationally defined target for this measure, a score of 95% or above is considered best practice.		HDFT's performance has improved over the last 2 years and the Trust has reported a harm free percentage above 95% for the last 10 months. The Trust reported 96.9% harm free care for August 2015, an improvement on last month. The latest available national data shows that the national average is just below 94%.
Pressure ulcers	The chart shows the cumulative number of grade 3 or grade 4 hospital acquired pressure ulcers in 2015/16. The data includes hospital teams only. A maximum threshold of 14 avoidable cases during 2015/16 has been locally agreed. This reflects a 50% reduction on last year's figure.		As at end August 2015, there were 15 hospital acquired grade 3 or grade 4 pressure ulcers year to date, of which 5 were deemed avoidable, 4 unavoidable and 6 were still under root cause analysis (RCA).
Falls	The number of inpatient falls expressed as a rate per 1,000 bed days. The data includes falls causing harm and those not causing harm. A low rate is good.		As can be seen from the chart, the rate of inpatient falls per 1,000 bed days has been reducing over the last 2 years.
Falls causing harm	The number of inpatient falls causing significant harm, expressed as a rate per 1,000 bed days. The falls data includes falls causing moderate harm, severe harm or death. A low rate is good.		There was no inpatient falls in August 2015 causing moderate harm, severe harm or death.

Quality - August 2015

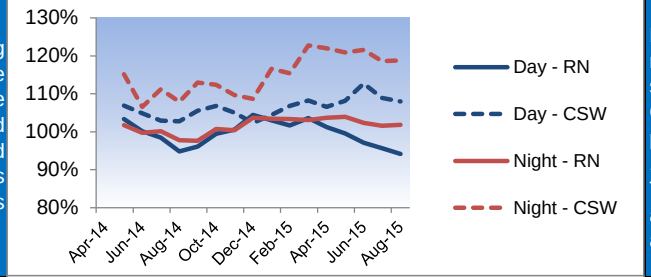
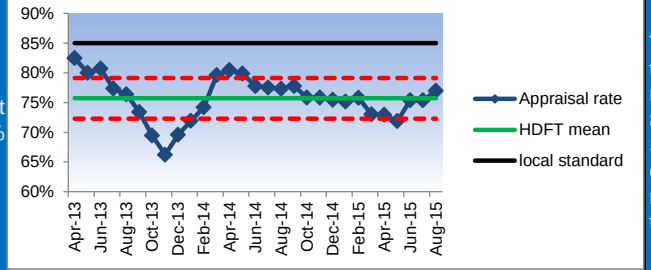
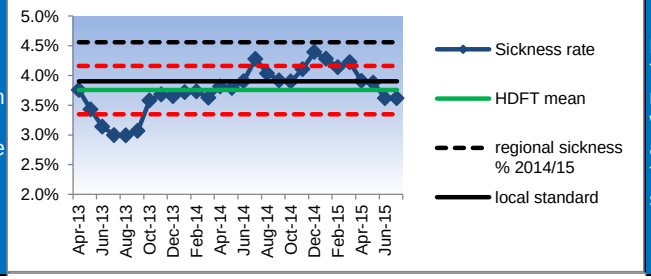
Indicator	Description	Trend chart	Interpretation
Infection control	The chart shows the cumulative number of hospital acquired C. difficile cases during 2015/16. HDFT's C. difficile trajectory for 2015/16 is 12 cases. Hospital acquired MRSA cases will be reported on an exception basis. HDFT reported no hospital acquired MRSA cases during 2014/15 and has a trajectory of 0 cases for 2015/16.		There were 5 cases of hospital acquired C. difficile reported in August 2015, bringing the year to date total to 11 cases at the end of August. 6 of the 11 cases have had root cause analyses completed and none were deemed to be due to a lapse in care. Cases when a lapse in care has been deemed to have occurred would count towards the Monitor risk assessment framework trajectory in the event that the Trust exceeds its annual trajectory of 12 cases. No cases of hospital acquired MRSA have been reported in 2015/16 to date.
Mortality - HSMR	The Hospital Standardised Mortality Ratio (HSMR) looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care. A low figure is good.		HDFT's HSMR increased in June to 103.52. It is above the national average but within expected levels. At specialty level, there were 3 specialties (Endocrinology, Respiratory Medicine and Gastroenterology) with a standardised mortality rate above expected levels.
Mortality - SHMI	The Summary Hospital Mortality Index (SHMI) looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care. A low figure is good.		HDFT's SHMI reduced in May to 96.11. This is below the national average and within expected levels. At specialty level, there were 2 specialties (Geriatric Meidicine and Respiratory Medicine) with a standardised mortality rate above expected levels. Looking at the data by site, Ripon hospital has a higher than expected mortality rate. The Clinical Director for UCC Directorate has commissioned a retrospective clinical case note review of all deaths at or within 30 days of discharge from Ripon Hospital.
Complaints	The number of complaints received by the Trust, shown by month of receipt of complaint. The criteria define the severity/grading of the complaint with green and yellow signifying less serious issues, amber signifying potentially significant issues and red for complaints related to serious adverse incidents. The data includes complaints relating to both hospital and community services.		15 complaints were received in August - of which 1 was classified as amber.

Quality - August 2015

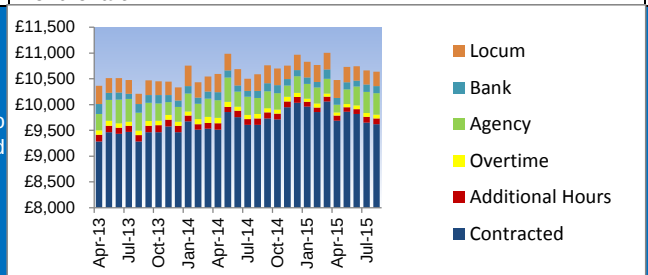
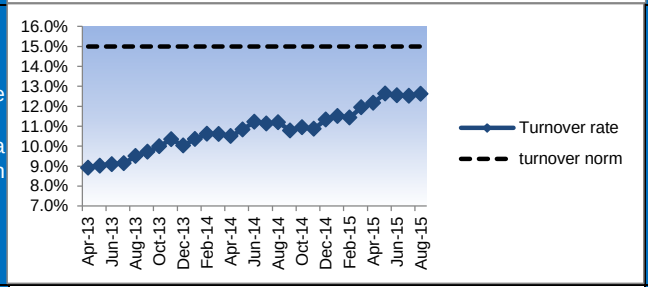
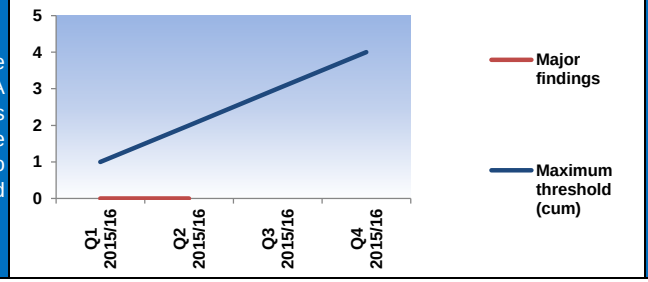
Indicator	Description	Trend chart	Interpretation
Incidents - all	The chart shows the number of incidents reported within the Trust each month. It includes all categories of incidents, including those that were categorised as "no harm". The data includes hospital and community services. A large number of reported incidents but with a low proportion classified as causing significant harm is indicative of a good incident reporting culture		The number of incidents reported each month remains fairly static and is generally between 400 and 500. There were 387 incidents reported in August 2015, a decrease on last month.
Incidents - SIRIs and never events	The chart shows the number of Serious Incidents Requiring Investigation (SIRIs) and Never Events reported within the Trust each month. The data includes hospital and community services.		There were no SIRIs and no never events reported in August 2015.
Friends & Family Test (FFT) - Staff	The Staff Friends and Family Test (FFT) was introduced in 2014/15 and gives staff the opportunity to give feedback on the organsation they work in. Trusts were only required to carry out the survey during Q1, Q2 and Q4 2014/15 so data for Q3 2014/15 is not available. HDFT surveyed all staff for each survey during 2014/15. During 2015/16, a proportion of staff will be surveyed each quarter, which is in line with national guidance. A high percentage is good.		In Q2 2015/16, staff from Elective Care Directorate and some staff from the Corporate Directorate were surveyed. 90.3% of staff surveyed would recommend the Trust as a place to receive care and 66.1% of staff would recommend the Trust as a place to work. These scores are above the most recently published national average.
Friends & Family Test (FFT) - Patients	The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment. This indicator covers a number of hospital and community services including inpatients, day cases, outpatients, maternity services, the emergency department, some therapy services, district nursing, community podiatry and GP OOH. A high percentage is good.		The chart shows the overall score (% patients who would recommend the service) for all HDFT services currently participating in the FFT survey. 93.9% of the 5,700 patients surveyed in August would recommend the service to friends and family. The number of patients participating in August reduced when compared to July, but this is partly due to reduced activity during the summer period. Response rates vary between services but the Clinical Directorates are working on maximising these.

Harrogate and District NHS
NHS Foundation Trust

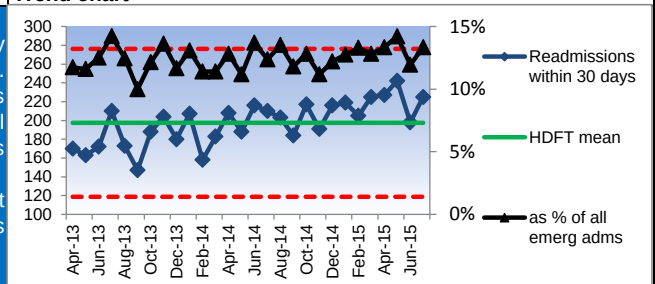
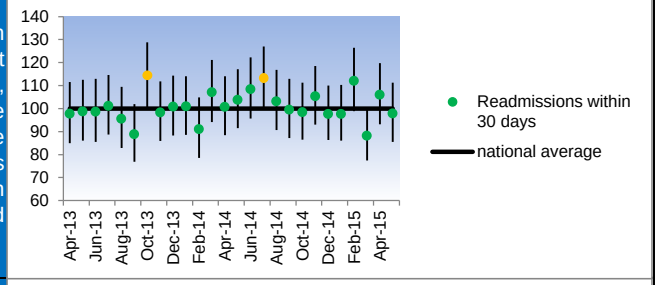
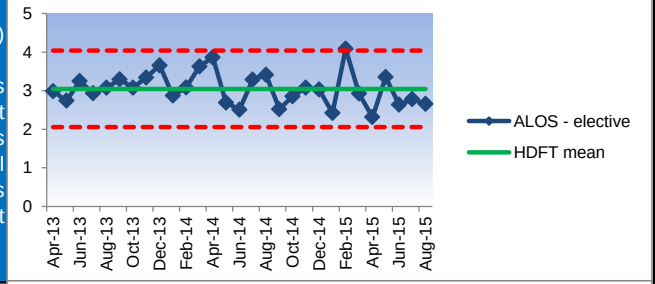
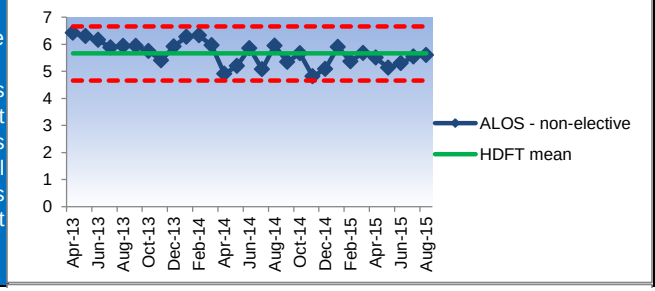
Quality - August 2015

Indicator	Description	Trend chart	Interpretation
Safer staffing levels	Trusts are required to publish information about staffing levels for registered nurses/midwives (RN) and care support workers (CSW) for each inpatient ward. The chart shows the overall fill rate at HDFT for RN and CSW for day and night shifts. The fill rate is calculated by comparing planned staffing with actual levels achieved. A ward level breakdown of this data is published on the Trust website.		Registered nurse/midwife (RN) staff levels reduced in August - reduced elective orthopaedic activity during the month enabled some bed closures and RN staffing was reduced as a result. Care support workers (CSW) staffing levels have increased, particularly at night. This is reflective of the increased need for 1-1 care for some inpatients. The Trust aims for 100% staffing overall but staffing below or above this level on any given day is not necessarily indicative of an inappropriate or unsafe staffing level.
Staff appraisal rates	The chart shows the staff appraisal rate over the most recent rolling 12 months. The Trusts aims to have 85% of staff appraised. A high percentage is good.		The locally reported cumulative appraisal rate for the 12 months to end August 2015 was 77.0%, an increase on the previous month. Data from the 2014 national staff survey suggested that 87% of HDFT had been appraised within the last 12 months. Skills for Health are currently in the Trust interviewing staff to establish how to improve appraisal complaince and asking line managers how they feel they can support staff in maximising talent management.
Mandatory training rates	The table shows the most recent training rates for all mandatory elements for substantive staff. A high percentage is good.	**Competence Name** / **Total Employees** / **% Completed** Equality and Diversity - General Awareness: 3400: 95 Fire Safety Awareness: 3400: 83 Health & Safety: 1305: 97 Infection Prevention & Control 1: 655: 100 Infection Prevention & Control 2: 2693: 86 Information Governance: Introduction: 3144: 86 Information Governance: The Beginners Guide: 254: 75 Safeguarding Adults Awareness: 3405: 98 Safeguarding Children & Young People Level 1: 3400: 73	The data shown is for end August 2015. The overall training rate for mandatory elements for substantive staff is 88%, compared to 90% last month. There has been a change in the training requirement regarding Safeguarding Children & Young People Level 1 which reflects the reduced complaince rate on this. Discussions continue with the directorate management teams to ensure non-compliant staff are individually followed up. In addition Skills for Health have interviewed line managers to probe around the usage of the individual follow-up procedure.
Sickness rates	Staff sickness rate - includes short and long term sickness. The Trust has set a threshold of 3.9%. A low percentage is good.		HDFT's staff sickness rate was 3.62% in July 2015, below the Trust threshold level (3.9%) and no change on the previous month. Work is continuing to progress the Trust's health and wellbeing agenda. The Wellbeing Adviser interviews occurred on Thursday 13th August and a preferred candidate has been selected.

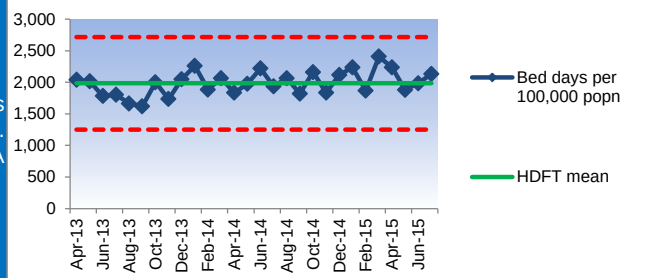
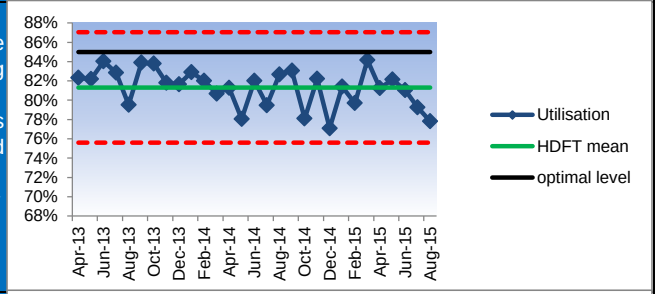
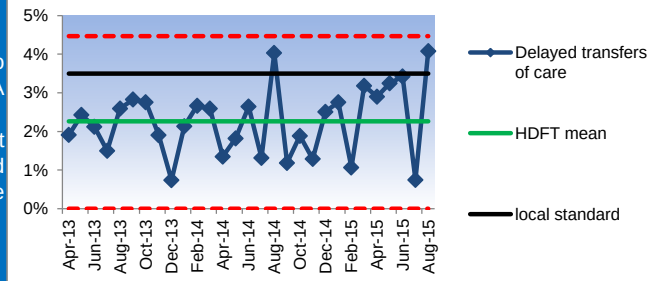
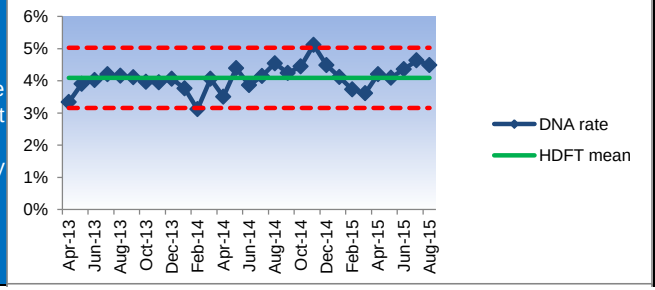
Quality - August 2015

Indicator	Description	Trend chart	Interpretation
Temporary staffing expenditure - medical/nursing /other	The chart shows staff expenditure per month, split into contracted staff, overtime and additional hours and temporary staff. Lower figures are preferable.		The proportion of spend on temporary staff during 2015/16 to date is 7.1%, compared to 7.5% in the same period in 2014/15.
Staff turnover rate	The chart shows the staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts. Data from the Times Top 100 Employers indicated a turnover rate norm of 15%, i.e. the level at which organisations should be concerned.		The staff turnover rate was at 12.6% in August 2015. HDFT's turnover rate has generally increased over the last two years but has levelled off during 2015/16 and remains below the turnover norm of 15%. Exit questionnaires are received by the Human Resources Department where they are reviewed. Any patterns identified prompt investigating further and on occasion departmental stress risk assessments may be conducted.
Research internal monitoring	The Trust internally monitors research studies active within the Trust. The department mirrors the MHRA categorisation of critical, major and other findings (departures from legislative or GCP requirements). The department has set a standard of no critical and no more than four major findings per annum. Major and other findings are non-notifiable and dealt with locally.		There were no critical or major findings reported in Q1 or in Q2 to date.

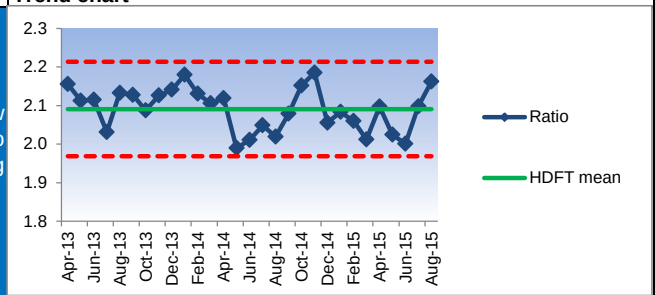
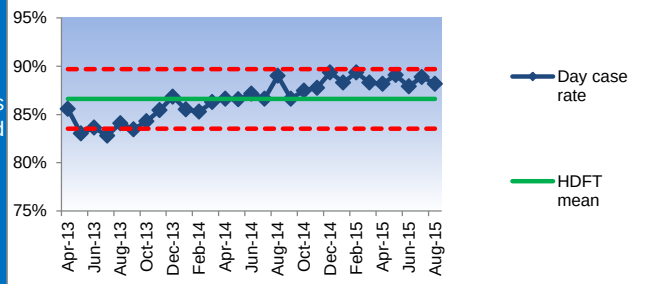
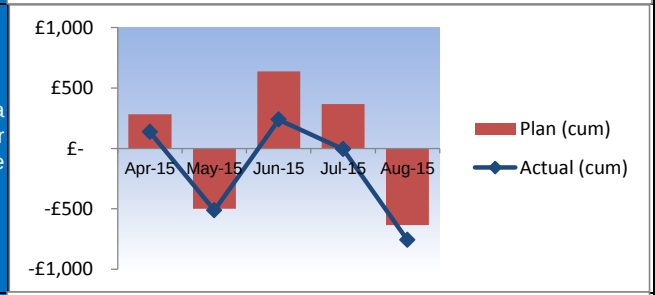
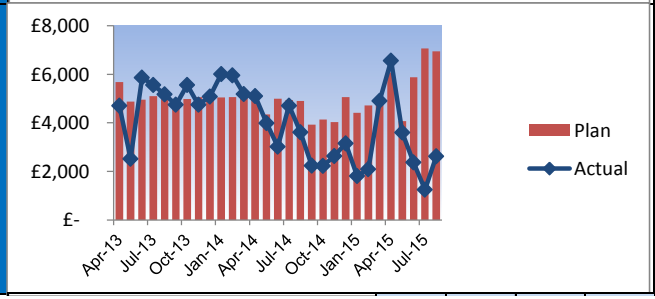
Finance and Efficiency - August 2015

Indicator	Description	Trend chart	Interpretation
Readmissions	% of patients readmitted to hospital as an emergency within 30 days of discharge (PbR exclusions applied). To ensure that we are not discharging patients inappropriately early and to assess our overall surgical success rates, we monitor the numbers of patients readmitted. A low number is good performance. This data is reported a month behind so that any recent readmissions are captured in the data. A low figure is good.		The number of readmissions within 30 days is increasing. However when expressed as a % of all emergency admissions (black line on the chart), there has been no significant change over the last two years. Data collection for the case note audit has commenced with a clinical proforma attached to notes of patients who have been readmitted to support the data capture.
Readmissions - standardised	This indicator looks at the standardised readmission rate within 30 days. The data is standardised against various criteria including age, sex, diagnosis, comorbidites etc. The standardisation enables a more like for like comparison with other organisations. The national average is set at 100. A low rate is good - rates below 100 indicate a lower than expected readmission rate and rates above 100 indicate higher than expected readmission rate.		The standardised readmission rate for HDFT for May-15 (latest data available) was 97.8. This is below the national average and a reduction on the previous month.
Length of stay - elective	Average length of stay in days for elective (waiting list) patients. The data excludes day case patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay.		The average elective length of stay for Aug-15 was 2.7 days, a decrease on the previous month. A focus on sustainably reducing this through the Planned Care Transformation programme is underway, which includes reducing the number of patients admitted the day before surgery.
Length of stay - non-elective	Average length of stay in days for non-elective (emergency) patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay.		The average non-elective length of stay for Aug-15 was 5.7 days, an increase on the previous month. There is a focus on patient flow and discharge through the Unplanned Care Transformation Programme which is looking to optimise internal efficiencies to minimise length of stay.

Finance and Efficiency - August 2015

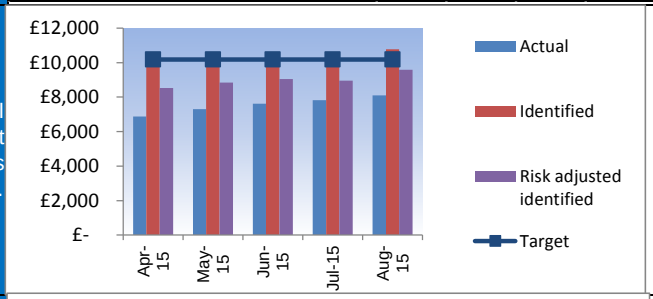
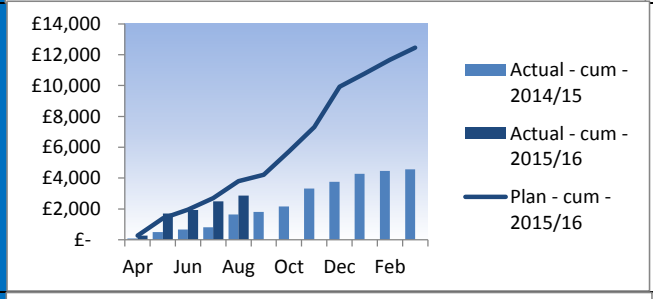
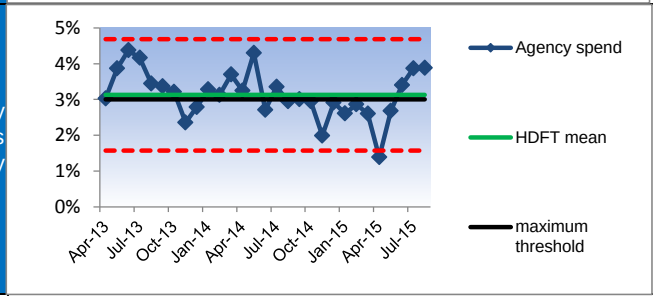
Indicator	Description	Trend chart	Interpretation
Non-elective bed days	The charts shows the number of non-elective bed days at HDFT for patients aged 18+, per 100,000 population. The chart only includes the local HARD CCG area. A lower figure is preferable.		As can be seen, the number of bed days for patients aged 18+ has remained fairly static over the last two years. Further analysis of this new indicator will be completed to look at the demograghic changes during this period and the number of admissions for this group will assist in understanding this further.
Theatre utilisation	The percentage of time utilised during elective theatre sessions only (i.e. those planned in advance for waiting list patients). A higher utilisation rate is good as it demonstrates effective use of resources. A utilisation rate of around 85% is often viewed as optimal. *Caution should be exercised when interpreting this indicator as there are data quality issues with the reported data.*		Theatre utilisation decreased in August 2015 to 77.8%. The Elective Care Directorate are continuing to review the utilisation of theatres and will be working with the anaesthetic team to ensure that the impact on elective theatre lists of gaps in the anaesthetic rota is minimised. The utilisation calculation is being reviewed to ensure that it correctly handles lists that are cancelled in advance.
Delayed transfers of care	The proportion of patients in acute hospital beds who are medically fit for discharge but are still in hospital. A low rate is preferable. A snapshot position is taken at midnight on the last Thursday of each month. The maximum threshold shown on the chart (3.5%) has been agreed with the CCG.		Delayed transfers of care were at 4.1% when the snapshot was taken in August. This is an increase on the previous month and above the maximum threshold of 3.5% set out in the contract. The discharge liaison team are working closely with North Yorkshire and Leeds local authorities to improve the position.
Outpatient DNA rate	Percentage of new outpatient attendances where the patient does not attend their appointment, without notifying the trust in advance. A low percentage is good. Patient DNAs will usually result in an unused clinic slot.		The outpatient DNA rate for first attendances in Aug-15 was 4.6%, a slight decrease on the previous month. DNA rates at outreach clinics are being monitored to ensure that they are not significantly higher than clinics on the main site. During Q1, the DNA rate for first outpatient appointments at outreach clinics was 4.7%, compared to 4.1% on the main Harrogate site. Directorate teams will be asked to focus on why offsite rates are higher if this persists.

Finance and Efficiency - August 2015

Indicator	Description	Trend chart	Interpretation
Outpatient new to follow up ratio	The number of follow-up appointments per new appointment. A lower ratio is preferable. A high ratio could indicate that unnecessary follow ups are taking place.		The new to follow up ratio was 2.16 in August 2015, an increase on the previous month. The Deputy Director of Performance & Informatics is leading a review with the CCG of patients who wait longer than 6 months for a follow up appointment. Changes to the PAS system have enabled the Trust to record clinical conditions for each follow up attendance and reports are being developed and shared to analyse this.
Day case rate	The proportion of elective (waiting list) procedures carried out as a day case procedure, i.e. the patient did not stay overnight. A higher day case rate is preferable.		The elective day case rate in July was 88.2%. As can be seen from the chart, the day case rate has steadily increased over the last two years. Through the Day Surgery Transformation group a number of new patient pathways have been assessed and setup recently. Work is ongoing to review and support developments of Best Practice Tariff and the directorate is agreeing a cross specialties 'default to day surgery' list of agreed procedures.
Surplus / deficit and variance to plan	Monthly Surplus/Deficit (£'000s). In some months, a deficit is planned for. This indicator reports positive or adverse variance against the planned position for the month.		The Trust reported a deficit in August of £758k, £123k behind plan. This has resulted in the year to date position worsening to a deficit of £897k, £1,048k behind plan.
Cash balance	Monthly cash balance (£'000s)		The Trust cash balance is reported at £2,625k for August 2015. This is significantly behind the planned position of £6,946k. The position significantly improved at the start of September when HaRD CCG made a significant payment to catch up to the the agreed contract profile. This payment was £20m greater than the payments to date.

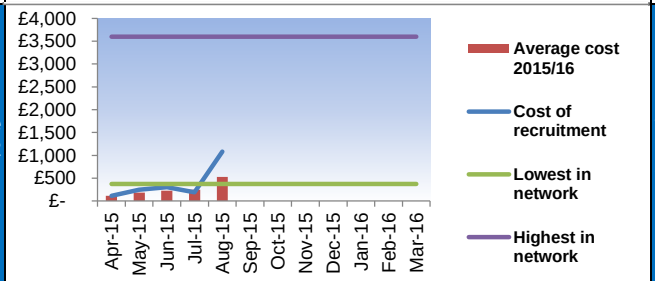
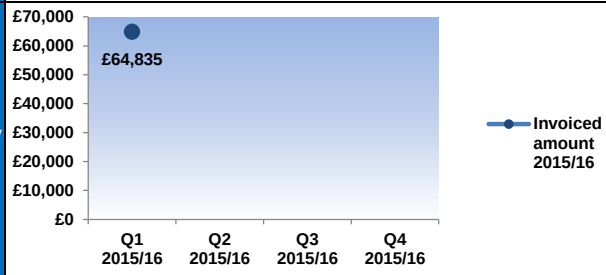
Harrogate and District NHS
NHS Foundation Trust

Finance and Efficiency - August 2015

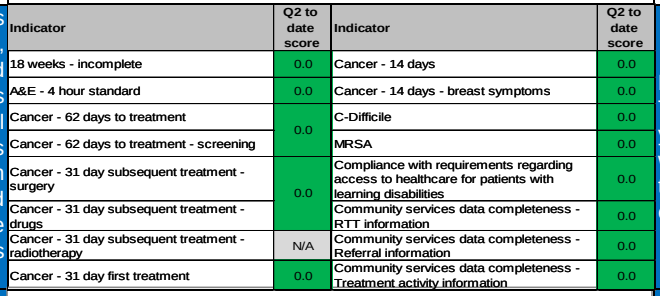
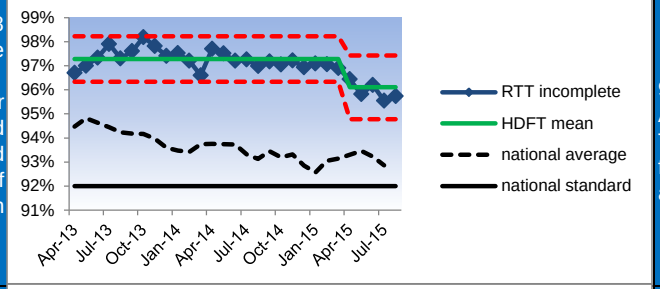
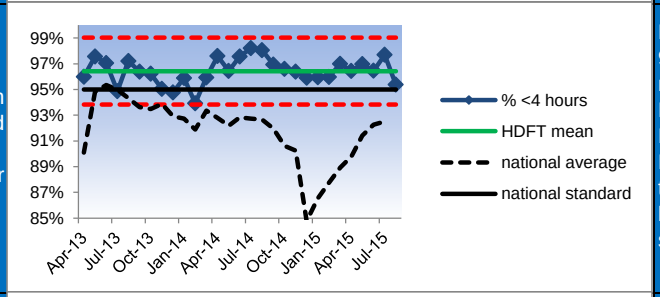
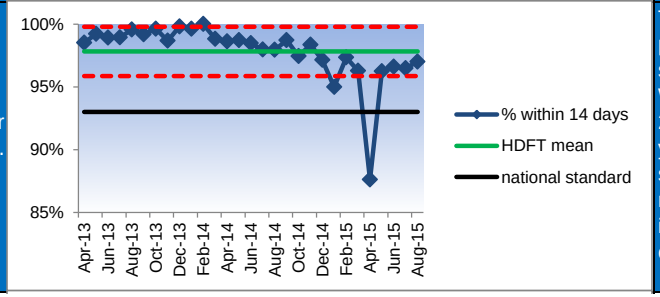
Indicator	Description	Trend chart	Interpretation
Monitor continuity of services risk rating	The Monitor Continuity of Services (CoS) risk rating is made up of two components, liquidity and capital service cover. An overall rating is calculated ranging from 4 (no concerns) to 1 (significant concerns). This indicator monitors our position against plan.		The Trust will report a risk rating of 3 for August, in line with plan. The potential new metrics as described in the RAF consultation paper would have resulted in the Trust reporting a risk rating of 2 for August but this is expected to increase to a 3 by the end of Quarter 2, when the new metrics come into effect.
CIP achievement	Cost Improvement Programme performance outlines full year achievement on a monthly basis. The target is set at the internal efficiency requirement (£'000s). This indicator monitors our year to date position against plan.		80% of plans have been actioned by directorates. A further 14% of plans are in place at present following risk adjustment. Work continues with the directorates to ensure plans are actioned and the planning gap is closed.
Capital spend	Cumulative Capital Expenditure by month (£'000s)		Capital expenditure is behind planned levels for the year to date. The Carbon Energy Fund scheme is the largest element of this.
Agency spend in relation to pay spend	Expenditure in relation to Agency staff on a monthly basis as a percentage of total pay bill. The Trusts aims to have less than 3% of the total pay bill on agency staff.		Agency expenditure has remained at the same percentage level in August as it was in July. This is an increase on the percentage reported earlier in the financial year

	Q1	Q2	Q3	Q4
Planned rating - consolidated rating	3	4	4	4
Actual rating - capital service cover	3			
Actual rating - liquidity	4			
Actual rating - consolidateds rating	4			

Finance and Efficiency - August 2015

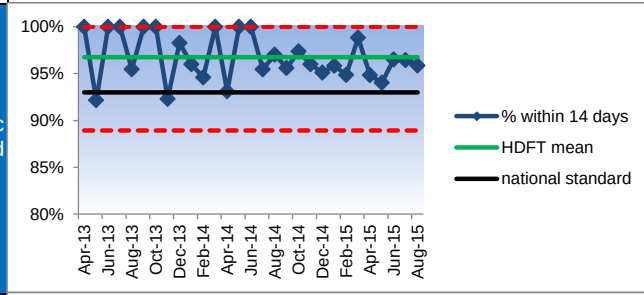
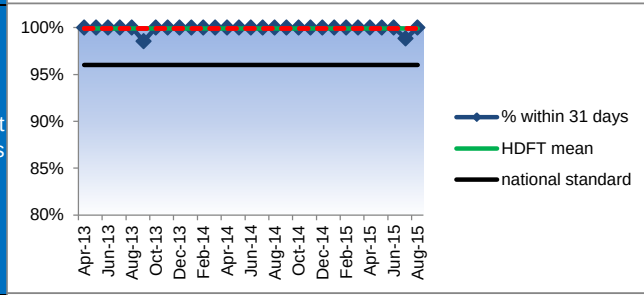
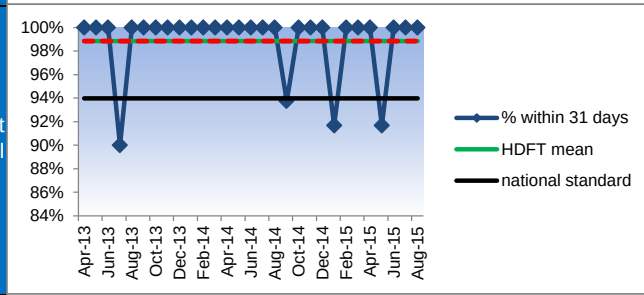
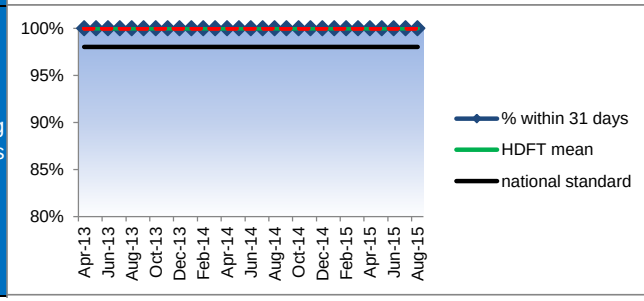
Indicator	Description	Trend chart	Interpretation
Research - Cost per recruitment	Cost of recruitment to NIHR adopted studies. The Research department has a delivery budget of £69,212 per month. A low figure is preferable.		In 2014/15, the range across the network for recruitment cost was £372 to £3599, HDFT achieved a figure of around £375. The cost of recruitment has increased during August 2015 but the data is provisional and it is anticipated that this figure will reduce once the data has been finalised.
Research - Invoiced research activity	Aspects of research studies are paid for by the study sponsor or funder.		As set out in the Research & Development strategy, the Trust intends to maintain its current income from commercial research activity and NIHR income to support research staff to 2019. Each study is unique. Last year the Trust invoiced for a total of £223,606.

Operational Performance - August 2015

Indicator	Description	Trend chart	Interpretation
Monitor governance rating	Monitor use a variety of information to assess a Trust's governance risk rating, including CQC information, access and outcomes metrics, third party reports and quality governance metrics. The table to the left shows how the Trust is performing against the national performance standards in the "access and outcomes metrics" section of the Risk Assessment Framework. An amended Risk Assessment Framework was published by Monitor in August 2015 - updated to reflect the changes in the way that the 18 weeks standard is monitored.		HDFT's governance rating for Q2 to date is Green. The Trust reported 11 cases of hospital acquired C. difficile year to date at end August. 6 of these cases have been agreed with the CCG to not be due to lapses in care and therefore these would be discounted from the trajectory should the Trust exceed the 2015/16 target of 12 cases.
RTT Incomplete pathways performance	Percentage of incomplete pathways waiting less than 18 weeks. The national standard is that 92% of incomplete pathways should be waiting less than 18 weeks. NHS England announced in June that it will no longer monitor 18 weeks using the completed admitted and non-admitted measures (which have been removed from this report) and will only look at the proportion of incomplete pathways seen within 18 weeks. A high percentage is good.		95.7% of patients were waiting 18 weeks or less at the end of August. There has been a deterioration in performance over the last few month but HDFT consistently performs above national average and above the required national standard of 92%.
A&E 4 hour standard	Percentage of patients spending less than 4 hours in Accident & Emergency (A&E). The operational standard is 95%. The data includes all A&E Departments, including Minor Injury Units (MIUs). A high percentage is good.		HDFT's overall trust level performance for August 2015 was 95.4%, above the required 95% but a reduction on recent months. This includes data for the Emergency Department at Harrogate and Ripon MIU. Performance of the main Emergency Department was below the 95% standard at 94.5%. Performance in this area continues to be monitored daily and the Clinical Director for Urgent, Community and Cancer Care is leading on the work to ensure we sustainably deliver this standard as an organisation.
Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	Percentage of urgent GP referrals for suspected cancer seen within 14 days. The operational standard is 93%. A high percentage is good.		The Trust achieved the 93% standard in Q1 2015/16 and the provisional performance for Q2 to date is above the required standard at 96.7%. Whilst the Trust achieved the required 93% for each quarter of 2014/15, there was a deterioration in performance during the year as illustrated in the trend chart. There has been a significant increase in the number of 2 week wait referrals received by the Trust since Q4 2014/15, partly due to the impact of several national and local cancer awareness campaigns.

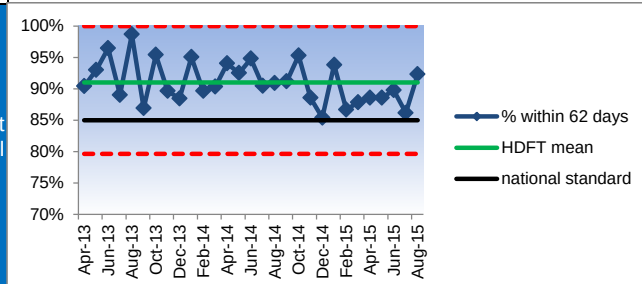
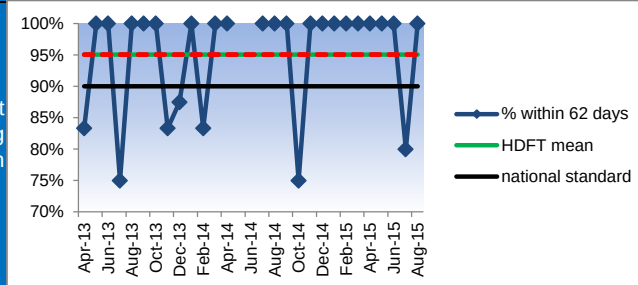
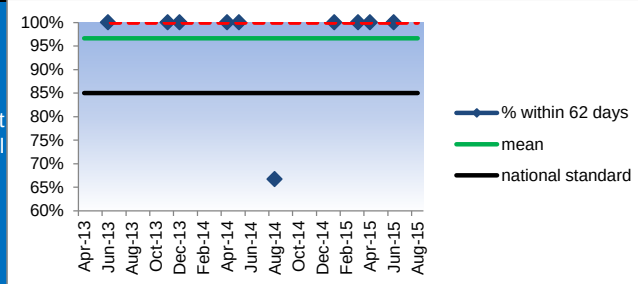
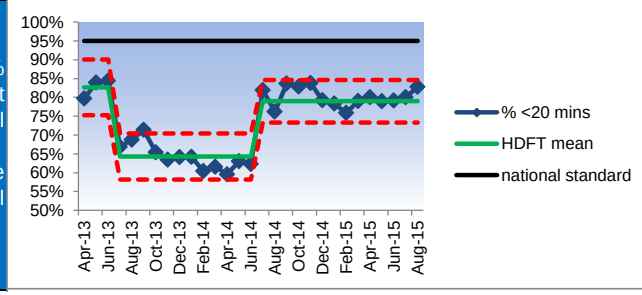
Indicator	Q2 to date score	Indicator	Q2 to date score
18 weeks - incomplete	0.0	Cancer - 14 days	0.0
A&E - 4 hour standard	0.0	Cancer - 14 days - breast symptoms	0.0
Cancer - 62 days to treatment	0.0	C-Difficile	0.0
Cancer - 62 days to treatment - screening		MRSA	0.0
Cancer - 31 day subsequent treatment - surgery	0.0	Compliance with requirements regarding access to healthcare for patients with learning disabilities	0.0
Cancer - 31 day subsequent treatment - drugs		Community services data completeness - RTT information	0.0
Cancer - 31 day subsequent treatment - radiotherapy	N/A	Community services data completeness - Referral information	0.0
Cancer - 31 day first treatment	0.0	Community services data completeness - Treatment activity information	0.0

Operational Performance - August 2015

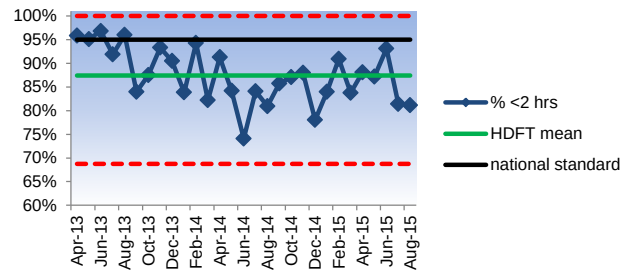
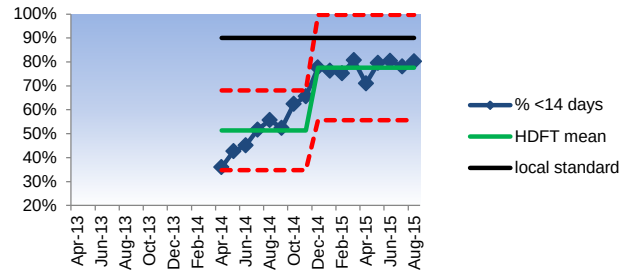
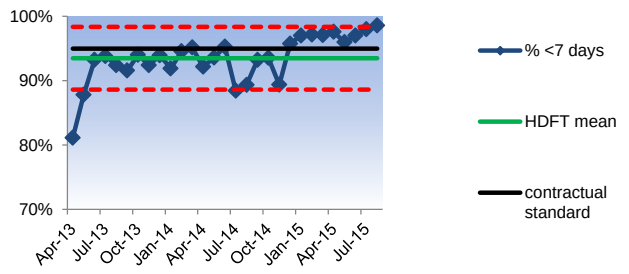
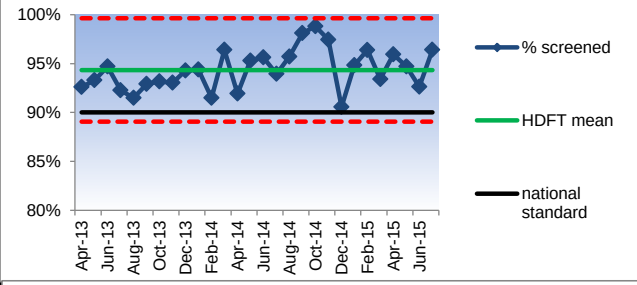
Indicator	Description	Trend chart	Interpretation
Cancer - 14 days maximum wait from GP referral for symptomatic breast patients	Percentage of GP referrals for breast symptomatic patients seen within 14 days. The operational standard is 93%. A high percentage is good.		The Trust consistently achieved the 93% standard throughout 2014/15 and 2015/16 to date with performance at 96.7% in August 2015.
Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	Percentage of cancer patients starting first treatment within 31 days of diagnosis. The operational standard is 96%. A high percentage is good.		Recurrent achievement of this standard. Ongoing monitoring. No new actions identified.
Cancer - 31 day wait for second or subsequent treatment: Surgery	Percentage of cancer patients starting subsequent surgical treatment within 31 days. The operational standard is 94%. A high percentage is good.		Only a small number of patients at HDFT are covered by this target which explains the variability in performance for some months. However the Trust was above the required 94% standard for Q1 2015/16 and for Q2 to date.
Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug	Percentage of cancer patients starting subsequent drug treatment within 31 days. The operational standard is 98%. A high percentage is good.		Recurrent achievement of this standard. Ongoing monitoring. No new actions identified.

Harrogate and District NHS
NHS Foundation Trust

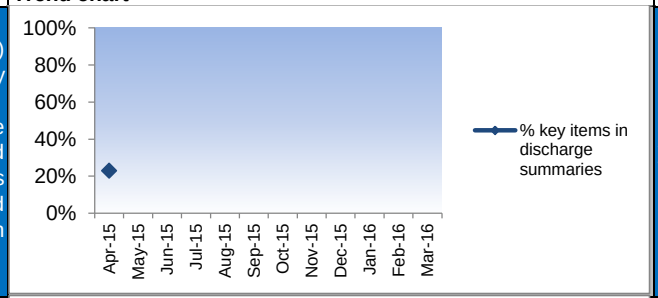
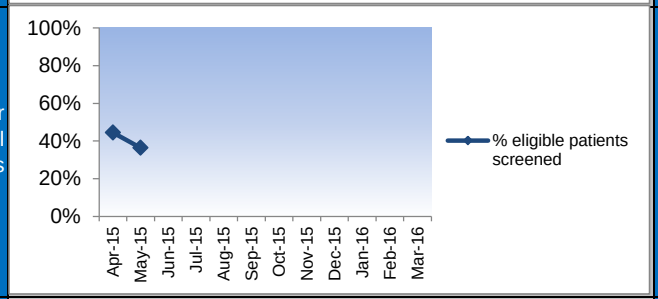
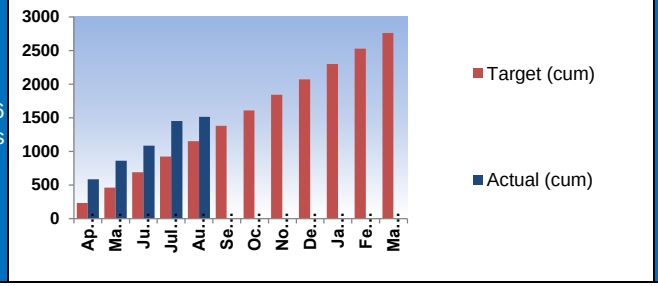
Operational Performance - August 2015

Indicator	Description	Trend chart	Interpretation
Cancer - 62 day wait for first treatment from urgent GP referral to treatment	Percentage of cancer patients starting first treatment within 62 days of urgent GP referral. The operational standard is 85%. A high percentage is good.		The Trust achieved the operational standard of 85% throughout 2014/15 and 2015/16 to date. Performance for August 2015 was at 91.0%. Of the 11 cancer sites treated at HDFT, 6 had performance above 85% in August and 5 had performance below 85% - colorectal (1 breach), gynaecological (1 breach), head and neck (0.5 breach), upper gastrointestinal (1 breach) and urological (1 breach).
Cancer - 62 day wait for first treatment from consultant screening service referral	Percentage of cancer patients starting first treatment within 62 days of referral from a consultant screening service. The operational standard is 90%. A high percentage is good.		Only a small number of patients at HDFT are covered by this target which explains the variability in performance for some months. However the Trust has been above the required 90% standard for each month where the number of pathways reported has been above the de minimis level for reporting performance.
Cancer - 62 day wait for first treatment from consultant upgrade	Percentage of cancer patients starting first treatment within 62 days of consultant upgrade. The operational standard is 85%. A high percentage is good.		Only a small number of patients at HDFT are covered by this target which explains the variability in performance for some months. However the Trust has been above the required 85% standard for each month where the number of pathways reported has been above the de minimis level for reporting performance.
GP OOH - NQR 9	NQR 9 (National Quality Requirement 9) looks at the % of GP OOH telephone clinical assessments for urgent cases that are carried out within 20 minutes of call prioritisation. The data presented excludes Selby and York as these do not form part of the HDFT OOH service from April 2015. A high percentage is good.		Performance in August 2015 was at 84.6%, an improvement on recent months, but below the 95% standard. The local NHS 111 service started in July 2013. From July 2014, the performance data was amended to correctly show the start time as the time that the case is passed to OOH service, as opposed to the initial call to NHS 111. It is not possible to re-work the historical data so this trend anomaly will remain.

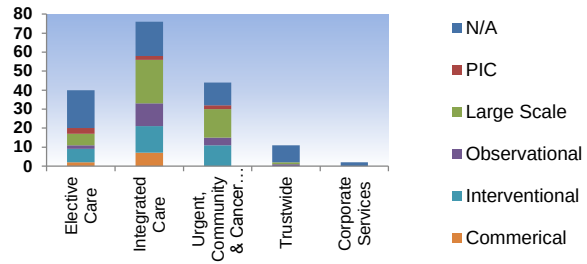
Operational Performance - August 2015

Indicator	Description	Trend chart	Interpretation
GP OOH - NQR 12	NQR 12 (National Quality Requirement 12) looks at the % of GP OOH face to face consultations started for urgent cases within 2 hours. The data presented excludes Selby and York as these do not form part of the HFT OOH service from April 2015. A high percentage is good.		Performance in July 2015 was at 81.1%, a reduction on last month and below the 95% standard.
Health Visiting - new born visits	The number of babies who had a new born visit by the Health Visiting team within 14 days of birth. Data is not available for 2013/14. A high percentage is good.		As can be seen from the chart, the performance on this metric improved significantly during 2014/15 - this was partly due to improved data capture over this period. In August 2015, 80.1% of babies had a new born visit within 14 days of birth.
Community equipment - deliveries within 7 days	The number of standard items delivered within 7 days by the community equipment service. A high percentage is good.		In August 2015, 98.7% of standard items were delivered within 7 days, above the 95% contractual requirement. In addition, 100% of priority items were delivered within 24 hours and 100% of urgent items were delivered within 6 hours.
CQUIN - dementia screening	The proportion of emergency admissions aged 75 or over who are screened for dementia within 72 hours of admission (Step 1). Of those screened positive, the proportion who went on to have an assessment and onward referral as required (Step 2 and 3). The operational standard is 90% for all 3 steps. A high percentage is good.		Recurrent achievement of this standard. Ongoing monitoring. No new actions identified.

Operational Performance - August 2015

Indicator	Description	Trend chart	Interpretation
CQUIN - Acute Kidney Injury	Percentage of patients with Acute Kidney Injury (AKI) whose discharge summary includes four defined key items. The aim of this national CQUIN is to improve the provision of information to GPs for patients diagnosed with AKI whilst in hospital. The target for the CQUIN is to achieve at least 90% of required key items included in discharge summaries by Q4 2015/16. A high percentage is good.		*There is no update on this data this month - Q2 data will be reported in October.* In line with national guidance, the Trust performed a baseline audit of a sample of patients who were diagnosed with AKI in April 2015. The audit results showed that 23% of key items were included in discharge summaries for the sampled patients. These results now form the baseline position and the Trust need to agree an improvement trajectory with the CCG to ensure delivery of the required 90% compliance by Q4.
CQUIN - sepsis screening	Percentage of patients presenting to ED/other wards/units who met the criteria of the local protocol and were screened for sepsis. A high percentage is good.		*There is no update on this data this month - Q2 data will be reported in October.* In line with national guidance, the Trust performed a baseline audit during April and May 2015 which showed that 44% of eligible patients in April and 36% in May were screened for sepsis using the established local screening protocol. These results now form the baseline position and the Trust need to agree an improvement trajectory with the CCG to ensure delivery of the required 90% compliance by Q4.
CQUIN - severe sepsis treatment	Percentage of patients presenting to ED/other wards/units with severe sepsis, Red Flag Sepsis or Septic Shock and who received IV antibiotics within 1 hour of presenting. A high percentage is good.		This data will be reported quarterly from the end of Quarter 2, 2015/16.
Recruitment to NIHR adopted research studies	The Trust has a recruitment target of 2,750 for 2015/16 for studies adopted onto the NIHR portfolio. This equates to 230 per month. A higher figure is good.		Recruitment has been good to date. Currently recruitment stands at 365 over its target.

Operational Performance - August 2015

Indicator	Description	Trend chart	Interpretation
Directorate research activity	The number of studies within each of the directorates - included in the graph is Trustwide where the study spans directorates. The Trust has no specific target set for research activity within each directorate. It is envisaged that each clinical directorate would have a balanced portfolio.		The directorate research teams are subject to studies that are available. The 'type of study', Commercial, Interventional, Observational, Large scale, PIC or N/A influence the activity based funding received by HDFT. Each category is weighted dependant on input of staff involvement. N/A studies are those studies which are not adopted by the NIHR. They include commercial, interventional, observational, large scale, PIC, local and student projects. They do not influence the recruitment target.

Indicator traffic light criteria

Section	Indicator	Further detail	Proposed traffic light criteria	Rationale/source of traffic light criteria
Quality	**Safety thermometer - harm free care**	% harm free	Green if latest month >=95%, red if latest month <95%	National best practice guidance
Quality	**Pressure ulcers**	No. grade 3 and grade 4 avoidable pressure ulcers (hosp and community)	Green if no. avoidable cases is below local trajectory year to date, red if above trajectory year to date.	
Quality	**Falls**	IP falls per 1,000 bed days	Green if latest month < UCL, Red if latest month > UCL.	
Quality	**Falls causing harm**	IP falls causing moderate harm, sever harm or death, per 1,000 bed days	Green if latest month < UCL, Red if latest month > UCL.	
Quality	**Infection control**	No. hospital acquired C.diff and MRSA cases	Green if below trajectory YTD, Amber if above trajectory YTD, Red if above trajectory at end year.	NHS England, Monitor and contractual requirement
Quality	**Mortality - HSMR**	Hospital Standardised Mortality Ratio (HSMR)	Green = better than expected or as expected, Amber = worse than expected (95% confidence interval), Red = worse than expected (99% confidence interval).	
Quality	**Mortality - SHMI**	Summary Hospital Mortality Index (SHMI)	Green = better than expected or as expected, Amber = worse than expected (95% confidence interval), Red = worse than expected (99% confidence interval).	
Quality	**Complaints**	No. complaints, split by criteria	Green if no red graded complaints in most recent month.	
Quality	**Incidents - all**	Incidents split by grade (hosp and community)	Green if latest month < UCL, Red if latest month > UCL.	
Quality	**Incidents - SIRIs and never events**	SIRI and never events (hosp and community)	Green if latest month =0, red if latest month >0.	
Quality	**Friends & Family Test (FFT) - Staff**	% recommend work and % recommend care	Green if latest data on or above national average, red if below national average.	
Quality	**Friends & Family Test (FFT) - Patients**	% recommend, % not recommend - combined score for all services currently doing patient FFT	Green if latest month < UCL, Red if latest month > UCL.	
Quality	**Safer staffing levels**	RN and CSW - day and night overall fill rates at trust level	Green if latest month overall staffing >=100%, amber if between 95% and 100%, red if below 95%.	
Quality	**Staff appraisal rate**	Latest position on no. staff who had an appraisal within the last 12 months	Annual rolling total - 85% green. Amber between 65% and 85%, red<65%.	Locally agreed target level based on historic local and NHS performance
Quality	**Mandatory training rate**	Latest position on the % staff trained for each mandatory training requirement	Blue if latest month >=95%; Green if latest month 75%-90% overall, amber if between 65% and 75%, red if below 65%.	Locally agreed target level - no national comparative information available until February 2016
Quality	**Staff sickness rate**	Staff sickness rate	Green if <3.9%, amber if between 3.9% and regional average, Red if > regional average	HDFT Employment Policy requirement. Rates compared at a regional level also
Quality	**Temporary staffing expenditure - medical/nursing/other**	Expenditure per month on staff types.	Green if spend on temporary staff < last YTD, red if > last YTD.	Locally agreed target level
Quality	**Staff turnover**	Staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts.	Green if remaining static or decreasing, amber if increasing but below 15%, red if above 15%.	Based on evidence from Times Top 100 Employers
Quality	**Research internal monitoring**	No. critical or major findings reported	Green if <1 per quarter (cumulative)	
Finance and efficiency	**Readmissions**	No. emergency readmissions (following elective or non-elective admission) within 30 days.	Green if latest month < UCL, Red if latest month > UCL.	
Finance and efficiency	**Readmissions - standardised**	Standardised emergency readmission rate within 30 days from HED	Green = better than expected or as expected, Amber = worse than expected (95% confidence interval), Red = worse than expected (99% confidence interval).	
Finance and efficiency	**Length of stay - elective**	Average LOS for elective patients	Green if latest month < UCL, Red if latest month > UCL.	
Finance and efficiency	**Length of stay - non-elective**	Average LOS for non-elective patients	Green if latest month < UCL, Red if latest month > UCL.	
Finance and efficiency	**Non-elective bed days for patients aged 18+**	Non-elective bed days at HDFT for HARD CCG patients aged 18+, per 100,000 population	to be agreed	
Finance and efficiency	**Theatre utilisation**	% of theatre time utilised for elective operating sessions	Green = >=85%, Amber = between 75% and 85%, Red = <75%	
Finance and efficiency	**Delayed transfers of care**	% acute beds occupied by patients whose transfer is delayed - snapshot on last Thursday of the month.	Red if latest month >3.5%, Green <=3.5%	Contractual requirement

Section	Indicator	Further detail	Proposed traffic light criteria	Rationale/source of traffic light criteria
Finance and efficiency	**Outpatient DNA rate**	% first OP appointments DNA'd	Green if latest month < UCL, Red if latest month > UCL.	
Finance and efficiency	**Outpatient new to follow up ratio**	No. follow up appointments per new appointment.	Green if latest month < UCL, Red if latest month > UCL.	
Finance and efficiency	**Day case rate**	% elective admissions that are day case	Green if latest month >LCL, Red if latest month < LCL.	
Finance and efficiency	**Surplus / deficit and variance to plan**	Monthly Surplus/Deficit (£'000s)	Green if on plan, amber <1% behind plan, red >1% behind plan	
Finance and efficiency	**Cash balance**	Monthly cash balance (£'000s)	Green if on plan, amber <10% behind plan, red >10% behind plan	
Finance and efficiency	**Monitor continuity of services risk rating**	The Monitor Continuity of Services (CoS) risk rating is made up of two components - liquidity and capital service cover.	Green if rating =4 or 3 and in line with our planned rating, amber if rating = 3, 2 or 1 and not in line with our planned rating.	as defined by Monitor
Finance and efficiency	**CIP achievement**	Cost Improvement Programme performance	Green if achieving stretch CIP target, amber if achieving standard CIP target, red if not achieving standard CIP target.	
Finance and efficiency	**Capital spend**	Cumulative capital expenditure	Green if on plan or <10% below, amber if between 10% and 25% below plan, red if >25% below plan	
Finance and efficiency	**Agency spend in relation to pay spend**	Expenditure in relation to Agency staff on a monthly basis (£'s).	Green if <1% of pay bill, amber if between 1% and 3% of pay bill, red if >3% of pay bill.	
Finance and efficiency	**Research - Cost per recruitment**	Cost of recruitment to NIHR adopted studies	to be agreed	
Finance and efficiency	**Research - Invoiced research activity**		to be agreed	
Operational Performance	**Monitor governance rating**	Trust performance on Monitor's risk assessment framework.	As per defined governance rating	as defined by Monitor
Operational Performance	**RTT Incomplete pathways performance**	% incomplete pathways within 18 weeks	Green if latest month >=92%, Red if latest month <92%.	NHS England
Operational Performance	**A&E 4 hour standard**	% patients spending 4 hours or less in A&E.	Green if latest month >=95%, Red if latest month <95%.	NHS England, Monitor and contractual requirement
Operational Performance	**Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals**	% urgent GP referrals for suspected cancer seen within 14 days.	Green if latest month >=93%, Red if latest month <93%.	NHS England, Monitor and contractual requirement
Operational Performance	**Cancer - 14 days maximum wait from GP referral for symptomatic breast patients**	% GP referrals for breast symptomatic patients seen within 14 days.	Green if latest month >=93%, Red if latest month <93%.	NHS England, Monitor and contractual requirement
Operational Performance	**Cancer - 31 days maximum wait from diagnosis to treatment for all cancers**	% cancer patients starting first treatment within 31 days of diagnosis	Green if latest month >=96%, Red if latest month <96%.	NHS England, Monitor and contractual requirement
Operational Performance	**Cancer - 31 day wait for second or subsequent treatment: Surgery**	% cancer patients starting subsequent surgical treatment within 31 days	Green if latest month >=94%, Red if latest month <94%.	NHS England, Monitor and contractual requirement
Operational Performance	**Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug**	% cancer patients starting subsequent anti-cancer drug treatment within 31 days	Green if latest month >=96%, Red if latest month <96%.	NHS England, Monitor and contractual requirement
Operational Performance	**Cancer - 62 day wait for first treatment from urgent GP referral to treatment**	% cancer patients starting first treatment within 62 days of urgent GP referral	Green if latest month >=85%, Red if latest month <85%.	NHS England, Monitor and contractual requirement
Operational Performance	**Cancer - 62 day wait for first treatment from consultant screening service referral**	% cancer patients starting first treatment within 62 days of referral from a consultant screening service	Green if latest month >=90%, Red if latest month <90%.	NHS England, Monitor and contractual requirement
Operational Performance	**Cancer - 62 day wait for first treatment from consultant upgrade**	% cancer patients starting first treatment within 62 days of consultant upgrade	Green if latest month >=85%, Red if latest month <85%.	NHS England, Monitor and contractual requirement
Operational Performance	**GP OOH - NQR 9**	% telephone clinical assessments for urgent cases that are carried out within 20 minutes of call prioritisation	Green if latest month >=95%, Red if latest month <95%.	Contractual requirement
Operational Performance	**GP OOH - NQR 12**	% face to face consultations started for urgent cases within 2 hours	Green if latest month >=95%, Red if latest month <95%.	Contractual requirement
Operational Performance	**Health Visiting - new born visits**	% new born visit within 14 days of birth	Green if latest month <=95%, Amber if between 90% and 95%, Red if <90%.	Contractual requirement
Operational Performance	**Community equipment - deliveries within 7 days**	% standard items delivered within 7 days	Green if latest month >=95%, Red if latest month <95%.	Contractual requirement
Operational Performance	**CQUIN - dementia screening**	% emergency admissions aged 75+ who are screened for dementia within 72 hours of admission	Green if latest month >=90%, Red if latest month <90%.	CQUIN contractual requirement
Operational Performance	**CQUIN - Acute Kidney Injury (AKI)**	% patients with AKI whose discharge summary includes four defined key items	to be agreed	CQUIN contractual requirement
Operational Performance	**CQUIN - sepsis screening**	% patients presenting to ED/other wards/units who met the criteria of the local protocol and were screened for sepsis	to be agreed	CQUIN contractual requirement
Operational Performance	**CQUIN - severe sepsis treatment**	% patients presenting to ED/other wards/units with severe sepsis, Red Flag Sepsis or Septic Shock and who received IV antibiotics within 1 hour of presenting	to be agreed	CQUIN contractual requirement
Operational Performance	**Recruitment to NIHR adopted research studies**	No. patients recruited to trials	to be agreed	
Operational Performance	**Directorate research activity**	The number of studies within each of the directorates	to be agreed	

Harrogate and District NHS
NHS Foundation Trust

Report to the Trust Board of Directors: 23 September 2015	Paper No: 7.0

Title	Report from the Medical Director
Sponsoring Director	Dr David Scullion, Medical Director
Author(s)	Dr David Scullion, Medical Director
Report Purpose	To update the Board on clinical matters for the months of August and September 2015

Key Issues for Board Focus:

- An update on mortality statistics
- Progress towards establishing seven-day care
- Progress with reviewing the complaints process
- Tertiary cancer referrals to Leeds

Related Trust Objectives	
1. Driving up quality	YES
2. Working with partners	YES
3. Integrating care	YES
4. Growing our business	YES

Risk and Assurance	The paper provides a measure of assurance on clinical issues to the Board.
Legal implications/ Regulatory Requirements	None

Action Required by the Board of Directors

1. The Board is recommended to **note** the report
2. The Board is recommended to **approve the signature** of the Annual Statement of Compliance for Medical Appraisal

Report by Medical Director – September 2015

1. Mortality update:

No alerts were received in the most recent data collection period. (May14-May15). Two months worth of data release show a further fall in SHMI (97.22 to 96.11) and a slight rise in HSMR (102.53 to 103.52). Filtered data under the sub-heading "General Medical Practice" (this is the descriptor used for inpatients at RMH), show 19 reported deaths against an expected figure of 7.5. I will be working with the Directorate and general practice colleagues to arrange a case note review. An initial crude analysis of data indicates that 55% of the patient cohort had a diagnosis of advance malignancy. I will be discussing with the Directorate Lead options for a more detailed and objective case note review.
Further crude analysis of mortality for 2014/15 has focused on those patients who died within 48hrs of admission. Data shows that 19% of patients dying within 48hrs were admitted on a Sunday. This compares with 14% on Monday and 12% on Tuesday. Interestingly only 10% of patients admitted on Saturday died within 48hrs. I believe this data is exceptionally crude, can be interpreted in a variety of ways and gives us limited information around quality of care.
I will be participating in a regional mortality group teleconference a few days before BoD. I will update the Board verbally of any important items arising from this discussion.

2. Duty of Candour:

An appendix to this report is attached for update and information.

3. Establishing a baseline of seven day services in acute care:

The Trust has received a joint letter from the MDs of Monitor, NHSE and the TDA. The purpose of this letter is to gather baseline data from acute providers on current accessibility to key services across the week. There is a focus on acute care beginning to emerge (positive in my view). Following consultation, four standards have been shown to have the biggest impact on acute care outcomes and reducing weekend mortality. These will be the focus:

- Time to Consultant review
- Access to diagnostics
- Access to Consultant directed intervention
- Ongoing review

The Trust has been asked to complete the relevant sections of the NHS Improving Quality Seven Day Service Self-Assessment Tool. Pooled data across the NHS will be analysed and used to track progress against roll out of the standards nationally. We await publication of the national data and accompanying recommendations for implementation.

4. National Safety Standards for Invasive Procedures (NatSSIPs):

A letter has been received from the Director of patient Safety at NHSE. This letter introduces the new quality standards that have been published and asks for Trust

support in ensuring they are embedded in local practice through the development of LocSSIPs. There is a very heavy focus on surgical safety using approved checklist, and also the avoidance of never event s relating directly to surgical practice (wring site surgery and retained foreign objects principally).
The standards have been developed by a multidisciplinary group of professional leaders and human factors experts. Trusts will be expected to implement the standards. This work links in well with the SUTS campaign and intelligence received from National audits. Implementation will be overseen by the Patient Safety Steering Group.
A link to the standards is provided for further information.

www.england.nhs.uk/ourwork/patientsafety/never-events/natssips/

5. Review of complaints process:

Following a discussion at an earlier BoD meeting, a review of the Trust complaints process is currently underway.
This has been triggered by a number of concerns, not least the number of reopened complaints and number referred to the PHSO (both upheld and not upheld). The current process is perceived a time consuming for both patients and staff. The current response format is perceived as somewhat long winded and unwieldy and does not always address the concerns raised. This in itself implies a problem with the quality assurance process for complaints response. Meetings have taken place with myself, the Andrea Leng Head of RM, Anne Dell, (PET), Jill Foster (Chief Nurse)and Sue Proctor (NED). Further meetings are planned with Directorate Governance Leads and senior nursing establishment.
The focus of the discussions have been largely twofold:

- **Getting "up front" of potential complaints at source in order to resolve concerns earlier and more informally.**
- **Streamlining the whole process in order to improve contact experience, turnaround timescales and overall quality of complaint responses.**

A summary of the outcomes of discussions to date is attached as an appendix to this report for further discussion as necessary. I will be overseeing the project and will update the BoD as to its progress.

6. Tertiary referrals for cancer treatment to Leeds.

In addition to treating a large number of patients with cancer locally, HDFT is obliged to transfer the care of a proportion of cancer to patients to Leeds for onward treatment. These patients tend to be of a greater complexity or have been diagnosed with types of cancers whose treatments are provided only at a Tertiary level.
The same national cancer targets apply regardless of the type of patient. In order to assist the cancer centre in meeting these targets, it has been agreed that referrals for patients requiring tertiary treatment will be received by the centre at no later than day 38 of the cancer pathway.
At the end of May 2015, Dr Yvette Oade (CMO LTHT) communicated with all external Trust Medical Directors on this subject. Local data was provided that highlighted individual cases whereby patients were received beyond the 38 day limit and therefore were potentially disadvantaged in terms of timely cancer care. Though numbers from Harrogate are modest, the monthly data supplied suggested that 38 day referrals fell

significantly short of the 100% target in all but one month between April 2014 and May 2015.
Whilst it is not easy to capture the complexities of cancer diagnosis and referral in simple statistics, the Trust analysed this data in a genuine effort to work with LTHT in order to improve the pathway for all patients with a diagnosis of cancer who required onward referral.
The Trust provided a detailed response to the Leeds data in July.
On the 13th August, the Chair of HDFT received a letter form the Chair of LTHT on the same subject matter (appended). This letter did not reference the previous response from this Trust, but again highlighted the difficulties LTHT face when trying to meet cancer targets for perceived delay in external referrals. Similar data to the earlier communication was produced together with a request that this important matter be elevated to board level discussion.
The Trust takes this matter seriously and is committed to working with the centre to highlight areas where the pathway can be improved at both ends. A detailed response to the most recent communication is attached as an appendix to this report for discussion. The main points highlighted in this response are the pressures placed on all providers due to increased numbers of potential cancer referrals from primary care, and ongoing discrepancies of data recording that affect Trust performance.

7. Research update:

All Trust CEOs in the network have received a letter from Sir Andrew Cash, the CEO of the host organisation to the YandH LCRN. This letter highlights the importance of the research quality agenda and emphasise the need for continued vigilance in terms of local recruitment into research studies. Whilst our LCRN performs well in absolute terms, we fall short on recruitment per capita of population. There is a strong message in the letter that recruitment numbers will heavily influence resource allocation. A number of requests for assistance are made in the letter, all of which will be taken through the local RandD committee to ensure local recruitment and facilitation of research is maximized. A copy of the letter is appended for information.
The research team are currently working on a series of informative metrics that might be included in the integrated board report.

8. Healthy Futures Stroke Programme:

The WY hyperacute stroke services review is now complete. HaRD CCG were also part of the work programme. The focus of the review is twofold:

- Strategies for prevention of stroke
- System resilience.

The second is particularly relevant to this Trust, particularly in the light of the recent collapse in the acute stroke service in Airedale, with sudden shift of patients into Bradford. This clearly puts extreme strain on the system. Representatives of both commissioners and providers attended a facilitated workshop on 11th September in order to discuss the outcomes of the review and plan a way forward, largely around strengthening system resilience. I attended on behalf of the Trust. The meeting was a useful one. Data clearly shows that a number of key metrics for acute stroke services are not being met by many acute

providers across West and North Yorkshire. System resilience can only flow from a consistently high quality of care.
It was quite clear from the discussion that there is no current appetite for major reconfiguration and centralization of HASS in YandH. There was a general consensus that sharing of best practice and support for the current hub and spoke model is the way forward at least in the medium term. Harrogate supports this approach and continue to be an interested partner in future collaborative discussion.
The next steps will include discussions around manpower resource (HR level) and sharing of best practice to improve performance outcomes (clinically led). I will update the BoD on future developments.

9. West Yorkshire Medical Directors' meeting

The initial meeting in early September was cancelled due to apologies. A meeting has been scheduled for 4th November in Bradford. Agenda items are currently being collected. I will update the BoD on any important issues that arise from this meeting.

10. Chaplaincy service

The Rev Payne is now in post. The Rev Parker has returned from forced leave of absence. Some work has already been done around rotas in order to alleviate the burden of work. My early impression is that morale is high. St Michael's Hospice have recently appointed their own Chaplain. We continue to look for opportunities for collaboration around Chaplaincy services that are mutually beneficial. I have asked the Chaplaincy for their views on how they can help me in getting up front of potential complaints on the ward. They feel there is a role to play and are keen to progress this.

11. National Cardiac Arrest audit

Trust performance has improved. Numbers overall are small and therefore percentage swings can be large, but recent data confirms 30 day post resuscitation survival rates have soared to 40%. All cardiac arrests continue to be reviewed on a monthly basis. Lessons continue to be learned regarding end of life care planning.
Recent notification of national work has arrived. This is welcome and timely. The Health Select Committee has recently published an enquiry into EoLC, focusing in part on the use of DNACPR decisions. A working group has been established in order to develop a national form to record anticipatory decisions around CPR and other life sustaining treatments. The aim is to establish best practice and support healthcare professionals and patients, and put a decision support framework in place. Communication with patients and relatives will be at the very centre of this. Work is ongoing. I will update the BoD on any future major developments.

12. Harrogate/Leeds/York Bowel Cancer Screening Centre QA visit

A two day visit is scheduled for 5th/6th October. I will update the BoD on any important issues arising from this.

13. Parliamentary and Health Service Ombudsman Report – Complaints about Acute Trusts

This embargoed report has been received recently in the Trust and is being considered. I will give an oral update to the Board.

14. Medical Appraisal – Annual Statement of Compliance

The Annual Organisational Audit of Appraisal and Revalidation was submitted to NHS England, in accordance with the Framework of Quality Assurance (FQA) process earlier in the year. As last year, this is a process which all Designated Bodies must undertake in order to provide assurance to NHS England that our appraisal and revalidation process operates effectively.

NHS England requires Designated Bodies to send an annual Statement of Compliance (below) with the appraisal and revalidation process by 30 September each year. The Board is recommended to **approve** the signature of the Statement by the Chairman and Chief Executive.

Designated Body Statement of Compliance

The board / executive management team of St Michael's Hospice Harrogate can confirm that

- an AOA has been submitted,
- the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013)
- and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   YES

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   YES:

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   YES:

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent);

   YES:

5. All licensed medical practitioners[2] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   YES:

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1] (which includes, but is not limited to, monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues) and ensuring that information about these matters is provided for doctors to include at their appraisal;

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

YES:

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

YES

8. There is a process for obtaining and sharing information of note about any licensed medical practitioner's fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where the licensed medical practitioner works;[3]

YES

9. The appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that all licensed medical practitioners[4] have qualifications and experience appropriate to the work performed;

YES

10. A development plan is in place that ensures continual improvement and addresses any identified weaknesses or gaps in compliance.

YES

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: **Harrogate and District Foundation Trust**

Signed……..

Name: S Dodson

Role: Chairman

Date: 23 September 2015

Signed: ……

Name: R Tolcher

Role: Chief Executive

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

1. DUTY OF CANDOUR

1.1. Background

From November 2014, NHS provider bodies registered with the Care Quality Commission (CQC) are required to comply with a new Statutory Duty of Candour (DOC). This involves giving patients accurate, truthful, prompt information when mistakes are made and treatment does not go to plan.

Being open and honest with patients when things go wrong has been a fundamental principle in the NHS for a long time and part of the NHS Standards Contracts since April 2003. Since the introduction of the Health & Social Care Act (Duty of Candour 2014c) regulations, it is now mandatory to apply the Duty of Candour when any Notifiable Safety Incident is reported. This is defined as any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in a reasonable opinion of a health care professional, could result in, or appears to have resulted in moderate harm, severe harm or death or prolonged psychological harm (which service user has experienced, or is likely to experience, for a continuous period of at least 28 days).

The Trust set up a Duty of Candour Task and Finish Group to develop the processes required in order to ensure DoC is embedded into the Trusts practices. This group has developed guidance and information for staff to demystify DoC and to ensure the processes for incident management trigger the DoC requirements at the appropriate time. All the information and associated documentation currently sits within Risk Management as the leaders on DoC, however work is currently ongoing to roll out the information to staff across the organisation and a toolkit is available on the intranet for all staff to access. The facilities and systems that are needed to support this, including updating the Datix system to record DoC and enable performance monitoring are also being developed. In the meantime this is tracked through a spreadsheet in the risk management office.

An information leaflet outlining the principles of Duty of Candour was circulated to all staff in June 2015 and is also now given during Trust Induction for new starters, and during advanced risk management training and via the e-learning package for investigations of incidents, complaints and claims. Training on Duty of Candour requirements is also provided within the three directorates by Governance Leads and supported by Risk Management.

1.2. Process

The HDFT process for DoC begins when an incident occurs that impacts on a patient that is deemed to have caused moderate or severe harm or resulted in death. The

verification of harm is done at the time by the clinician involved / in charge of the care in conjunction with Risk Management.

If the criteria is met then the DoC process begins with a full verbal apology (known as the 'being open' conversation) to the patient which explains exactly what has happened with all the details known at the time. This is followed up with a written letter of acknowledgement and apology from the Chief Executive.

Immediate safety actions are identified and addressed initially and the incidents are reviewed at the Complaints and Risk Management Group (CORM) who will then identify a lead to investigate and complete a Root Cause Analysis (RCA) report.

The DoC acknowledgement and apology letters are attached to the incident reports and a copy is printed within the Directorate for the patients' notes. A copy is also kept in an evidence file within Risk Management.

1.3. Compliance

The following table demonstrates compliance for all incidents triggering the duty of candour requirements for Q1:

All incidents triggering DoC	Q1
Number of incidents matching DoC	**58**
DoC not applicable *(staff, external, home acquired injury)*	10
DoC not applicable following review of severity	10
Total Requiring DoC Application	**38**
Number with DoC applied	**36**
Applied in writing	**35**
Applied verbally	**1**
Not applied or Unclear evidence	**2**

This includes all significant events and SIRI's (Serious Incidents Requiring Investigation) of which the following table demonstrates the numbers of these for Q1:

SIRI's	Q1
Comprehensive SIRI	**3**
Concise SIRI (Pressure	**16**
Concise SIRI (Fall)	**5**

Review of HDFT Complaints and Opportunities to Learn from Patient Experience (Making Experiences Count)

1. Current Process

- PET team deal with all 4 c's comments, concerns, compliments and complaints (PALS and complaints merged in 2010). Current PET team comprises 2.1 PET officers and 0.53 Administrative Assistant.
- Feedback comes via comment forms, emails, telephone calls, letters to Pet or Chief Exec and via PET volunteers at front desk.
- PET will establish whether can be dealt with as PALS type issue and nipped in bud based on type of issue and severity and will liaise with Depts, Ward managers and Consultants to seek early resolution or treat as complaint.

If Complaint:-

- Complaint received, graded by PET, sent to Governance Lead for Lead Investigator (LI).
- Acknowledgement letter sent from CE with details of LI & date for response.
- LI triages and establishes issues of concern.
- Investigations Report competed by LI.
- Q/A done by OD or senior manager in Directorate.
- Sent back to PET for checking & further Q/A.
- Signed off by CE with a separate covering letter.

2. Problems

- Triage process not always competed by LI, sometimes by Governance Lead.
- Issues and expectations not always fully explored/established at Triage.
- Deadlines not always met.
- Complainants not kept updated.
- Reports do not fully address all issues or are too complicated/lengthy for complainant to understand.

- Complainants wait for a report that is not complete and call back even more unhappy or contact the Ombudsman. By the time the report arrives they have lost all faith and relationship broken down.
- PET cover needs looking at to ensure cover all of week.
- Problems are not always recognised at 'ground level' when they are bubbling away.
- Staff feel unsupported or unable to deal with what are perceived as demanding relatives/carers/patients.
- Lead Investigators, during the process of the investigation hit barriers when requesting statements, particularly form consultants.
- Lead Investigators do not always test out what is being said in statements i.e. by checking records/cross checking statements.
- Complicated medical complaints are often given to staff who are not qualified or are unable to question the medical care so either take longer as a result or are incomplete.
- PET resource – not always available to visit wards to assist nipping in bud of concerns. Physical presence on HDH site as majority of cases reported there but need to consider service across community.
- Huge opportunities missed in handling on line feedback in real time in a positive way.

3. Revisions to Complaint Process

- **Improve triage and use PET Officers to agree resolution plan**

Within 3 days have a detailed conversation to agree all issues, method of resolution- which may include a meeting to resolve the issues or may be a complaint investigation and report. The resolution plan will be agreed and may not necessarily mean a complaint is logged- it may be a concern dealt with swiftly and efficiently buy the service and PET.

CE acknowledgement letter to be issued following agreed grading and dates/Lead Investigator availability.

Wider use of initial meetings to address issues and resolve asap.

Cases will continue to be graded and assessed for severity to ensure cases that warrant investigation are not missed and treated informally.

Consistency of approach through PET team doing the triage and ensuring robust liaison with Directorates to agree plan.

Ask complainant what the problems were but also were there any areas of good experience to share with staff?

- **Reduce timeframes for reply**

  In line with other Trusts introduce a model for response to formal complaints which include 15 day response from directorate and 25 working day response to complainant.

  This will include a QA process by a multidisciplinary team which may include LI, OD, Clinical Lead, PET, Medical Director and or Chief Nurse.

- **Maintain close contact with complainant**

  Share early findings and test out conclusions before committing to response so it doesn't appear as a shock when reply sent.

- **Change format of response report**

  To include all questions agreed as part of resolution and be question and answer document. Identify which parts of complaint upheld and actions to learn and improve as a summary at end of document. To be clear if not upheld, why not- on what basis.

- **Send out draft reports for comment to complainant**

  Final Letter of response does not go from Chief Executive until is clear local resolution is exhausted. Draft report is shared from PET to enable debate, dialogue and challenge and discussion of findings either face to face or via telephone.

- **Final letter form Chief Executive**

  Summarises believe resolution complete- provides apology if required and conclusion that local resolution complete. Sign post to Ombudsman.

4. Ideas to get ahead of concerns and proactive management

- **On line feedback- websites, Friends and Family**

  Need to proactively manage and respond- Comms Lead to review and share with PET to reply.

  Signage on wards stating that Matron will be available at xx-xx time to discuss any issues.

Staff to recognise when unable to deal with issue raised/breakdown in relationship and escalate to manager / PET.

- **PET Actively seek feedback**

  Through greater presence / visibility of PET Officers- mainly on acute site where majority of complaints arise.

  Use of PET volunteers and/or Apprentices doing some of PET admin work to free up skills of PET.

  Greater publicity of PET and wanting to know feedback from patients / carers/ relatives- pop up stands, display board in all depts.

- Electronic app asking patients / visitors for feedback on experience within a few days/text messages? – leaflets on lockers displaying PET details and asking to contact if have any feedback whatsoever.

- PET Information given in writing to all patients on admission– wording to represent that if they have any worries/concerns about raising issues to contact PET who will provide assistance

- Matrons and Nurse in Charge working with PET to seek out issues and resolve asap as some patients still feel reluctant to raise concerns for fear of care being affected.

5. Measures of Success

- Number of complaints reduced.
- Number of concerns resolved within two days increased.
- Number of re-opened complaints reduced.
- Number of complaints to Ombudsman reduced.
- Number of complaints upheld by Ombudsman reduced.
- Audit of methods for resolution.

6. Implementation

- To consider revision of MEC policy and process.
- Review of PE opportunities – online, FFT etc, Comms role.
- Review PET team, hours and location.
- Review recruitment and management of volunteers and their role.

- Publicity material.
- Training and briefing of staff.
- Benchmarking data to establish baseline for monitoring.

Background

The national standards for the 62 day cancer pathway require 85% of patients to be treated by day 62. There is no agreed standard nationally which identifies when patients requiring transfer to a tertiary centre should be transferred by. However, most regions have been working to day 38, with an expectation that at least 85% of patients should be transferred by that day. Clearly patients requiring transfer are often the most complex and require the type of service only delivered in tertiary centres. Therefore the achievement of 85% being transferred by day 38 should not be underestimated.

In March 2014, in response to a letter from Dr Mark Smith, Chief Operating Officer at LTHT, HDFT described the 38 day position and the process we had implemented to improve performance with the inter-provider transfer. We also highlighted some challenges with tertiary centre diagnostic waits such as specialist histology and thoracic diagnostics.

In September 2014, in response to a request from LTHT, via the Cancer Network Board, all local providers supplied reports detailing their current position. The one submitted by HDFT, included a summary of the data discrepancies, actions which had been taken, or were under way to improve pathway processes and the ongoing challenges which some of the pathways were consistently highlighting. In this document there was a plan which aimed to reach 75% by October 14 and 85% of inter-provider transfers by December 14.

In Q3 of 2014/15 HDFT did achieve 85% IPT transfers by day 38. However, since then HDFT have fallen below this level. The two main factors affecting the achievement have been the significant demand increase in 2 week wait referrals from January 15 onwards and the ongoing discrepancies in the data between the two Trusts in respect of the recording of Inter-provider transfers, with a resulting 15-20% difference in performance.

On the 31st May 2015 Dr Yvette Oade, Medical Director LTHT, emailed all Medical Directors in Trusts who refer patients on cancer pathways to Leeds as their local specialist unit. This outlined LTHT's ongoing concern regarding their performance against the 62 day cancer standard. It also included LTHT's improved position with regard to local pathways highlighting the further work needed in Urology and Lung but essentially identifying the most significant reason for their continued failure to meet the standard as the failure of local providers to refer to them by day 38.

The Trust provided a detailed response to Dr Oade, via Dr Scullion, which set out a number of issues and actions.

Following this on the 13th August 2015, Dr Linda Pollard, Chair LTHT, wrote to Sandra Dodson outlining the background to LTHT's position in relation to the 62 day standard and their ongoing issues, which again pointed towards inter-provider transfers occurring after day 38. The letter states that LTHT would have to achieve over 92% for patients primarily referred to Leeds and treated in Leeds to enable them to achieve the overall 62 day standard of 85% due to the performance for tertiary referrals.

Data Discrepancies

Table 1 below highlights the difference in reporting of the day 38 position between HDFT and LTHT. This issue has been discussed at the Cancer Network and continues to be highlighted by a number of Trusts within the network. This is caused by a difference in opinion of the day that is recorded as to when a patient is transferred from one unit to another. Clearly this is unhelpful and can lead to the teams focusing in the wrong areas to resolve performance issues.

Table 1

HDFT data								
Site	Wait	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Total
All	<=Day 38	5	9	8	10	9	9	**50**
	Day 38-62	3	4	4	5	6	2	**24**
	Day 62	0	2	1	0	2	0	**5**
	Total	**8**	**15**	**13**	**15**	**17**	**11**	**79**
	% within 38 days	62.5%	60.0%	61.5%	66.7%	**52.9%**	81.8%	63.3%

Leeds data								
Site	Wait	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Total
All	No alert	0	0	2	2	1	2	**7**
	<=Day 38	4	6	7	7	6	7	**37**
	Day 38-62	4	5	3	6	8	1	**27**
	Day 62	0	3	0	0	2	1	**6**
	Total	**8**	**14**	**12**	**15**	**17**	**11**	**77**
	% within 38 days	50.0%	42.9%	58.3%	46.7%	**35.3%**	63.6%	48.1%

Impact of Tertiary Referral Pathways

Table 2 outlines the difference in performance for patients referred and treated only within HDFT and those which are referred to HDFT but treated at an alternative provider (mainly Leeds). As can be seen HDFT is recurrently achieving above 93% for patients treated at HDFT, however, the overall performance falls significantly when patients treated elsewhere are included.

Table 2

		2013/14					**2014/15**					**2015/16**		
Site	Wait	2013/14 Q1	2013/14 Q2	2013/14 Q3	2013/14 Q4	**2013/14**	2014/15 Q1	2014/15 Q2	2014/15 Q3	2014/15 Q4	**2014/15**	2015/16 Q1	2015/16 Q2	**2015/16**
All (HDFT)	Within target	112	111	114	103	**440**	108	112	102	127	**449**	124	51	**175**
	Outside target	6	8	7	2	**23**	3	4	6	5	**18**	7	5	**12**
	Total	**118**	**119**	**121**	**105**	**463**	**111**	**116**	**108**	**132**	**467**	**131**	**56**	**187**
	%	94.9%	93.3%	94.2%	98.1%	**95.0%**	97.3%	96.6%	94.4%	96.2%	**96.1%**	94.7%	91.1%	**93.6%**
All (Trust total)	Within target	120.5	118.5	128	113.5	**463**	114	119.5	111	136	**466**	137.5	101.5	**187**
	Outside target	8.5	11.5	12.5	10	**42.5**	7.5	12	12.5	15.5	**47.5**	17	14	**31**
	Total	**129**	**130**	**140.5**	**123.5**	**505.5**	**121.5**	**131.5**	**123.5**	**151.5**	**513.5**	**154.5**	**115.5**	**218**
	%	93.4%	91.2%	91.1%	91.9%	**91.6%**	93.8%	90.9%	89.9%	89.8%	**90.7%**	89.0%	87.9%	**85.8%**
% differential between HDFT and Trust total		1.5%	2.1%	3.1%	6.2%	**3.4%**	3.5%	5.7%	4.6%	6.4%	**5.4%**	5.7%	3.2%	**7.8%**

It should be noted that where a Trust has a low number of patients being referred this leads to significant variation in percentage performance on a monthly basis, where one patient may account for a 50% failure to refer by day 38 in any month

Summary of Actions

Clearly the most important outcome from ongoing collaborative work with LTHT is to improve timeliness of treatment for patients receiving care on a cancer pathway in the region.

HDFT Cancer Team maintains a good working relationship with colleagues in Leeds and in January 2015 a joint breach analysis meeting was held. Both teams found the meeting constructive and useful. It was raised with Dr Oade that due to competing demands for time in Leeds this has not happened since then, however a further meeting is now scheduled for the 5th October. This is welcomed as an opportunity to share challenges and work through solutions in greater detail.

Outlined below is a summary of the many issues which are being worked on to improve the position:

Processes HDFT can improve and are working on:

- Since Q3 2015, there has been a significant increase in two week wait cancer referrals. Outpatient capacity needs to ensure patients can be seen within the first 7 days of the 14 day standard. Directorate teams are aware of this need and continue to work to achieve this.
- Diagnostic imaging has seen unprecedented increases in demand through new guidelines for cancer and non-cancer pathways. Capacity within 7 days for imaging and reporting needs to be achieved so the pathway to specialist review here or at an LTHT MDT can proceed quickly. A thorough radiology review was conducted in early 2015 and business cases are being worked up for an additional two radiologists. The requirement for an additional CT scanner has been acknowledged and fundraising by the Trust is to commence.
- Histology reporting has previously been excellent and is key to ensuring rapid diagnosis, MDT review and transfer to LTHT if required. Support to this service is being worked up through business cases for endoscopy to ensure the previously excellent reporting times do not further suffer as the number of investigations on a two week pathway increases.
- Thorough patient counselling and information at first appointment so that a telephone call to advise the patient of any further specialist investigations and discussion can be undertaken. This reduces the need for a follow up clinic appointment which may delay the time taken to refer on to tertiary centre.
- Improving the availability of follow up appointments will ensure patients move through the system more quickly without the need for ‘chasing’ appointments.
- Improving our tracking backlog so that any blocks in the system are identified sooner and can be chased.
- To hold a pathway meeting with York regarding our Head and Neck patients to understand any blocks in the pathway and how we may ensure quicker transfer to Leeds for chemotherapy/radiotherapy when patients require dental work before treatment.

Processes Leeds can improve on and we are aware are being worked on:

- Outpatient capacity needs to ensure patients can be seen within the first 7 days of the 14 day standard.
- Improvement in capacity in the thoracics specialty so consultation appointments and decision making is swifter and surgery happens sooner.
- Better preparation and availability of scans at the Leeds specialist MDT resulting in less deferment to the following week.

- Standardisation for tracking and switching back of IPT after day 38 when a patient has a follow up clinic appointment at Harrogate. There should be acknowledgement that this consultation is purely local and therefore the pathway should continue in parallel at Leeds.

Processes outside of our control

- Patient choice to delay appointments.
- Delays to PET scans. A network approach is being undertaken to ensure that investigation and reporting takes place in line with the timeframes agreed in the SLA.
- In lung pathology concurrent infection at presentation can delay diagnosis. CT lung nodule follow-up stays on the pathway and so may be diagnosed well beyond 62 days.
- In prostate pathology a raised PSA could be due to infection and a TRUS biopsy is delayed to rule this out in the first instance. In the cases where a flexible cystoscopy is indicated this can delay a repeat PSA until infection and swelling resolves.

The Board is asked to note the following:

That the Cancer team continue to work closely with LTHT and the Cancer Strategic Clinical Network (SCN) to ensure regional pathways are commissioned and provided collaboratively to support timeliness of access to diagnosis and treatment within the national standards.

That the Cancer team continue to work with LTHT and the SCN to agree standard definitions for IPT to enable performance monitoring to be standardised so that areas of performance difficulties are recognised and acted upon by all parties.

That HDFT will continue to work towards delivery of the day 38 IPT for as many patients as possible, recognising that these are often the most complex pathways and therefore the achievement of the 62 day standard is likely to require all providers to exceed the 85% standard for patient treated locally without involvement from another provider.

Sheffield Teaching Hospitals NHS
NHS Foundation Trust

Chief Executive's Office
8 Beech Hill Road
SHEFFIELD
S10 2SB

Tel: 0114 2712436
Fax: 0114 2712580
andrew.cash@sth.nhs.uk

Our Ref: AJC/GS

25 August 2015

To: Chief Executives of NHS Trusts and NHS Foundation Trusts in Yorkshire and the Humber
Accountable Officers of Clinical Commissioning Groups in Yorkshire and the Humber

Dear Colleague

As you know, clinical research is a driver of clinical quality and a number of high quality research studies in the UK have shown better outcomes for patients cared for in organisations and healthcare systems that undertake clinical research.

Yorkshire and the Humber has a strong record of delivering high quality clinical research. The Yorkshire and the Humber Local Clinical Research Network (LCRN), hosted by Sheffield Teaching Hospitals NHS Foundation Trust, is one of the top recruiting networks in England. Whilst study recruitment in absolute numbers is competitive with other LCRNs in England, recruitment per capita is less good suggesting that we are not giving our patients as wide an opportunity to be involved in research as we would like. Recruitment numbers will influence resource allocation and we are therefore keen to ensure we better serve our patients in the region by encouraging and supporting increased and broader recruitment both in non-commercial and commercial studies. The latter also have the benefit of bringing significant income into our organisations.

To this end, I wanted to let you know that the Clinical Directors and Chief Operating Officer (Dr Simon Howell, Dr Alison Layton and Dr Caroline Pickstone) of the Y&H LCRN have recently written to Clinical Research Leaders in the region and in your organisations asking them to support the network and a drive to increase recruitment numbers. They are specifically asking the following:

- To ensure that clinical colleagues who are local or national investigators on clinical research studies continue to be encouraged to allow them to deliver this role.
- To ensure that clinical teams embed research into the delivery of care whenever possible.
- To encourage study investigators to upload data on study recruitment to the National Portfolio Database promptly. This is especially important in the months of August and September as the funding for the network will be determined by the data uploaded by the end of September.

- To encourage flexibility within the research workforce in your organisation in order to realise as many opportunities as possible for patients to participate in clinical research studies.

- To ensure that income from commercial studies is invested to support the research endeavour in your organisation.

I do hope you will be able to support additional research taking place in your organisation to increase the rate of recruitment particularly in the immediate months ahead.

Many thanks for your help in this matter.

Yours sincerely

Sir Andrew Cash OBE
Chief Executive
(Host organisation to the Y&H Local Clinical Research Network)

cc: Dr Simon Howell, Clinical Director, Y&H Clinical Research Network
Dr Alison Layton, Clinical Director, Y&H Clinical Research Network
Dr Caroline Pickstone, Chief Operating Officer, Y&H Clinical Research Network

The Leeds Teaching Hospitals NHS

NHS Trust

Date: **13th August 2015**
Our Ref: **LP/jcm/173**

Chair
Trust Headquarters
St James's University Hospital
Beckett Street
Leeds
LS9 7TF

Direct Line: (0113) 2064326
Fax: (0113) 2067007
E-Mail: linda.pollard3@nhs.net
PA: joy.murphy1@.nhs.net

www.leedsth.nhs.uk

Ms Sandra Dodson
Trust Chair
Harrogate & District NHS Foundation Trust
Harrogate District Hospital
Lancaster Park Road
Harrogate
HG2 7SX

Dear Sandra,

Re: Improving and Sustaining Cancer Performance

I am writing to you as Chair of Leeds Teaching Hospitals Trust (LTHT) following receipt of a tripartite letter from Richard Barker - NHS England, Lyn Simpson - NHS TDA, and Paul Chandler - Monitor, dated 4th August, concerning delivery of the 62 day Cancer Performance standard. This letter requested the submission of a Trust level improvement plan by 31st August which would enable LTHT to sustainably meet the standard by the end of Q4.

I hope you will find it helpful for me to share with you LTHT's position and some background.

LTHT has not delivered the 62 day Cancer Standard since Q2 of 2013-14, and following a change in key personnel, we have undertaken a substantial and in-depth root cause analysis into the primary reasons for this failure.

As a Trust we have reviewed all pathways, the Board having agreed to a £3.5 million investment programme in order to implement revised pathways. We have also established a Cancer Board, which is chaired by the Medical Director of Operations, attended by the Leeds Cancer team and senior members of our Clinical Service and Support Units (CSUs), in order to have shared responsibility and accountability for the delivery of the 62 day standard.

We are now seeing the fruits of that work, as our internal cancer performance continues to improve, as does our ability to treat in target the Inter-Provider Transfers (IPTs), transferred to LTHT before day 38. We as an organisation are on track to deliver our trajectory for delivering 62 days cancer performance for 85% of internal, and IPTs by day 38 patients, by the start of October.

You may be aware that the Yorkshire Cancer Network established an agreement in September 2011, which remains in place to date, that 85% of patients who are transferred from one Trust to another Trust on a Cancer pathway (Inter Provider Transfers) should be transferred by day 38 of their pathway.

This agreement is supported by an Inter Provider Transfer Policy, which was reviewed and agreed at the Regional Commissioners and Managers meeting on 2nd April 2014. All Trusts in the region were represented at the meeting.

Why this is important to LTHT is because approximately 38% of LTHT's 62 day patients commence their cancer pathways in other organisations.

In order to accommodate the volume of IPTs referred post day 38, LTHT's internal 62 day performance would need to be in the region of 92% most months increasing to 95% in others which I think you would all agree is a challenge.

Clearly LTHT can submit an Improvement plan to the TDA, Monitor and NHSE regarding internal actions to improve performance, but we cannot submit an Improvement Plan on how other providers will improve their IPTs by day 38.

I am aware that as part of discussions to improve and develop the relationship between our Trusts conversations have been had in relation to IPTs.

Recently LTHT's Chief Medical Officer, Dr Yvette Oade, liaised with her counterpart at your Trust; and last year at the request of our Trust Board, our Deputy Chief Executive, Prof. Suzanne Hinchliffe, wrote to your Chief Operating Officer asking whether you could advise us of your trajectory for transfer of patients by day 38, 85% of the time.

Your Trust kindly informed us that you would be able to deliver transfer by day 38 by December 2014. I am also aware that late transfers are also regularly discussed at the Chief Executive Officers Forum.

To assist you in the navigation of complex cancer targets and performance, I have inserted two tables below indicating transfer performance for Harrogate & District NHS Foundation Trust. You will note that some patients are transferred to LTHT after day 62 (of a 62 day pathway). Table 1 indicates all 62 day IPTs from your Trust irrespective of whether the patient is subsequently diagnosed to have cancer; table 2 indicates those patients who were diagnosed with cancer.

Target 85%

Harrogate	Jan	Feb	Mar	Apr	May	Jun	Total
<= Day 38	53.9% (7)	61.5% (8)	41.7% (5)	66.7% (6)	50% (9)	60% (9)	55% (44)
Day 38-62	6	4	6	2	7	3	35% (28)
> Day 62	0	1	1	1	2	3	10% (8)
Total	13	13	12	9	18	15	80

Table 1: All 62 day IPTs irrespective of diagnosis

Harrogate	Jan	Feb	Mar	Apr	May	Jun	Total
No Alert	0	0	2	2	1	2	9.1% (7)
<= Day 38	50% (4)	42.9% (6)	58.3%(7)	46.7% (7)	35.3% (6)	63.6% (7)	48.1% (37)
Day 38-62	4	5	3	6	8	1	35.1% (27)
> Day 62	0	3	0	0	2	1	7.8% (6)
Total	8	14	12	15	17	11	77

Table 2: 62 day IPTs for patients with a diagnosis of cancer

I recognise that there are national issues affecting all of us which impact directly on Trusts' ability to meet the 62 day standard and as such we face a challenge in managing patients to the terms set out in the NHS Constitution.

It is in all of our interests, not least our patients, to improve the position on cancer delivery and LTHT is committed to working with you on this.

In the meantime, it would be helpful to know what the position is within your Trust in relation to achieving 85% of transfers by day 38 and I would be grateful if you could consider this at your next Trust Board, which I understand will be 23rd September 2015.

This performance measure will be discussed in detail at our next Board meeting on 24th September 2015 and after that with NHS England.

I look forward to hearing from you.

Best Wishes

Linda.

Dr Linda Pollard CBE JP DL
CHAIR

Report to the Trust Board of Directors: 24 September 2015	Paper No: 8.0

Title	Chief Nurse Report
Sponsoring Director	Chief Nurse
Author(s)	Jill Foster, Chief Nurse
Report Purpose	To provide the Board of Directors with an update on care quality improvement and patient experience within the Trust

Executive Summary
This paper sets out the position for defined aspects of care quality and patient experience within the Trust. There is particular focus on local and national nursing and midwifery issues including safe nurse staffing levels, nurse recruitment and nurse revalidation. In addition, there is information regarding the Trust's responsibility for Adult Safeguarding and the preparation by the Trust for implementing the Equality Delivery Scheme 2 for the NHS.

Related Trust Objectives	
1. Driving up quality	Yes by improving patient safety, the effectiveness of care and patient experience
2. Working with partners	Yes
3. Integrating care	Yes
4. Growing our business	Yes

Risk and Assurance	The paper provides assurance on the quality monitoring systems in use and identifies risks and challenges.
Legal implications/ Regulatory Requirements	The contents of this report reflect the focus on quality and safety standards which are integral to the Trust's regulatory framework

Action Required by the Board of Directors

The Board of Directors is asked to receive this report on the progress with care quality and patient experience

Nurse Recruitment

After careful consideration the Director Team decided not to recruit internationally for registered nurses this year. Nursing, Workforce and Communication are working jointly on a robust local and national campaign to attract registered nurses to Harrogate. The aim is a target of 30 registered nurses. A number of actions have already been completed including local advertising, upgrading the Trust website, revamping job adverts and organising a recruitment event in conjunction with the Trust Open Event to showcase the Trust to potential employees offering the option of being interviewed on the evening. A number of candidates have already submitted application forms.

In addition, the nurse recruitment group have medium and long term actions in development.

Adult Safeguarding

The Board will be aware the Care Act came into force in April 2015, bringing with it a clear statutory role for provider organisations for safeguarding adults. During the last year I have been assessing the Trusts readiness for the care act.

The North Yorkshire Safeguarding Adults Board (NYSAB) has joined forces with the five West Yorkshire Boards to publish a joint adult safeguarding policy and procedure, which reflects the requirements of the Care Act 2014. This was formally adopted by NYSAB on 22 April 2015. The NYSAB requires the Trust to assure these policy and procedures are being embedded into practice and training across the organisation and has written to the Trust seeking our confirmation that we are in a position to take this forward.

The core stages of the process are:

a) Formal adoption/ratification of the Multi-agency Policy and Procedure by your organisation

b) Written procedures/operational guidance for your organisation that interpret the procedures for your agency and tell your staff what their responsibilities are.

c) An implementation plan in place which sets out how all staff will be made aware of the procedures, with any relevant training in place and how you will ensure compliance with the procedures.

It is the expectation of NYSAB that by the end of September the Trust will be able to confirm that that a) has been achieved and that by end of December that b) and c) are in place.

I can confirm the Trust has been working toward compliance with the social care act and is in a position to take this process forward, and the requirements of the NYSAB will be in place by December 2015.

Equality Delivery Scheme for the NHS (EDS2)

The EDS2 was published in November 2013 to help local NHS organisations, in discussion with local partners, including local people, review and improve their performance for people with characteristics protected by the Equality Act 2010. These are:

Age
Disability
Gender reassignment
Marriage and civil partnership
Pregnancy and maternity
Race including nationality and ethnic origin
Religion or belief
Sex
Sexual orientation

The Trust is required to complete and publish an e-template report by 31 January 2016 covering 18 outcome areas, 9 service related, 6 workforce related and 3 relating to inclusive leadership. These 3 are:

1. Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisation.
2. Papers that come before the Board and other major committees identify equality-related impacts including risks, and say how these risks are to be managed.
3. Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination.

All outcomes have to be rated against grades with written evidence for the rating and separate boxes to indicate which of the 9 protected characteristics fare well. The grades are: under-developed; developing; achieving; excelling.

For most outcomes the key question is: **how well do people from protected groups fare compared with people overall?**

Performance should be assessed and graded by NHS organisations *in discussion with local people and the workforce, with the use of independent third parties to help with assessment and grading encouraged e.g. local Healthwatch.* Organisations can self-assess first, but must take the views of stakeholders into account for the grading.

The document suggests that organisations should make EDS2 work for them. Organisations can choose to look at just one or a few aspects of work when assessing or grading each outcome, and EDS2 suggests a focus on areas where there is local evidence of a significant equality-related concern, and/or where progress has been made and good practice can be spread. A proportionate mix of progress and challenge should be selected. There should be comprehensive implementation over 3-5 years.

Getting robust evidence across protected groups is recognised as a challenge. Evidence and insight from focus groups and other structured qualitative means is recommended.

The document identifies 9 steps to implementation:

1. Confirm governance arrangements *"Placing the EDS and the management of equality business into a mainstream governance structure is a pre-requisite for success. All organisations need to recognise this important aspect".*
2. Identify local stakeholders
3. Assemble evidence
4. Agree roles with the local authority
5. Analyse performance
6. Agree grades
7. Prepare equality objectives
8. Integrate equality work into main stream business planning
9. Publish grades, equality objectives and plans

Actions

1. Establish a task and finish group to work on this.
2. The Board and senior leaders to confirm commitment to, and vision for, services with fair access and equivalent outcomes for people who use services, and workplaces where people thrive based on their talent. Stress that promoting equality is everyone's business.
3. Confirm location of EDS2 governance within existing governance structures so not isolated from mainstream business.

4. Need to confirm inclusion of members of the public, patients, carers, governors, members, communities, staff networks, staff-side organisations and LA partners in governance structures.
5. Identify local stakeholders to be involved in EDS2 – involve patients, carers, members of community groups, other members of the public, governors, membership, representatives of voluntary and community organisations, NHS staff and representatives of staff-side organisations and encompass all protected groups.
6. Assemble evidence for analysing equality performance – considering gaps in evidence and how they can be filled. Use Joint Strategic Needs Assessments (JSNAs), public health intelligence, CQC registration evidence, NHS Outcomes Framework data, surveys of patient and staff experience, workforce data and reports, local equality monitoring and demographic data, local Healthwatch insight, complaints and PALS data. Use to determine which outcomes, which services and which aspects of each protected group are explored and how.
7. Agree roles with LA for part that local Healthwatch, health and wellbeing boards and public health etc. will play. Healthwatch can be pivotal.
8. Analyse performance with local stakeholders
9. Agree grades with local stakeholders, whose views should be given weight in the event of disagreement.
10. Prepare no more than 4-5 equality objectives for the coming business planning period.
11. Integrate equality work into mainstream business planning.
12. Publish grades, equality objectives and plans on website, in Annual Report etc.

Directors Inspections and Patient Safety Visits

The outcomes and actions from Directors Inspections and Patient Safety Visits are now being reported to the Quality Committee.

Nursing and Midwifery Strategy

The Nursing and Midwifery Strategy continues to be developed to support the Trust's overall vision, strategic goals and objectives. Senior Nurses from across the organisation is meeting on October 1st 2015 with the aim of finalising the strategy. The Nursing and Midwifery Strategy will be ready for Board in November 2015.

Nurse Revalidation

I have submitted confirmation to Monitor regarding the Trust's state of readiness for Nurse Revalidation.

CNO Safe Nurse Staffing Levels

The Board will remember in June I was notified by the Chief Nursing Officer for England of a change in direction on safe nurse staffing levels away from NICE guidelines. I have received a letter regarding next steps from NHS England and have included an extract for information. I will continue to work within existing guidance to assure the Trust has a safe, effective and competent nursing and midwifery workforce.

Next steps in guidance for safe staffing
Following Jane's letter of 11 June 2015, we are pleased to write to update you on the safe staffing plans that the Secretary of State has announced will now be led by the new body, NHS Improvement, working with the Chief Nursing Officer.

The previous letter set out the key principles that would inform the development of this work on ensuring the NHS is safely staffed, specifically that we:

- take a multi-professional approach that takes into account all staff involved, not just nurses;
- take into account that there are many care settings that are not in a hospital and span organisational boundaries;
- remember that this is not just about filling rotas or looking only at numbers or input measures;
- recognise that there is no one-size fits all approach for new models of care and the mix of staff we need;
- that the work should be underpinned by the need for career progression for non-registered staff, nurse retention and flexible working;
- recognise that, other than in acute wards, there is as yet little research or evidence into what safe staffing looks like for other care settings.

In line with these principles, this letter sets out in more detail our next steps for delivering this important programme of work. These next steps are guided by the need to:

- improve experience of care for patients and staff;
- improve the effective and safe clinical outcomes of our patients; and
- achieve an improved efficiency and productivity in every pathway of care and staffing guidance.

There can be no compromise on the issue of staffing and its impact on patient safety (as set out in the letter of 11 June) and we need a methodology that properly assesses and publishes what appropriate levels of staffing should be, taking full account of the changes that can be made with new technology and modern multidisciplinary work practices. In his speech on 16 July the Secretary of State confirmed that, as previously proposed, the patient safety function will transfer from NHS England to a new body, NHS Improvement. One of the early priorities will be to develop additional guidance on safe staffing levels, in conjunction with the CNO. Dr Mike Durkin will lead this work ensuring there is a multi-professional approach to safe staffing.

Over the summer NHS Improvement, with the CNO, will identify leads for each of the programmes (Mental Health, Learning Disability, Urgent and Emergency Care, Primary and Community Services and Maternity) and work with them to scope the plan and delivery. This will involve identifying what evidence reviews and other support is needed, finalise the expert members of each and confirm links with key stakeholders including patients.

To ensure that the outcomes of the programmes' work are robust they will be independently reviewed by NICE, CQC and Sir Robert Francis QC to ensure they meet the high standards of care the NHS aspires to and of which patients, their families and communities deserve. Staffing guidance will be published by the National Quality Board taking into account the feedback from an oversight advisory group and the independent reviews.

It is important that there is systematic oversight by a multi-stakeholder advisory group for these programmes. The group's role will be to assure that there has been effective widespread engagement and to quality assure the outputs of the programme. It will also review the impact on patient outcomes, together with the economic, workforce development, and operational impact.

It is important to reiterate that this work does not replace the important work and guidance previously developed by NICE and we will continue to work with NICE throughout this programme to ensure the ongoing access to their expertise and support for delivering safe staffing.
We will bring together and set out in one place all of the existing guidance and emphasise the importance of the NQB guidance and 10 expectations published in November 2013. In future, as further NQB guidance is generated it will be published and available for all stakeholders.

Nurse Staffing – August 2015

Actual versus planned nurse staffing - inpatient areas

The table below summarises the average fill rate on each ward during **August 2015.** The fill rate is calculated by comparing planned staffing hours and actual staffing achieved.

	Aug-2015			
	Day		Night	
Ward name	**Average fill rate - registered nurses/midwives**	**Average fill rate - care staff**	**Average fill rate - registered nurses/midwives**	**Average fill rate - care staff**
AMU-Bolton	97%	98%	144%	111%
AMU-Fountains	93%	103%	100%	105%
Byland	95%	118%	98%	169%
Farndale	95%	104%	102%	111%
Granby	109%	113%	100%	147%
Harlow	105%	90%	100%	-
ITU/HDU	92%	-	93%	-
Jervaulx	90%	117%	96%	142%
Lascelles	77%	121%	100%	100%
Littondale	98%	101%	98%	103%
Maternity Wards	89%	148%	101%	158%
Nidderdale	100%	103%	118%	80%
Oakdale	98%	110%	100%	134%
Special Care Baby Unit	100%	90%	94%	-
Trinity	96%	102%	100%	119%
Wensleydale	83%	90%	102%	84%
Woodlands	96%	94%	111%	119%
Trust total	**94%**	**108%**	**102%**	**119%**

Further information on this month's data

On Bolton ward the increase in night duty Registered Nurses (RN) above plan is to support the activity on the ward.

On the medical wards Fountains and Jervaulx, where the (RN) fill rate was less than 100% against planned; this reflects current band 5 RN vacancies and some sickness. The Trust is actively recruiting to fill vacancies.

On Granby ward the increase in (RN) and care staff hours above plan was to support the opening of additional escalation beds, as required.

On Harlow Suite the daytime care staff hours in August were less than planned due to vacancies.

The ITU /HDU day and night staffing levels which appear as less than planned are flexed when not all beds are occupied and staff assist in other areas. National standards for RN's to patient ratios are maintained.

The actual daytime RN hours on the Lascelles Unit were less than planned in August due to staff sickness; however the number of staff on duty was sufficient to meet the dependency needs of the patients at that time.

The planned staffing levels on the Delivery Suite and Pannal ward (maternity wards) have been combined from March 2015 to reflect the close working relationship of these two areas and the movement of staff between the wards in response to fluctuating occupancy and activity levels.

On Nidderdale ward where the night duty care staff hours were less than planned, this was compensated for in RN hours.

For the Special Care Baby Unit (SCBU) although the daytime care staff hours and night duty RN hours appear as less than planned it is important to note that the bed occupancy levels fluctuate in this area and a professional assessment was undertaken on a shift by shift basis to ensure that the planned staffing matched the needs of both babies and families.

In some wards the actual care staff hours show additional hours used for 1:1 care for those patients who require intensive support. In August this is reflected on Bolton, Byland, Jervaulx, Farndale and Oakdale ward.

On Wensleydale ward although the RN and care staff hours were less than planned in August, the ward occupancy levels varied throughout the month which enabled staff to assist in other areas.

Jill Foster

Chief Nurse

September 2015

Harrogate and District NHS
NHS Foundation Trust

Report to the Trust Board of Directors: 23rd September 2015	**Paper No: 9.0**

Title	**Report from Chief Operating Officer**
Sponsoring Director	Robert Harrison, Chief Operating Officer
Author(s)	Rachel McDonald, Head of Performance & Analysis Jonathan Green, Information Analyst
Report Purpose	For information

Key Issues for Board Focus:

- The Trust has submitted a self-assessment form in response to the national drive for improving 62 day cancer performance.
- Results of the 2014 National Children's survey were published in June. Further details are contained within this report.
- HDFT's SSNAP rating has fallen from C to D for Quarter 1 of 2015/16.
- Results of the Patient Led Assessments of the Care Environment (PLACE) were published in August. A summary is contained within this report.

Related Trust Objectives	
1. Driving up quality	Yes
2. Working with partners	Yes
3. Integrating care	Yes
4. Growing our business	Yes

Risk and Assurance	The report provides assurance on the delivery of national performance standards, including the Monitor Risk Assessment Framework and identifies risks to delivery.
Legal implications/ Regulatory Requirements	The Trust is required to report its performance against the Monitor Risk Assessment Framework on a quarterly basis and to routinely submit performance data to NHS England and Harrogate & Rural District CCG.

Action Required by the Board of Directors
That the Board of Directors note the information provided in the report.

1.0 CANCER 62 DAY PERFORMANCE

Monitor, National Trust Development Authority and NHS England have agreed to lead a national delivery group for improving 62 day performance, which will work closely with the Cancer Waiting Times Taskforce (CWTT) and Intensive Support Team (IST). This reflects a recognition that, as with many areas of operational performance, poor 62 day performance and the required solutions will sit with a combination of commissioners and often multiple providers. The CWTT have identified 8 key priorities for local health systems to implement as a matter of urgency, and all Trusts have been required to submit a response to these 8 priorities (with supporting narrative). HDFT's response is attached to this report. Further to this, ALL Trusts (previously Foundation Trusts were excluded) are now required to submit a weekly PTL (Patient Tracking List) to the Department of Health in order to closely monitor 62 day performance. HDFT provided its first submission at the end of July.

2.0 NATIONAL CHILDREN'S SURVEY 2014

The results of the Children and Young People's survey were published in June. The survey was sent to over 22,000 children and young people (aged 8-15) who went to hospitals in England in August 2014, and 33 children admitted to HDFT responded to the survey. The responses show that HDFT did better than most other hospitals in two areas: clear and understandable communication by hospital staff, and the provision of privacy for patients when receiving care and treatment. There were no categories were HDFT was rated as being worse than other hospitals. A benchmark document, produced by Picker and designed to be made available to younger patients, is attached to this report.

3.0 SSNAP (SENTINEL STROKE NATIONAL AUDIT PROGRAMME)

HDFT has been rated D for Quarter 1 after improving to a C rating last quarter. The stroke unit, Specialist assessments, and MDT working have all seen deterioration in score this quarter from B to C, but Thrombolysis and Speech and Language Therapy have seen an improvement this quarter (E to D and D to C respectively). The stroke unit domain looks at access to and time spent on the stroke unit – bed pressures within the Trust during Q1 will have contributed to the Trust's reduced score within this domain. HDFT's performance on the "audit compliance" data quality measure has deteriorated this quarter and this has impacted on our overall score (the rating was C prior to the data quality adjustment).

4.0 PLACE RESULTS 2015

In Spring 2015, Patient Led Assessments of the Care Environment (PLACE) were undertaken at Ripon Community Hospital (RCH), Harrogate District Hospital (HDH), and Lascelles. The results of the assessments for all Trusts were published in August 2015, and the Trust performed well against the national average for the following areas:

- Cleanliness
- Food and Hydration
- Condition, Appearance and Maintenance (with Lascelles and Ripon Hospital slightly below the national average)

The Trust's results were below the national average for the criteria relating to Privacy, Dignity and Wellbeing, and Dementia.

For the first time, the PLACE process included assessing dementia criteria for those areas that would be potentially accessed by dementia sufferers. The national average score for the dementia domain was relatively low at 74.5%, and the scores for HDH, RCH, and Lascelles were 60%, 61.3%, 66.6% respectively.

Action Plans have been produced for each HDFT site, including separate Dementia action plans. Progress on addressing the issues on the Action Plans will be monitored by the Internal Patient Environment Action Group.

5.0 INTEGRATED BOARD REPORT

Trust board asked us to consider two items in relation to the new Integrated Board Report:

5.1 Proposed community services metrics

To ensure that the full breadth of the Trust's services are covered by the metrics within the report, the proposal is to add all or some of the following metrics to the report:

i. Number of avoidable emergency admissions to hospital (based on the national CQUIN definition) – a reduction in avoidable emergency admissions would indicate that our adult community services are working well;
ii. Proportion of older people 65+ who were still at home 91 days after discharge from hospital into rehabilitation or reablement services;
iii. Proportion of people in the local health community feeling supported to manage their (long term) condition – this metric will be taken from the GP patient survey results for HARD CCG GP Practices;
iv. Number of new grade 3 or 4 pressure ulcers acquired whilst in receipt of HDFT community services.

5.2 RAG rating thresholds for metrics

Where the metric has a defined national or contractual target level, the RAG rating will be set around these thresholds. Where there is no nationally or contractually defined target, RAG ratings will be set based on the Trust's performance in comparison to all other acute trusts nationally, where appropriate benchmarking data is available. The Trust will be assigned a red rating if it is within the bottom 25% nationally, a green rating if it within the top 25% nationally and a stretch target (indicated by a blue rating) if it is within the top 10% of Trusts nationally.

6.0 IM & T UPDATE

Stage 4 of the Patientrack project has now been closed, with key activities completed including: escalation bleeps distributed to remaining wards/clinicians; auto-alerting and escalation go live; NEWS2 and Comfort Observations deployed; preparation for assessments; end stage report and next stage plan developed. Stage 5 activities include the engagement, design and development of clinical assessments.

We are working with Yorkshire and Humber Commissioning Support Unit (CSU) to fully understand the IT infrastructure arrangements in each of the properties occupied by our community service teams. This is an important and significant piece of work to ensure we are in an informed position and able to support the community teams when the CSU closes at the end of the year.

7.0 COMMUNITY SERVICES ACTIVITY

There has been increased activity recorded across all community teams. There were 404 face to face patient contacts per calendar day across the district nursing teams in August 2015 compared to 381 contacts per day in March.

Specialist Nursing activity has also increased since April 2015 as a result of two new nursing teams now inputting onto Systmone, although there was a decrease in contacts in August 2015, similar to the drop seen in August 2014. Activity peaked in June with 1,247 contacts and fell to 909 in August.

8.0 CARBON AND ENERGY FUND

During the course of August, Imtech, who are the main contractor on the CEF project, have undergone a management buyout following trading difficulties experienced by their Dutch parent company. They are now trading as a completely independent mechanical and electrical services and technical maintenance provider. Imtech have kept the Trust fully informed during this transition with direct correspondence from their Managing Director and CEO. With respect to the impact of this on the project there has been a delay in the procurement of materials due to the suppliers renegotiating supply terms and this is expected to have an overall delay of 4 weeks to the project programme. The project management team on site will remain unchanged ensuring consistency in the delivery of the project.

The coordination of the project with the operation of the hospital continues to be managed well with the High Voltage electrical works around the site perimeter and through the car parks now complete without disruption to the organisation.

9.0 SERVICE ACTIVITY

For 2015/16 to date at the end of August, elective admissions from all commissioners were 5.8% above plan. For Leeds North and West CCG new outpatient appointments were 3.6% below plan, follow-up outpatient appointments were 4.5% below plan, and elective admissions were 14.7% above plan for the year to date.

10.0 FOR APPROVAL

There are no items for approval this month.

Attachments:

1. Self-assessment Improving and Sustaining Cancer Performance.

2. Children and Young People's survey benchmark report.

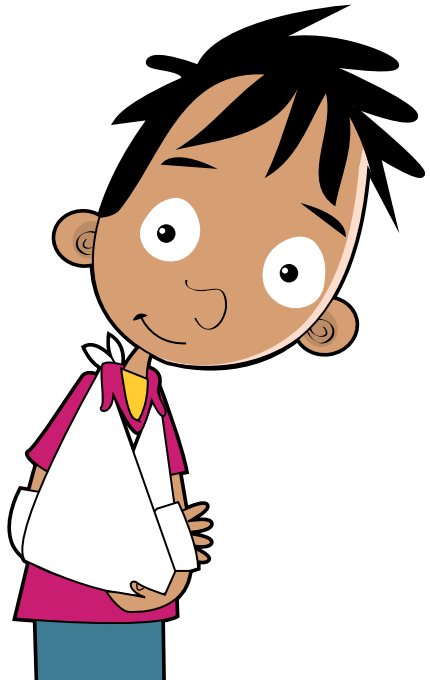
Harrogate and District NHS Foundation Trust

Why we ran the survey

The Care Quality Commission (CQC) makes sure that hospitals, like this one, give patients good care. We do this through inspections, but we also use information from patients like you. We listen to patients about the time they spent in hospital so we know about the good things and the things that could be better.

This hospital will use this information to improve the care that it gives to patients.

You'll see we use the name 'hospital trust' as this is the name for organisations that run hospitals where patients receive care.



Who filled out the survey?

The survey was sent to over 22,000 children and young people (aged 8-15) who went to hospitals in England in August 2014. In this report you'll see how many young patients from this hospital trust told us about the care they received.

The results

We looked at information from all of the completed surveys and gave each hospital trust a score for each question.

We compared the scores against those from other hospital trusts so you can see if this hospital is better, or not as good as many other hospitals.*

If a trust didn't do as well as many other trusts, this means their results are lower than we would expect for that question. We have asked hospital trusts to tell patients about the work they are doing to improve in these areas.

Would you like to see more information?

You can find out more here:

www.cqc.org.uk/yoursurvey

*We've explained how we compared the scores on our children's survey webpage.

Care Quality Commission

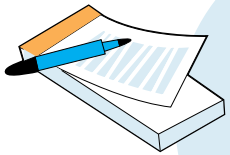
picker Institute Europe

THE CHILDREN & YOUNG PEOPLE'S SURVEY 2014

Harrogate and District NHS Foundation Trust

This hospital trust did better than other hospitals for making sure:

- Hospital staff talked to patients in a way they could understand
- Patients had enough privacy when receiving care and treatment



33

patients aged between 8 and 15 told us about their care at this hospital trust.

This hospital trust did about the same as other hospitals for making sure:

- Patients knew what would happen to them at the hospital
- Patients felt safe on the hospital ward
- Someone from the hospital told patients what to do or who to talk to if they were worried about anything when they got home
- People looking after them listened
- The people looking after patients were friendly
- Patients had a good overall experience of care in the hospital

This hospital trust didn't do as well as other hospitals for making sure:

There were no results for this section

National TDA - Improving and Sustaining Cancer Performance Priorities

Monitor, National Trust Development Authority and NHS England have agreed to lead a national delivery group for improving 62 day performance, which will work closely with the Cancer Waiting Times Taskforce (CWTT) and Intensive Support Team (IST). This reflects a recognition that, as with many areas of operational performance, poor 62 day performance and the required solutions will sit with a combination of commissioners and often multiple providers. It is recognised that some Trusts have already been taking action to address performance issues and this group is intended to bring together this work under a national programme.

Eight Improving & Sustaining Performance Priorities

The CWTT have identified 8 key priorities for local health systems to implement as a matter of urgency

1. **The Trust Board must have a named Executive Director responsible for delivering the national cancer waiting time standards.**
2. **Boards should receive 62 day cancer wait performance reports for each individual cancer tumour pathway, not an all pathway average.**
3. **Every Trust should have a cancer operational policy in place and approved by the Trust Board. This should include the approach to auditing data quality and accuracy, the Trust approach to ensure MDT coordinators are effectively supported, and have sufficient dedicated capacity to fulfil the function effectively.**
4. **Every Trust must maintain and publish a timed pathway, agreed with the local commissioners and any other Providers involved in the pathway, taking advice from the Clinical Network for the following cancer sites: lung, colorectal, prostate and breast. These should specify the point within the 62 day pathway by which key activities such as OP assessment, key diagnostics, inter-Provider transfer and TCI dates need to be completed. Assurance will be provided by regional tripartite groups.**
5. **Each Trust should maintain a valid cancer specific PTL and carry out a weekly review for all cancer tumour pathways to track patients and review data for accuracy and performance. The Trust to identify individual patient deviation from the published pathway standards and agree corrective action**
6. **A root cause breach anlaysis should be carried out for each pathway not meeting current standards, reviewing the last ten patient breaches and near misses (defined as patients who came within 88 hours of breaching). These should be reviewed in the weekly PTL meetings.**
7. **Alongside the above, a capacity and demand analysis for key elements of the pathway not meeting the standard (1st OP appointment; treatment by modality) should be carried out. There should also be an assessment of sustainable list size at this point.**
8. **An Improvement Plan should then be prepared for each pathway not meeting the standard, based on breach analysis, and capacity and demand modelling, describing a timetabled recovery trajectory for the relevant pathway to achieve the national standard. This should be agreed by local commissioners and any other providers involved in the pathway, taking advice from the local Cancer Clinical Network. Regional tripartite groups**

Submission Details	
NHS Trust Name (please select from drop down list)	HARROGATE AND DISTRICT NHS FOUNDATION TRUST
Submission Date	26-Aug-15
Completed by (including role)	Paul Nicholas, Deputy Director of Performance and Informatics
Contact details (telephone and email)	01423 553767 paul.nicholas@hdft.nhs.uk

Please submit the completed template to the following e-mail account: **james.skelly@nhs.net** **by 31 August 2015**

If you have any queries regarding the completion of the template please, in the first instance, contact **...**

HARROGATE AND DISTRICT NHS FOUNDATION TRUST

		Trust Response - Yes/No	Please provide appropriate supporting narrative for each question. Where you have given a "No" response could you please include in your narrative when you expect to be compliant.
1	**Does the Trust Board must have a named Executive Director responsible for delivering the national cancer waiting time standards?**	**Yes**	Mr Robert Harrison, Chief Operating Officer.
2	**Does the Board receive 62 day cancer wait performance reports for each individual cancer tumour pathway, not an all pathway average?**	**Yes**	The Trust Board report includes aggregate 62 day cancer performance, where the Trust has fallen below the 85% standard it has included detail regarding pathways, however, from September specific narrative identifying 62-day performance for each cancer site will be provided.
3	**Does the Trust have a cancer operational policy in place and approved by the Trust Board?** This should include the approach to auditing data quality and accuracy, the Trust approach to ensure MDT coordinators are effectively supported, and have sufficient dedicated capacity to fulfil the function effectively.	**No**	The Trust is in the process of reviewing the Access Policy and will include the appropriate requirements identified including audit and MDT functionality. We plan to have this completed by 31 October 2015. A review of data for each MDT is carried out as part of an annual Peer Review process and through the MDT AGMs. MDTs and support staff requirements are identified during the review of any business cases that may have an impact and infrastructure is re-assessed.
4	**Does the Trust maintain and publish a timed pathway, agreed with the local commissioners and any other Providers involved in the pathway, taking advice from the Clinical Network for the following cancer sites: lung, colorectal, prostate and breast?** These should specify the point within the 62 day pathway by which key activities such as OP assessment, key diagnostics, inter-Provider transfer and TCI dates need to be completed. Assurance will be provided by regional tripartite groups.	**No**	The Trust plans to utilise the YCN / SCN pathways and determine timelines against each element to be agreed with commissioners and tertiary centres. We will use the recent regional pathway event work to inform the process. We plan to have this complete by 31 December 2015. See also 6 below
5	**Does the Trust maintain a valid cancer specific PTL and carry out a weekly review for all cancer tumour pathways to track patients and review data for accuracy and performance?** The Trust to identify individual patient deviation from the published pathway standards and agree corrective action.	**Yes**	The Trust maintains a cancer specific PTL, tracking patients and reviewing data on a daily basis. The MDT team proactively highlight any concerns with operational leads to enable corrective action on a daily basis.
6	**Is root cause breach analysis carried out for each pathway not meeting current standards, reviewing the last ten patient breaches and near misses (defined as patients who came within 48hours of breaching)?** These should be reviewed in the weekly PTL meetings.	**Yes**	Weekly meetings are held with operational teams to review the cancer PTL discussing patients of concern. In addition we hold a detailed breach analysis meeting each month to review all breach patients for the previous month. Timeliness on the 14 day, 31 day and 62 day targets are all reviewed for each patient. This is also assessed at each MDT AGM for all patients including those who met the 62 day target. A weekly report will be developed to include near misses for review at the weekly PTL meeting. We plan to have this completed by 31 October 2015.
7	**Is capacity and demand analysis for key elements of the pathway not meeting the standard (1st OP appointment; treatment by modality) carried out?** There should also be an assessment of sustainable list size at this point.	**Yes**	Capacity and demand is continuously analysed and reviewed. There are challenges in responding to AEDI campaigns and resulting pressure on diagnostics, including imaging, histology and radiology. There are local and regional work streams underway to support this.
8	**Is an Improvement Plan prepared for each pathway not meeting the standard, based on breach analysis, and capacity and demand modelling, describing a timetabled recovery trajectory for the relevant pathway to achieve the national standard.** This should be agreed by local commissioners and any other providers involved in the pathway, taking advice from the local Cancer Clinical Network. Regional tripartite groups will carry out escalation reviews in the event of non-delivery of an agreed Improvement Plan.	**No**	We will develop a system agreed improvement plan for each pathway that is not meeting the standard, with a timetabled recovery for each relevant pathway to meet the national standard. This will be agreed with local commissioners and other local providers involved in the pathway. Work has already commenced in the Network with a Prostate Pathway Improvement Event on 2nd July 2015 and a resulting action plan. We plan to have this completed by 31 March 2016.

Harrogate and District NHS
NHS Foundation Trust

You matter most

Board of Directors Meeting

EPRR Assurance 2015/16

Report from: **Robert Harrison, Chief Operating Officer**

Report Purpose: **For Information**

1. Introduction

1.1 Each year NHS England request that NHS organisations designated as Category 1 responders under the Civil Contingencies Act 2004 undertake a self-assessment and provide assurance to the Local Health Resilience Partnership (LHRP) against the revised Emergency Preparedness, Resilience and Response (EPRR) core standards.

2. Statement of Assurance

2.1. Appendix 1 is the statement of Assurance authorised by the Chief Operating Officer, who is the organisations Accountable Emergency Officer. This states that the Trust has self-assessed as Full compliance as having reviewed the plan and work programme that the Emergency Planning Lead has in place it is clear these appropriately address all the core standards and that any identified gaps do not expose the organisation to unnecessary risk.

3. Recommendation

3.1. It is recommended that the Board notes receipt of the Self-assessment Assurance for information and confirmation of compliance level

KS
September 2015

Harrogate and District NHS
NHS Foundation Trust

Report to the Trust Board of Directors: 23 September 2015	Paper number : 9.1

Title	EPRR Assurance 2015/16
Sponsoring Director	Robert Harrison, Chief Operating Officer
Author(s)	Kirsty Stead, Operational Delivery Manager / Emergency Planning Lead Michael England, Governance Officer Robert Harrison, Chief Operating Officer
Report Purpose	For information

This report is for information. It provides detail of the EPRR Assurance which will be submitted to the Local Health Resilience Partnership, chaired by NHS England.

Related Trust Vision	
1. Driving up quality	Yes
2. Working with partners	Yes
3. Integrating care	Yes
4. Growing our business	Yes

Risk and Assurance	The report provides assurance against the revised EPRR core standards.
Legal implications/ Regulatory Requirements	The LHRP requests that the assurance is noted and agreed by the Board.

Action Required by the Board of Directors
That the Board of Directors note the information provided in the report.

Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework

NHS England INFORMATION READER BOX

Directorate		
Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	03108
Document Purpose	Guidance
Document Name	Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework
Author	NHS England
Publication Date	2nd July 2015
Target Audience	CCG Clinical Leaders, CCG Accountable Officers, CSU Managing Directors, Care Trust CEs, Foundation Trust CEs , Directors of Nursing, Local Authority CEs, Directors of Adult SSs, NHS England Regional Directors, NHS England Directors of Commissioning Operations, All NHS England Employees, GPs, Directors of Children's Services, NHS Trust CEs
Additional Circulation List	
Description	This document updates and replaces Safeguarding Vulnerable People in the Reformed NHS – Accountability and Assurance Framework issued by the NHS Commissioning Board in March 2013. This document is to set out clearly the safeguarding roles, duties and responsibilities of all organisations commissioning NHS Healthcare
Cross Reference	N/A
Superseded Docs (if applicable)	Previous document published March 2013: http://www.england.nhs.uk/wp-content/uploads/2013/03/safeguarding-vulnerable-people.pdf
Action Required	N/A
Timing / Deadlines (if applicable)	**N/A**
Contact Details for further information	Safeguarding Team Nursing Directorate Quarry House Quarry Hill LS2 7UE 0113 8251076

Document Status

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Safeguarding Vulnerable People in the NHS – Accountability and Assurance

Version number: 2.0

First published: March 2013

Updated: June 2015

Prepared by: NHS England

The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

Contents

1 Foreword

Dear Colleagues,

It gives me great pleasure to present the second NHS England Accountability and Assurance Safeguarding Framework. This updated framework builds on the previous one and reaffirms and strengthens our commitment to safeguarding vulnerable individuals.

The framework has been developed by leaders in the system in collaboration with those who will use it. The Department of Health, Department for Education, CQC, Monitor and the TDA have made significant contributions along with safeguarding and commissioning leaders across the whole commissioning system. The framework has also been subject to rigorous legal review to ensure changes in legislation are reflected appropriately.

As vulnerable children and adults face more challenges and the NHS commissioning system matures, it is important to have a document that sets out with greater clarity the responsibilities of each part of the system and the key individuals who work within it. It is also important to recognise that our communities have local characteristics and relationships that are needed to keep our most vulnerable citizens safe. We have therefore worked extensively with our local commissioning practitioners and partner agencies to ensure this framework is flexible to support appropriate decision making between partners at a local level.

NHS England together with CCGs has developed capability at individual and system level and delivered a significant programme of work over the last two years. Major achievements have been evidenced since the first Accountability and Assurance Framework was published in 2013 and I refer now to just a few of these.

The establishment of the National Safeguarding Steering Group has brought together safeguarding leaders for both adults and children from across the commissioning system. They have provided clinical leadership, developed common policies, shared good practice and have ensured that the growing areas within safeguarding such as CSE, Savile, FGM and Prevent have been integrated into the safeguarding agenda in a sensible and coherent way.

We commissioned the delivery of the executive safeguarding leaders programme across England, which received outstanding evaluations from our director colleagues, CCG Chief Operating Officers and Clinical Directors alike. We have invested and supported the development of a national Designated Professionals' network for children and commissioned an excellent leadership programme for our most senior clinical safeguarding experts that work across our commissioning system. NHS England also contributed significantly to the House of Lords inquiry into the Mental Capacity Act 2005, subsequently investing 14 million pounds into the system to support commissioners, providers and partners.

I would like to take this opportunity to thank all those who contributed to the development of the framework and all who work with passion and professionalism to safeguard the health and wellbeing of our most vulnerable people.

Safeguarding is challenging and I do not underestimate the daily issues that our practitioners, leaders and managers face in establishing and maintaining environments that keep people safe. I am proud of what these dedicated teams and individuals achieve.

Jane Cummings

Chief Nursing Officer

2 Introduction and background

This document updates and replaces Safeguarding Vulnerable People in the Reformed NHS – *Accountability and Assurance Framework* issued by the NHS Commissioning Board in March 2013. This section gives an overview of the importance of the procedural document.

2.1 Purpose of the document

The purpose of this document is to set out clearly the safeguarding roles, duties and responsibilities of all organisations commissioning NHS health and social care. It has been refreshed in partnership with colleagues from across the health and social care system, the Department of Health (DH) and the Department for Education (DfE), particularly recognising that the new responsibilities set out in the Care Act 2014 that came into force on 1st April 2015. The framework aims to:

- Identify and clarify how relationships between health and other systems work at both strategic and operational levels to safeguard children, young people and adults at risk of abuse or neglect.

- Clearly set out the legal framework for safeguarding as it relates to the various NHS organisations in order to support them in discharging their statutory requirements to safeguard children and adults.

- Promote empowerment and autonomy for adults, including those who lack capacity for a particular decision as embodied in the Mental Capacity Act 2005 (MCA), implementing an approach which appropriately balances this with safeguarding.

- Outline principles, attitudes, expectations and ways of working that recognise that safeguarding is everybody's business and that the safety and well-being of those in vulnerable circumstances is at the forefront of our business.

- Set out how the health system operates, how it will be held to account both locally and nationally and make clear the arrangements and processes to be undertaken to provide assurance to the NHS England Board with regard to the effectiveness of safeguarding arrangements across the system; and

- Outline how professional leadership and expertise will be developed and retained in the NHS, including the key role of Designated and Named Professionals for Safeguarding Children and Designated Adult Safeguarding Managers.

This accountability and assurance framework is not intended to generate new policy or priorities for either the NHS or its partners. It articulates how the performance of the wider NHS with respect to the duties and priorities defined elsewhere will be delivered and assured.

This framework aims to provide guidance and minimum standards but should not be seen as constraining the development of effective local safeguarding practice and arrangements in line with the underlying legal duties. The responsibilities for safeguarding form part of the core functions for each organisation and must therefore be discharged within agreed baseline funding.

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of this document we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

- Given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities.

2.2 Scope

The definition of safeguarding is necessarily broad as there is a wide range of risks of abuse or neglect that can result in harm to children and adults. Effective safeguarding arrangements seek to protect individuals from harm caused by abuse or neglect occurring regardless of their circumstances. The arrangements set out within this framework will apply whenever a child or an adult is at risk of abuse or neglect, regardless of the source of that risk.

2.3 Context

Safeguarding is firmly embedded within the wider duties of all organisations across the health system but there is a distinction between providers' responsibilities to provide safe and high quality care and support, and commissioners' responsibilities to assure themselves of the safety and effectiveness of the services they have commissioned. The wider context continues to change in response to the findings of large scale inquiries, such as Francis[1] and Lampard[2], and new legislation, such as the Care Act 2014. There has also been revised statutory and intercollegiate guidance, reflected in this framework. This document will support NHS England in maintaining the personalisation agenda as described in the Care Act 2014.

It is essential to continue to revisit and develop the safeguarding arrangements in place. NHS England, in its system leadership role, has revised and re-issued this framework to reflect these recent developments and to provide further clarity of roles and expectations where necessary.

[1] The Francis Inquiry investigated the quality and safety failing in Mid Staffordshire Foundation NHS Trust.
[2] The Lampard Inquiry investigated the activities of Jimmy Savile in the NHS https://www.gov.uk/government/publications/jimmy-savile-nhs-investigations-lessons-learned

The framework seeks to set out clearly how these roles are discharged and statutory duties are fulfilled across the health system. It also describes how the health system works in partnership with the local authorities to discharge its statutory safeguarding duties.

Fundamentally, it remains the responsibility of every NHS funded organisation and each individual healthcare professional working in the NHS to ensure that the principles and duties of safeguarding adults and children are holistically, consistently and conscientiously applied, with the well-being of those adults and children at the heart of what we do. For adult safeguarding this also needs to respect the autonomy of adults and the need for empowerment of individual decision making, in keeping with the Mental Capacity Act and its Code of Practice.

This framework sets out the minimum standards expected across the system; however, it must be recognised that needs vary across England and therefore local arrangements must be tailored to meet these local needs.

All NHS organisations need to ensure that there is sufficient capacity in place to fulfil their statutory duties and should regularly review their arrangements to assure themselves that they are working effectively. Organisations need to come together to mitigate risks and develop workable local solutions based on local need. Some of the issues that must be considered include:

- The size and geography of the 'patch'.
- The deprivation of the population served and the numbers of children and adults in need, including looked after children.
- The evidence and advice from recent inspections, reviews, audits and case reviews of safeguarding.
- The number of providers and the complexity of the provider landscape.

The views of the LSCB, SAB and Health and Wellbeing Boards should be considered in the assessment of capacity.

Safeguarding adults at risk of abuse or neglect is a collective responsibility. Indeed the Care Act 2014 places a duty on agencies to co-operate to help and support adults in need and their carers[3]. Whilst individuals and organisations have distinct roles, the system cannot operate effectively unless the different individuals and organisations work together. The following section sets out a number of ways in which the system works together to do this.

In 2011 the Government published the third version of the United Kingdom's Counter-terrorism strategy, CONTEST. The strategy set out the threat the population face and the priorities for dealing with it through to 2015, as part of this strategy Health is involved in the fourth aspect of Prevent, which looks at identifying and supporting individuals who may be vulnerable and at risk of radicalisation before they

[3] Care Act 2014 sections 6 & 7.

become radicalised. As this process is primarily looking at individuals who are at risk then it links to the safeguarding agenda highlighted in this framework.

Good partnership working is essential and individual practitioners should continue to develop relationships and work closely with colleagues across their local safeguarding system to develop ways of working that are collaborative, enable learning and effective information sharing. There are a number of systems that support this, for example the Child Protection Information Sharing (CP-IS) solution[4], which provides key data from local authorities to unscheduled care providers in health on children and unborn children who are subject to child protection plans or have looked after child status. The use of such systems is crucial to ensure there are no gaps that allow children or adults to be overlooked.

3 Legal Framework

3.1 Legal Duties

Responsibilities for safeguarding are enshrined in legislation. Some duties apply only to children, some apply only to adults, and some apply to both. This section deals with each in turn.

There are fundamental differences between the legislative framework for safeguarding children and that for adults which stem from who can make decisions.

Adults have a legal right to make their own decisions, even if they are unwise, as long as they have capacity to make that decision[5] (which must be free from coercion or undue influence). However, if an 'adult repeatedly makes unwise decisions that put them at significant risk of harm or exploitation, or makes a particular unwise decision that is obviously irrational or out of character'. There might be need for further investigation[6]. Moreover, the wishes of victims of crime can be overridden in the public interest, which includes responding to suspected offences against them or the suspected abuse or neglect of others[7].

When children, or those with parental responsibility for them, reject measures that could save them from significant harm, their wishes can be overridden. This is part of the statutory principle that makes the welfare of the child the paramount consideration[8] subject to that, decision-making power relating to children lies with those who have parental responsibility for the child.

However, when a child understands fully the choice to be made and its consequences, based on the Gillick competency, the child's decision prevails[9];

[4] http://systems.hscic.gov.uk/cpis
[5] Mental Capacity Act 2005, Section 1 Principle 3.
[6] Mental Capacity Act Code of Practice, HMG, 2005, 2.11.
[7] Care and Support Statutory Guidance, DH, 2014, 14.158.
[8] Children Act 1989 section 1(1).
[9] Gillick v West Norfolk and Wisbech AHA [1986] AC 112.

Parents and carers should still be fully involved[10] unless the criteria set out in the Fraser guidelines apply.[11]

The Mental Capacity Act covers and empowers children aged 16 and 17 ('young persons'). A young person has capacity unless it is established he or she lacks it.[12] If a young person lacks capacity because of an impairment of, or a disturbance in the functioning of, the mind or brain, the Mental Capacity Act will apply in the same way as it does to adults (people aged 18 or over). However if the young person is unable to make a decision for another reason, for example, because he or she is overwhelmed by its implications the common law principles set out in Gillick will apply[13].

3.1.1 Children

The legislation and guidance relevant to safeguarding and promoting the welfare of children includes the following:

Children Act 1989 and 2004.
Working Together to Safeguard Children (2015) – statutory guidance.
Promoting the Health and Well-being of Looked After Children – statutory guidance (2015).
Safeguarding children and young people: roles and competences for health care staff, intercollegiate document (updated 2014).

A full exposition of statutory provisions relating to children's safeguarding can be found in appendix B of the statutory guidance document *Working Together to Safeguard Children*. This document focuses on those which are relevant to the NHS.

There are some broad, fundamental safeguarding duties, namely:

- All public sector agencies providing services to children, including local authorities and all NHS bodies, "must make arrangements for ensuring that their functions are discharged having regard to the need to safeguard and promote the welfare of children"[14].

- There is a duty on local authorities to "safeguard and promote the welfare of children within their area who are in need"[15]. The concept of "need" is defined very broadly, covering any child whose health or development will be impaired without support, or who has a disability[16].

[10] Children Act 2004 section 10(3).
[11] Gillick v West Norfolk and Wisbech AHA [1986] AC 112, R (on the application of Sue Axon) v Secretary of State for Health EWCA 372006 (Admin) (and see http://www.nspcc.org.uk/preventing-abuse/child-protection-system/legal-definition-child-rights-law/gillick-competency-fraser-guidelines/)
[12] Mental Capacity Act 2005 section 1 Principle 1.
[13] Mental Capacity Act 2005 Code of Practice, HMG, 2005, 12.13.
[14] Section 11 Children Act 2004.
[15] Section 17(1) Children Act 1989.
[16] Section 17(10) Children Act 1989.

- Local authorities also have a further duty to "take reasonable steps…to prevent children within their area suffering ill-treatment or neglect"[17].

- A child-centred approach is required. As far as reasonably possible, local authorities must ascertain the child's wishes and feelings[18], and devise their support in consideration of those wishes and feelings. Local authorities do not have to provide the support themselves.

- A local authority must enquire whether it needs to take safeguarding action if it has reasonable cause to suspect a child in its area is suffering, or is at risk of, significant harm. This duty also covers any child in police protection, or under an emergency protection order[19].

It is essential practice that all agencies recognise that safeguarding is everyone's business. 'No professional should assume that someone else will pass on information which they think may be critical to keeping a child safe. If a professional has concerns about a child's welfare and believes they are suffering or likely to suffer harm, then they should share the information with local authority children's social care'[20]. Particular duties of inter-agency co-operation that support this general principle include:

- If, in discharging its safeguarding duties, a local authority asks certain specified agencies for help, those agencies must help as long as it is compatible with their own duties, and does not hamper the discharge of their own functions. These agencies include NHS England, CCGs, and all NHS trusts[21].

- Local authorities are under a duty to make arrangements to promote co-operation with other agencies, including NHS England and all CCGs, in order to promote the well-being of children in general, and to protect them from harm and neglect in particular. Those other agencies are under an express reciprocal duty to co-operate with the local authority[22].

The task of monitoring inter-agency co-operation falls to the Local Safeguarding Children Board (LSCB). Local authorities must establish an LSCB for their area. NHS England, CCGs, Designated Professionals and local providers should ensure appropriate representation on the LSCB. The local authority and the other board members owe to each other reciprocal duties of co-operation specifically in relation to the establishment and operation of the LSCB[23].

The objectives of an LSCB are to co-ordinate activities of board members to safeguard and promote the welfare of children, and to ensure the effectiveness of those activities. LSCBs must commission serious case reviews where abuse or neglect of a child is known or suspected, the child has either died or been seriously

[17] Paragraph 4, Schedule 2, Children Act 1989.
[18] Section 53 Children Act 2004.
[19] Section 47 Children Act 1989.
[20] Working together to safeguard children, HMG, 2015, paragraph 1.24.
[21] Section 27 Children Act 1989.
[22] Section 10 Children Act 2004.
[23] Section 13 Children Act 2004.

harmed, and there is concern over how agencies and service providers have worked together[24].

3.1.2 Mental Capacity Act 2005

The Mental Capacity Act 2005 (MCA) aims to empower people to make decisions for themselves as much as possible and to protect people who may not be able to take some decisions. The Act applies to anyone aged 16 or over in England and Wales and is relevant for both care and treatment decisions. The MCA is supported by a Code of Practice and health and social care staff are specifically highlighted as a category of professionals that are required to have regard to the code of practice. As a legal duty, NHS England expects all service providers that are funded by the NHS to meet the requirements of the Act. Equally, commissioners are required to ensure that the services that they commission are complying with the MCA.

3.1.3 MCA and safeguarding

The relationship between mental capacity and adult safeguarding has come under much scrutiny in recent months. The report of the House of Lords Select Committee on the Mental Capacity Act[25] reflected the views of many when they said:
"a consistent theme was the tension between the empowerment which the Act was designed to deliver, and the tendency of professionals to use the Act for safeguarding purposes. Prevailing professional cultures of risk aversion and paternalism have inhibited the aspiration of empowerment from being realised".

In its response, the Government noted[26] : "professionals need to be aware of their responsibilities in regard to safeguarding and the MCA in all that they do. Of course, the two do have interdependencies and professionals should ensure the empowering ethos of the MCA is built into the safeguarding discussion as is often already the case. Traditionally, there has been a tendency in health and care organisations to assign responsibility for the MCA to the named safeguarding lead. It is not for Government to determine other organisations' management arrangements but we would urge that in such an arrangement care is taken to ensure that the "MCA voice" is heard in equal measure to the "safeguarding voice". If this is not happening, then steps should be taken to ensure that the MCA does indeed have a strong advocate within the organisation."

NHS England supports this view: care must be taken not to treat the MCA simply as a tool of safeguarding, and lose sight of the principles of empowerment and autonomy. Staff will need considerable support from their employers if they are to successfully safeguard adults and empower those adults to express their own wishes and preferences. Employers should ensure they have policies and procedures in place to achieve this.

[24] Section 14 Children Act 2004 and paragraph 5 of the Local Safeguarding Children Boards. Regulations 2006.
[25] House of Lords post legislative scrutiny report March 2014.
[26] Government response "Valuing Every Voice" June 2014.

All practitioners should be aware that additional procedural and substantive obligations arise when care provided to a person, who lacks the capacity to consent to those arrangements, constitute a deprivation of that person's liberty[27].

3.1.4 Adults at risk of abuse or neglect

The legislation and guidance relevant to safeguarding adults at risk of abuse or neglect includes the following:

Care Act 2014
Care and Support Statutory Guidance (Chapter 14 – Safeguarding)

Further practice materials to support implementation of the Care Act have been commissioned and will be found on the LGA website as they are published.

There are some broad and fundamental safeguarding duties covering adult services, namely:

- Local authorities must promote the adult's "well-being"[28]. Within this broad concept, the authority must "have regard to the need to protect people from abuse and neglect"[29].

- If a local authority has reasonable cause to suspect an adult in its area is suffering or is at risk of abuse and neglect, and has needs which leave him or her unable to protect himself or herself, then it must ensure enquiries are made in order to decide what action (if any) should be taken, and by whom (the "duty to enquire"[30]). Enquiries should be made by the most appropriate professional, and in some circumstances that will be a health professional.

In discharging these duties, there are express reciprocal duties to co-operate on local authorities and their "relevant partners", and that category includes NHS England, and all CCGs and health trusts in the local authority's area[31].

Where the safeguarding action requires assessing an adult's needs, or the preparation or revision of care plans, or care and support plans, the local authority is under a duty to consider if the adult needs an independent advocate. The trigger is when the adult would experience substantial difficulty in understanding or retaining relevant information, or weighing that information as part of the decision-making process, or communicating their views[32].

Each local authority must establish a Safeguarding Adults Board (SAB) in its area[33]. Its main objective is to help and protect those adults in its area. CCGs, working with

[27] MCA 2005 Schedule A1 (the "Deprivation of Liberty Safeguards" or "DOLS") and as regards deprivation of liberty outside the scope of DOLS, e.g. in a community setting – see Cheshire West and Surrey, Supreme Court, 19 March 2014.
[28] Section 1(1) Care Act 2014.
[29] Section 1 (2) (c) Care Act 2014.
[30] Section 42 Care Act 2014.
[31] Section 6 and 7 Care Act 2014.
[32] Section 68 Care Act 2014.
[33] Section 43 Care Act 2014.

the health system, should ensure appropriate representation on the SAB. The local authority may include any other body it considers appropriate following consultation with other members[34].

A SAB can arrange a safeguarding adult review whenever it chooses. However it must arrange one where an adult has died from or experienced serious abuse or neglect, and there is reasonable cause for concern about how those agencies and service providers involved worked together to safeguard the adult[35]. Core partners are required to contribute to such reviews when requested.

The Government has issued a policy statement on adult safeguarding which sets out six principles for safeguarding adults. Whilst not legal duties, these do represent best practice and provide a foundation for achieving good outcomes:

- Empowerment - presumption of person led decisions and consent.
- Protection - support and representation for those in greatest need.
- Prevention of harm or abuse.
- Proportionality and least intrusive response appropriate to the risk presented.
- Partnerships - local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- Accountability and transparency in delivering safeguarding.

3.2 Information sharing

Good information sharing practice is at the heart of good safeguarding practice. The area is covered by legislation, principally the Data Protection Act 1998, and by court decisions on issues of confidentiality and privacy. Professionals will wish to refer to specific advice from their professional body regarding information sharing e.g. GMC guidance; http://www.gmc-uk.org/guidance/ethical_guidance/13388.asp or NMC Code section 5; NMC Code 2105. This is further supported by the newly updated Caldicot Guidelines, principle seven which individuals are informed that the duty to share information can be as important as the duty to protect patient confidentially, this is described in further detail at Information to share or not to share - DH. It is very important to understand that sharing information when there is a need to share it and maintaining its security and confidentiality are compatible activities.

At its heart is the principle that information should be shared if that helps to protect children or adults, or to prevent a crime (abuse and many cases of neglect are crimes). In addition, there are some specific statutory provisions (for example relating to the operation of LSCBs, and SABs, and relating to the statutory scheme for vetting and barring) which require information sharing[36].

[34] Schedule 2 Care Act 2014.
[35] Section 44 Care Act 2014.
[36] Section 14B Children Act 2004; sections 37 and 40 Safeguarding Vulnerable Groups Act 2006; section 45 Care Act 2014.

3.2.1 Vetting and barring

There is a statutory scheme for vetting people working with children and adults at risk of abuse or neglect. It is administered by the Disclosure and Barring Service. The system provides for checks on people entering the workforce, and maintains lists of individuals who are barred from undertaking regulated activity with either children or adults at risk of abuse or neglect.

3.2.2 Domestic Violence, Crime and Victims Act 2004

Statutory guidance places a duty on Community Safety Partnerships to make arrangements for Domestic Homicide Reviews. Health bodies are required to participate in these as requested[37].

3.2.3 Fit and proper persons test

There are new legal requirements that board level appointments of NHS trusts, foundation trusts and special health authorities are "fit and proper persons". This excludes individuals who have been involved in "any serious misconduct or mismanagement". Clearly, safeguarding falls within that definition[38].

3.2.4 Duty of candour

Good safeguarding practice requires openness, transparency and trust. There is a legal "duty of candour" on health service bodies[39]. This is detailed in the DH paper "Introducing the Statutory Duty of Candour" following the Francis inquiry.

There is an overall duty that health service bodies "must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity".

In addition, there is a specific duty triggered by a "notifiable safety incident", where any "unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity" has caused, or could cause, death, severe, or moderate harm, or prolonged psychological harm, defined in detail in the Regulations. In this case, there is a duty is to tell people (both in person and in writing), explain, apologise, and advise on any action taken as a result.

3.2.5 Statutory reviews

A number of statutory reviews are required to be undertaken by relevant health agencies when particular circumstances arise. The different types of review include:

- Domestic homicide review: convened by the local community safety partnership when the defined criteria has been met following the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect.

[37] Section 9 Domestic Violence, Crime and Victims Act 2004.
[38] Regulation 5, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
[39] Regulation 20, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Safeguarding adult review: convened by a SAB for every case where an adult has died from, or experienced serious abuse or neglect, and there is reasonable cause for concern about how agencies and service providers involved worked together to safeguard the person.

- Serious case review: convened by a LSCB for every case where abuse or neglect is known or suspected and either: a child dies; or a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child;

- Child death review: a review of all child deaths up to the age of 18.

All NHS agencies and organisations that are asked to participate in a statutory review must do so. The input and involvement required will be discussed and agreed in the terms of reference for the review but broadly this will involve meeting regularly with colleagues and attending panels or review group meetings throughout the investigative phase.

Health commissioners will provide a panel member, provide oversight of health involvement at panel meetings, ensure that recommendations and actions are achievable, and disseminate learning across the NHS locally. NHS England may support panel chairs where lessons learned have wider implications and need co-ordinated national action and/or where there are obstacles to full NHS participation which require a range of relationship, contractual and professional influences.

Mental health homicide reviews are carried out under separate arrangements but may, depending upon the circumstances, need to link to a safeguarding statutory review.

4 Roles and responsibilities

Safeguarding children and adults at risk of abuse or neglect is a collective responsibility. This section provides greater clarity around the individual roles and responsibilities of the different elements of the system. These are summarised and mapped to the health commissioning system in figure 1 at Annex A.

4.1 Health Providers

4.1.1 Health and care professionals

All staff, whether they work in a hospital, a care home, in general practice, or in providing community care, and whether they are employed by a public sector, private or not-for-profit organisation, have a responsibility to safeguard children and adults at risk of abuse or neglect in the NHS.

4.1.2 Provider leadership

Health providers are required to demonstrate that they have safeguarding leadership, expertise and commitment at all levels of their organisation and that they are fully engaged and in support of local accountability and assurance structures, in particular via the LSCBs, SABs and in regular monitoring meetings with their commissioners.

Health providers must ensure staff are appropriately trained in safeguarding adults, children, Prevent, domestic violence, the MCA and deprivation of liberty[40] at a level commensurate with their role and in line with the intercollegiate document 2014, and future guidance that may be produce to support training of staff. It is strongly recommended that safeguarding forms part of any mandatory training in order to develop and embed a culture within their organisation that ensures safeguarding is acknowledged to be everybody's business from "the board to the floor".

All health providers are required to have effective arrangements in place to safeguard children and adults at risk of abuse or neglect and to assure themselves, regulators and their commissioners that these are working. These arrangements include:

- Safe recruitment practices and arrangements for dealing with allegations against people who work with children or vulnerable children as appropriate.

- A suite of safeguarding policies including a chaperoning policy.

- Effective training of all staff commensurate with their role and in accordance with the intercollegiate competences 2014.

- Effective supervision arrangements for staff working with children / families or adults at risk of abuse or neglect.

- Effective arrangements for engaging and working in partnership with other agencies.

- Identification of a named doctor and a named nurse (and a named midwife if the organisation provides maternity services) for safeguarding children. In the case of out of hours services, ambulance trusts and independent providers, this could be a named professional from any relevant health or social care background.

- Identification of a named lead for adult safeguarding and an MCA lead – this must include the statutory role for managing adult safeguarding allegations against staff.

- Developing an organisational culture such that all staff are aware of their personal responsibility to report concerns and to ensure that poor practice is identified and tackled.

[40] MCA 2005 Schedule A1 (the "Deprivation of Liberty Safeguards" or "DOLS") and as regards deprivation of liberty outside the scope of DOLS, e.g. in a community setting – see Cheshire West, Supreme Court, 19 March 2014.

- Policies, arrangements and records to ensure consent to care and treatment is obtained in line with legislation and guidance including the MCA 2005 and the Children Act 1989/2004.

All providers of health services are required to be registered with the Care Quality Commission (CQC). In order to be registered, providers must ensure that those who use the services are safeguarded and that staff are suitably skilled and supported. This includes private healthcare providers. NHS trusts without foundation trust status are also accountable to the NHS Trust Development Authority.

4.1.3 Named professionals (health providers)

Named professionals have a key role in promoting good professional practice within their organisation, supporting the local safeguarding system and processes, providing advice and expertise for fellow professionals, and ensuring safeguarding training is in place. They should work closely with their organisation's safeguarding lead, Designated Professionals and the LSCB/SAB.

All providers are required to have an MCA lead who is responsible for providing support and advice to clinicians in individual cases and supervision for staff in areas where these issues may be particularly prevalent and/or complex. They should also have a role in highlighting the extent to which their own organisation is compliant with the MCA through undertaking audit, reporting to the governance structures and providing training. The named lead(s) will work closely with the CCG adult safeguarding lead. GP practices are required to have a lead for safeguarding and MCA, who should work closely with named GPs and adult safeguarding lead. In some instances this role may be covered by the named professional.

4.2 Commissioners

4.2.1 Clinical Commissioning Groups

CCGs are statutory NHS bodies with a range of statutory duties, including safeguarding adults and children. They are membership organisations that bring together general practices to commission services for their registered populations and for unregistered patients who live in their area. CCGs are responsible for commissioning most hospital and community healthcare services. Initially in the reformed NHS CCGs were not directly responsible for commissioning primary medical care (or other primary care services), but they have a duty to support improvements in the quality of primary medical care. Further to this, co-commissioning arrangements between CCGs and NHS England are being put in place from 2015/16 and the implications for safeguarding duties are set out below.

CCGs as commissioners of local health services need to assure themselves that the organisations from which they commission have effective safeguarding arrangements in place. CCGs are responsible for securing the expertise of Designated Professionals on behalf of the local health system. It should be recognised that the Designated Professionals and Adult Safeguarding Leads undertake a whole health economy role. It is crucial that Designated Safeguarding Professionals play an integral role in all parts of the commissioning cycle, from procurement to quality

assurance if appropriate services are to be commissioned that support adults at risk of abuse or neglect, and children, as well as effectively safeguard their well-being.

Safeguarding forms part of the NHS standard contract (service condition 32) and commissioners will need to agree with their providers, through local negotiation, what contract monitoring processes are used to demonstrate compliance with safeguarding duties.

CCGs must gain assurance from all commissioned services, both NHS and independent healthcare providers, throughout the year to ensure continuous improvement. Assurance may consist of assurance visits, section 11 audits[41] and attendance at provider safeguarding committees.

CCGs are also required to demonstrate that they have appropriate systems in place for discharging their statutory duties in terms of safeguarding. These include:

- A clear line of accountability for safeguarding, properly reflected in the CCG governance arrangements, i.e. a named executive lead to take overall leadership responsibility for the organisation's safeguarding arrangements.

- Clear policies setting out their commitment, and approach, to safeguarding including safe recruitment practices and arrangements for dealing with allegations against people who work with children and adults as appropriate.

- Training their staff in recognising and reporting safeguarding issues, appropriate supervision and ensuring that their staff are competent to carry out their responsibilities for safeguarding.

- Effective inter-agency working with local authorities, the police and third sector organisations which includes appropriate arrangements to cooperate with local authorities in the operation of LSCBs, SABs and Health and Wellbeing Boards.

- Ensuring effective arrangements for information sharing.

- Employing, or securing, the expertise of Designated Doctors and Nurses for Safeguarding Children and for Looked After Children and a Designated Paediatrician for unexpected deaths in childhood.

- Having a Designated Adult Safeguarding Manager (DASM) which should include the Adult Safeguarding lead role and a lead for the MCA, supported by the relevant policies and training.

- Effective systems for responding to abuse and neglect of adults.

- Supporting the development of a positive learning culture across partnerships for safeguarding adults to ensure that organisations are not unduly risk averse.

[41] Section 11 Children Act 2004.

- Working with the local authority (LA) to enable access to community resources that can reduce social and physical isolation for adults.

The role of CCGs is also fundamentally about working with others to ensure that critical services are in place to respond to children and adults who are at risk or who have been harmed, and it is about delivering improved outcomes and life chances for the most vulnerable. CCGs need to demonstrate that their Designated Clinical Experts (children and adults), are embedded in the clinical decision making of the organisation, with the authority to work within local health economies to influence local thinking and practice.

4.2.2 Designated Professionals and Adult Safeguarding Leads

CCGs are responsible for securing the expertise of Designated Professionals on behalf of the local health system. Therefore, it is expected that many Designated Professionals will be employed by CCGs. In some areas there will be more than one CCG per local authority and LSCB/SAB area, and CCGs may want to consider developing 'lead' or 'hosting' arrangements for their Designated Professional team, or a clinical network arrangement. Where a Designated Professional (most likely a Designated Doctor for Safeguarding or a Designated Professional for Looked After Children) is employed within a provider organisation, the CCG will need to have a Service Level Agreement (SLA), with the provider organisation that sets out the practitioner's responsibilities and the support they should expect in fulfilling their designated role.

The Designated Professional's role is to work across the local health system to support other professionals in their agencies on all aspects of safeguarding and child protection. Designated Professionals are clinical experts and strategic leaders for safeguarding and as such are a vital source of advice and support to health commissioners in CCGs, the local authority and NHS England, other health professionals in provider organisations, quality surveillance groups (QSG), regulators, the LSCB/SAB and the Health and Wellbeing Board.

Whatever arrangements are in place for securing the expertise of Designated Professionals it is vital that CCGs enable and support Designated Professionals to fulfil their system-wide role.

4.2.3 Designated Professionals (children)

Further details on the Designated Professional role for safeguarding children include:

- The role of Designated Professionals for safeguarding children should always be explicitly defined in job descriptions, and sufficient time, funding, supervision and support should be allowed to enable them to fulfil their child safeguarding responsibilities across the wider system effectively.

- Model job descriptions and person specifications which can be found in the intercollegiate document, Safeguarding Children and Young People: roles and competences for healthcare staff

- CCG representatives at the LSCB must be accompanied by their Designated Professional to ensure their professional expertise is effectively linked into the local safeguarding arrangements.

- Designated Professionals are responsible for undertaking serious case reviews/ case management reviews/significant case reviews on behalf of health commissioners and for quality assuring the health content.

- Designated Professionals must be consulted and able to influence at all points in the commissioning cycle to ensure all services commissioned meet the statutory requirement to safeguard and promote the welfare of children.

- Designated Professionals are responsible for providing expert advice to HEE and Local Education and Training Boards to ensure that the principles of safeguarding are integral to education and training curricula for health professionals.

- Designated Professionals are expected to give clinical advice, for example in complex cases or where there is dispute between practitioners.

- Clear accountability and performance management arrangements are essential. These need to account for the particular working arrangements but key elements of this are:

  - As single subject experts, peer-to-peer supervision is vital to ensuring Designated Professionals continue to develop their practice in line with agreed best practice. Designated Professionals are required to attend supervision meetings regularly with a lack of attendance raised as a professional concern in the annual appraisal and review process. These supervision meetings are to be formally minuted and preferably professionally facilitated.

  - The Designated Professional must have direct access to the Executive (Board level) Lead to ensure that there is the right level of influence of safeguarding on the commissioning process.

  - The CCG Accountable Officer (or other executive level nominee) should meet regularly with the Designated Professional to review child safeguarding.

  - Where Designated Doctors, in particular, are continuing to undertake clinical duties in addition to their clinical advice role in safeguarding, it is important that there is clarity about the two roles and the CCG will need to be able to input into the job planning, appraisal and revalidation processes. Designated Doctors may liaise with the Regional Medical Director on those occasions that need solely medical professional consideration.

4.2.4 Designated Adult Safeguarding Manager (DASM)

As a member of the Safeguarding Adults Board CCGs are specifically required by statutory guidance[42] to have a Designated Adult Safeguarding Manager (DASM).

The DASM will support all activity required to ensure that the organisation meets its responsibilities in relation to safeguarding adults. The DASM will offer support and advice to the Board member responsible for adult safeguarding. The DASM will ensure the regular provision of training to the staff and Board of the CCG. The DASM will be a source of expertise and advice to those working in the CCG. He or she will be able to advise the local authority, police and other organisations on health matters in relation to adult safeguarding.

Specific responsibilities of the DASM will include:

- Responsibility for the management and oversight of individual complex cases.
- Coordination where allegations are made, or concerns raised, about a person, whether an employee, volunteer or student, paid or unpaid.
- Promoting partnership working and keeping in regular contact with their counterparts in partner organisations.
- Assessing and highlighting the extent to which their own organisation prevents abuse and neglect taking place.
- Ensuring that appropriate recording systems are in place that provide clear audit trails about decision making and recommendations in all processes relating to the management of adult safeguarding allegations against the person alleged to have caused the harm or risk of harm and ensure the control of information in respect of individual cases is in accordance with accepted data protection and confidentiality requirements.

It is recommended that the DASM role also incorporates the safeguarding adult lead role as required through the CCG authorisation process and that this combined role has a strategic overview of safeguarding adults across the local health economy.

The role of the safeguarding adult lead is to:

- Support and advise commissioners, including CCGs, NHS England and public health on adult safeguarding within contracts and commissioned services and in securing assurance from providers that they have effective safeguarding arrangements in place.
- Provide advice to commissioned services on how to improve systems for safeguarding adults.

[42] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf

- Provide guidance on identifying adults at risk from different sources and in different situations.

- Understand and embed the routes of referral for adults at risk across the health system.

- Provide a health advisory role to the Safeguarding Adults Board (SAB), supporting the CCG SAB member.

- Take a lead for health in working with the SAB to undertake safeguarding adult reviews and take forward any learning for the health economy.

The DASM needs to have a broad knowledge of healthcare for older people, those with dementia, learning disabilities, mental health issues and/or care leavers. Where further guidance is published on the role and competencies for the DASM then this should be followed.

4.2.5 Designated MCA lead

CCGs are required to have a Designated MCA lead who is responsible for providing support and advice to clinicians in individual cases and supervision for staff in areas where these issues may be particularly prevalent and/or complex. They should also have a role in highlighting the extent to which their own organisation, and the services that they commission, are compliant with the MCA through undertaking audit, reporting to the governance structures and providing or securing the provision of training.

4.2.6 Co-commissioning arrangements

Co-commissioning arrangements are being introduced from April 2015 and provide a number of different models for involving CCGs in the commissioning of primary care services – greater involvement of CCGs, joint commissioning or delegated arrangements.

Under delegated arrangements, CCGs will be responsible for ensuring that the GP services commissioned have effective safeguarding arrangements and are compliant with the MCA. NHS England will require assurance that such arrangements are in place before CCGs take on such responsibility. The overall effectiveness of CCGs in discharging their safeguarding and MCA duties will also be monitored as part of the CCG assurance process.

4.3 NHS England

The general function of NHS England is to promote a comprehensive health service so as to improve the health outcomes for people in England. NHS England discharges its responsibilities by:

- Allocating funds to, guiding and supporting CCGs, and holding them to account.

- Directly commissioning primary care[43], specialised health services, health care services for those in secure and detained settings, and for serving personnel and their families, and some public health services[44].

The mandate from Government sets out a number of objectives which NHS England is legally obliged to pursue. The objectives relevant to safeguarding are:

Objective 13 - NHS England's objective is to ensure that Clinical Commissioning Groups (CCGs) work with local authorities to ensure that adults at risk of abuse or neglect, particularly those with learning disabilities and autism, receive safe, appropriate, high quality care.

Objective 23 - NHS England's objective is to make partnership a success. This includes, in particular, demonstrating progress against the Government's priorities of:

Continuing to improve safeguarding practice in the NHS.

Contributing to multi-agency family support services for adults at risk of abuse or neglect and troubled families.

Contributing to reducing violence, in particular by improving the way the NHS shares information about violent assaults with partners, and supports victims of crime.

There is further narrative within the mandate that provides detail on the expectations of the Government:

"We expect to see the NHS, working together with schools and children's social services, supporting and safeguarding vulnerable, looked-after and adopted children, through a more joined-up approach to addressing their needs."

NHS England's overall roles in terms of safeguarding are direct commissioning and assurance and system leadership.

[43] The primary care commissioner may not be NHS England where some co-commissioning arrangements between CCGs and NHS England are in place.
[44] Commissioning of health visiting and family nurse partnerships transfers to local authorities in October 2015.

4.3.1 Direct commissioning

NHS England ensures that safeguarding duties are met in relation to the services that it directly commissions, such as primary care and specialised services. The duties are set out in section 4.3.2.

4.3.2 Assurance and system leadership

NHS England ensures that the health commissioning system as a whole is working effectively to safeguard adults at risk of abuse or neglect, and children. NHS England is the policy lead for NHS safeguarding, working across health and social care, including leading and defining improvement in safeguarding practice and outcomes. Key roles are:

- Provide leadership support to safeguarding professionals – including working with Health Education England (HEE) on education and training of both the general and the specialist workforce.

- Ensure the implementation of effective safeguarding assurance arrangements and peer review processes across the health system from which assurance is provided to the Board.

- Provide specialist safeguarding advice to the NHS.

- Lead a system where there is a culture that supports staff in raising concerns regarding safeguarding issues.

- Ensure that robust processes are in place to learn lessons from cases where children or adults die or are seriously harmed and abuse or neglect is suspected.

- Ensure that locally NHS England teams are appropriately engaged in the Local Safeguarding Boards and any local arrangements for safeguarding both adults and children, including effective mechanisms for LSCBs, SABs and Health and Wellbeing Boards to raise concerns about the engagement and leadership of the local NHS.

This role is discharged through the Chief Nursing Officer (CNO) who has a national safeguarding leadership role. The CNO is the Lead Board Director for Safeguarding and has a number of forums through which to gain assurance and oversight, particularly through the NHS England National Safeguarding Steering Group (NSSG).

The arrangements and processes through which NHS England provide oversight and assurance with regard to the effectiveness of safeguarding arrangements across the system are set out in Annex B.

4.3.3 Direct commissioning: safeguarding role

NHS England is responsible for commissioning primary care, specialised services, health care services in justice, health services for armed forces and families and some public health services[45]. As a commissioner of health services, NHS England needs to assure itself that the organisations from which it commissions have effective safeguarding arrangements in place.

In addition, in relation to primary care[46] NHS England is responsible for ensuring, in conjunction with local CCG clinical leaders, that there are effective arrangements for the employment and development of Named GP/Named Professional capacity for supporting primary care within the local area. This capacity is funded through the primary care budget but it is for local determination exactly how this is done and what employment arrangements are adopted. Further detail on the Named GP/Named Professional role is set out below.

NHS England supports training for primary care by providing access to safeguarding training through available e-learning products, expertise from the Named GP/Named professional for primary care, access to Safeguarding Board training and support through the primary care safeguarding toolkit. (RCGP/NSPCC).

4.3.4 Named GP/Named Professional (primary care)

Named GPs/Named Professionals have a key role in promoting good professional practice, providing advice and expertise for fellow professionals, and ensuring appropriate safeguarding training is in place. The Named GP/Named Professional capacity commissioned locally needs to reflect local needs as set out within the joint strategic needs assessment (JSNA) and in discussion with the Local Safeguarding Children Board. The criteria outlined below give further guidance to inform the precise nature of the local workforce; however, it is strongly recommended that two Named GP sessions per 220,000 population is secured as a minimum.

Broadly the role of the Named GP/Named Professional includes:

- Providing specific expertise on child health and development and in the care of families in difficulty as well as children who have been abused or neglected.

- Providing supervision, expert advice and support to GPs and other primary care staff in child protection issues.

- Offering advice on local arrangements with provider organisations for safeguarding children.

- Promoting, influencing and developing relevant training for GPs and their teams.

[45] Commissioning of health visiting and family nurse partnerships transfers to local authorities in October 2015.
[46] The primary care commissioner may not be NHS England where some co-commissioning arrangements between CCGs and NHS England are in place.

- Providing input as a skilled professional to child safeguarding processes, in line with the procedures of Local Safeguarding Children Boards.

- Taking a lead in writing the general practice components of serious case reviews, independent management reviews, SAAF, section 11 and multi-agency audits.

- Supporting processes required by regulator unannounced and announced single and multi-agency inspections.

- Working with commissioners to develop and improve the quality of safeguarding arrangements locally.

- Supporting and encouraging collaborative working across the local safeguarding system with a particular role to work with the nominated safeguarding leads in GP practices.

Training, experience and qualification requirements for Named GPs/Named Professionals are set out in the intercollegiate document "Safeguarding children and young people: roles and competences for health care staff".

A role description specific to Named GPs is found within the RCGP/NSPCC Safeguarding Children Toolkit 2014 and a competency framework is set out in "Guidance and Competences for the Provision of Services Using Practitioners with Special Interests (PwSIs) Safeguarding Children and Young People".

On-going training and personal development of practitioners with a special clinical interest is important and will require the specialist education as well as access to relevant peer support. It is crucial that if Named GPs/Named Professionals are to fulfil their role effectively that they are provided with a clear line of management accountability and responsibility, this must be agreed with the individual Named Professional in line with the precise employment arrangement adopted.

Whilst the Named GP role covers safeguarding of children and young people only it is recommended that NHS England/primary care commissioners and local CCG clinical leaders consider commissioning a cluster model of named safeguarding clinicians with a range of expertise. This could include child safeguarding, safeguarding people of all ages with mental health issues, physical disability, special educational needs, learning difficulties and learning disability, safeguarding looked after children and care leavers, adult safeguarding including domestic abuse, safeguarding in elderly care and dementia, and safeguarding in institutions including care homes.

4.3.5 Assurance of CCGs: safeguarding role

NHS England has a statutory requirement to oversee assurance of CCGs in their commissioning role. This is done through the application of the CCG Assurance Framework.

This involves formal assurance reviews carried out quarterly in line with the published framework and technical guidance, which includes a number of domains of assurance and a delivery dashboard of indicators that reflect the planning guidance requirements[47]. Safeguarding is a fundamental element of commissioning plans as set out in the planning guidance [48] and, therefore, is an area that forms a core part of the commissioning assurance process.

NHS England in conjunction with CCGs also needs to consider where there are risks and gaps in services to develop an action plan to mitigate against the risk.

4.3.6 Local authority commissioners

The commissioning of public health services for children is undertaken by local authorities and includes sexual health services, school nursing services, and, from October 2015, health visiting and family nurse partnership services. These health services have an integral role in safeguarding children and young people which should be clearly reflected within the relevant service specifications.

As commissioners of these health services, local authorities should liaise with the relevant Designated Professional as part of their assurance process to ensure that effective safeguarding arrangements are in place within these services to safeguard children and young people.

As with all organisations which are subject to the Children Act 2004 section 11 duty, local authorities are responsible for ensuring that their staff receive appropriate supervision and support, including undertaking safeguarding training. This applies to professionals delivering public health services commissioned by local authorities.

4.4 Other national organisations

4.4.1 Department of Health (DH)

The Department of Health (DH) provides strategic leadership for public health, the NHS and social care in England. It sets the strategic direction for the NHS, based on outcomes, and will hold it to account for achievements. DH assesses NHS England's performance against the mandate including the specific safeguarding elements. It also ensures that all parts of the health and care system work in partnership and collaboratively and convenes a number of national groups to support this.

[47] http://www.england.nhs.uk/ourwork/sop/
[48] http://www.england.nhs.uk/wp-content/uploads/2014/12/plan-guid-nhse-annx-231214.pdf

DH convenes two specific safeguarding stakeholder groups, one for children and one for adults. Membership of these groups includes representatives from across government departments, regulators and Arm Length Bodies. Both of these groups set out safeguarding policy, hold partners to account for implementing that policy and address specific national concerns.

4.4.2 Public Health England (PHE)

Public Health England (PHE) has a range of public health responsibilities to protect and improve the health and wellbeing of the population and to reduce health inequalities in health and wellbeing outcomes. PHE specific safeguarding duties in relation to the front-line delivery of services to individuals and families relate to its delivery of health protection services. PHE has a named doctor and nurse for safeguarding. Front-line services for the health protection function are delivered through nine PHE centres. PHE work with local arrangements for safeguarding, liaising with NHS England to access local expertise and advice.

Local Authorities (LAs) are held to account for the public health duties that are transferred to them, through local management structures and LSCBs/SABs in the usual way. They are able to access specialist support and advice via the CCG safeguarding team or the Safeguarding Forum.

PHE is responsible for supporting the on-going development of the public health workforce in LAs to inform commissioning of early years services and the on-going support and development of the children's public health nursing workforce – including school nursing, health visiting and family nurse partnerships.

4.4.3 Health Education England (HEE)

HEE supports the delivery of excellent healthcare and health improvement to the patients and public of England by ensuring that the workforce has the right numbers, skills, values and behaviours, at the right time and in the right place. HEE has a mandate commitment to ensure that the principles of safeguarding are integral to education and training curricula for health professionals. This primarily focuses on influencing the pre-registration training provided for health professionals and ensuring safeguarding is embedded into these programmes. HEE provider-led Local Education and Training Boards (LETBs) are responsible for local health workforce development and education commissioning in their areas. These boards are responsible for developing their own training priorities to meet locally identified needs including safeguarding as appropriate. Commissioned training should be in accordance with the intercollegiate guidance and LSCB/SAB requirements.

HEE supports NHS England to deliver their mandate through strategic leadership of education and training and workforce intelligence. Similarly NHS England works collaboratively with HEE to fulfil their commitment by providing support and specialist safeguarding advice as required. HEE maintains an e-learning platform within which safeguarding is embedded as appropriate and HEE ensures that this is kept up to date and is easily accessible across health.

4.5 Regulators

Regulation is an important element of the assurance and accountability arrangements in place across the health system. A number of organisations are involved and their roles and remit are set out in brief below. Regulators are in place and work at an individual and organisational level as well as looking across local safeguarding systems and assessing their effectiveness. Reports from regulators, as the independent watchdogs, provide an important source of intelligence which is used alongside other internal information by NHS England in providing assurance (see Appendix II) on the effectiveness of safeguarding arrangements in local health systems.

4.5.1 Care Quality Commission (CQC)

The Care Quality Commission (CQC) regulates and inspects health and social care services in England to make sure they meet fundamental standards of quality and safety. The CQC publishes reports on what they find including performance ratings to help people choose care.

The CQC role is to make sure that hospitals, care homes, dental and general practices and other care services in England provide people with safe, effective and high quality care, and to encourage them to improve. It carries out this role through:

- Checks it carries out during the registration process that all new care services must complete.

- Inspections.

- Monitoring a range of data sources that can indicate problems with services.

The CQC has appointed Chief Inspectors for hospitals, adult social care and primary and integrated care. CQC inspection teams include inspectors that specialise in particular areas of care and lead teams that include clinical and other experts and experts by experience (people with experience of care). CQC uses information and evidence in a focused and open way, including listening to people's views and experiences of care in order to predict, identify and respond quickly to services that are failing, or likely to fail.

Part of the CQC remit is protecting the interests of people whose rights have been restricted under the MCA. The inspection of the proper use of Deprivation of Liberty Safeguards and the MCA are given a high prominence.

CQC has powers to review how health services keep children safe and contribute to promoting the health and wellbeing of looked after children and care leavers. This evaluates the quality and effectiveness of local health arrangements provided within local authority areas. CQC also carries out thematic reviews which focus on specific aspects of care, for example a thematic review of the experience of children with complex physical health needs in transition to adult services was published in 2014.

4.5.2 Office for Standards in Education, Children's Services and Skills (Ofsted)

Ofsted inspects and regulates services which care for children and young people, and those providing education and skills for learners of all ages. Specialist inspectors carry out inspections across a range of services including children homes, nurseries, schools, colleges, and local authorities. Safeguarding forms a core part of the Ofsted inspection framework and they draw together a range of evidence and other information to make their professional judgements which they publish in inspection reports.

Whilst many services inspected by Ofsted are not strictly within the health sector there are many areas of overlap, for example where health professionals work locally with children services. In addition, as part of their inspections of local authority services for children in need of help and protection, children looked after and care leavers, Ofsted may also undertake a review of the effectiveness of the LSCB at the same time. This looks at whether the LSCB is complying with its statutory responsibilities including the co-ordination of the work of statutory partners which for health are CCGs, health trusts and NHS England.

4.5.3 Monitor

Monitor ensures that the boards of NHS foundation trusts are well-led and financially sustainable, in line with their duty to be effective, efficient and economic[49]. In addition, it assesses the remaining NHS Trusts applications for foundation trust status. As the sector regulator, Monitor manages key aspects of healthcare regulation, including regulating prices, enabling services to be provided in an integrated way, safeguarding, choice and competition and supporting commissioners so that they can ensure essential health services continue to run if a provider gets into financial difficulties.

In 2013, Monitor introduced the NHS provider licence for NHS foundation trusts, extending this to other eligible providers of NHS-funded care in 2014. The licence sets out a range of conditions that providers must meet.

The provider licence requires NHS foundation trusts to:

"Establish and effectively implement systems and/or processes… to ensure compliance with healthcare standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board[50] and statutory regulators of healthcare professions."

This includes the essential standard on safeguarding monitored by CQC. Where foundation trusts are not compliant with this standard, Monitor may investigate, and could find the foundation trust in breach of its licence and take enforcement action.

[49] Section 63 NHS Act 2006.
[50] NHS Commissioning Board is the legal name for NHS England.

4.5.4 NHS Trust Development Authority (NHS TDA)

The role of the NHS Trust Development Authority (NHS TDA) is to provide oversight and performance management of NHS Trusts in England, all of which have a duty to be effective, efficient and economic[51]. This involves a central focus on quality, including the expectation that trusts will have proper systems in place for child and adult safeguarding. The NHS TDA also has responsibility for the appointment of Board positions and the approval of foundation trust applications moving to Monitor.

In this context, the NHS TDA plays a significant role in the assurance and support system for all non-foundation trusts, working closely with commissioners and regulators via mechanisms such as QSGs and risk summits which involve safeguarding.

4.5.5 Professional regulators[52]

Health and social care professionals who work in the UK must be registered with one of 12 professional regulatory bodies. These organisations regulate individual professionals across the UK. In order to practice health and social care, professionals must be registered with the relevant regulator and demonstrate that they have the right skills and meet the standards given in the code of conduct or code of practice for their profession. Each regulator maintains a public register of those professionals who have demonstrated that they have met the standards set. These organisations investigate complaints and can take action to stop a professional working in all or part of the UK where there are serious concerns about a professional's ability to provide safe treatment or care.

4.5.6 Quality Surveillance Groups

The Quality Surveillance Groups (QSGs) support the discharge of local accountabilities for quality and for sharing non-personal information and intelligence in order to improve quality and safety. The key strength of the QSGs is that they draw together organisations with commissioning and regulatory roles to share their respective information and intelligence. Whilst they do not have any formal powers, members of the QSG can take action in line with their existing responsibilities. Published guidance[53,54] sets out in more detail how the groups operate including the QSG role for safeguarding and their links to other safeguarding bodies.

[51] Section 26 NHS Act 2006.
[52] http://www.gmc-uk.org/Who_regulates_health_and_social_care_professionals___English_1112.pdf_50487974.PDF
[53] How to establish a quality surveillance group http://www.dh.gov.uk/health/2013/01/establish-qsg
[54] How to make your quality surveillance group effective http://www.england.nhs.uk/wp-content/uploads/2014/03/quality-surv-grp-effective.pdf

Most notably:

- QSGs should routinely consider whether information and/or intelligence shared at the QSG may be relevant to the roles and functions of Safeguarding Boards, Health and Wellbeing Boards and Local Authority Overview and Scrutiny Committees. Where necessary, QSGs need to make sure that they have mechanisms in place to share any such information and intelligence.

- It is expected, however, that each QSG member would recognise their own responsibility for making referrals into either the safeguarding adults or safeguarding children process in their local area to ensure the protection of a child or adult at risk.

4.5.7 Safeguarding networks

CCGs and NHS England need to provide appropriate support and advice to the Designated and Specialist Professionals and to be able to access the widest possible expertise to support improving safeguarding practice across the NHS system. In order to support this, NHS England has established local safeguarding networks and forums. The role of these safeguarding networks includes:

- Underpinning system accountability through peer review-based assurance and other sources of intelligence to identify local improvement priorities.

- Identifying and sharing best practice across the local health system.

- Leading and driving improvement in safeguarding practice across the local NHS system, working closely with the LSCB/SAB as appropriate.

- Considering in detail the health implications and learning from inspection and local incidents including serious case reviews, safeguarding adult reviews, individual management reviews, domestic homicide reviews and developing local action plans as appropriate.

- Ensuring the commissioning of appropriate education and development for Designated and Specialist Professionals, through engagement with the Local Education and Training Boards.

- Maintaining an up-to-date business / operations risk register and an appropriate escalation mechanism.

- Contributing to and overseeing Section 11 and SAAT audits on behalf of the local system.

4.5.8 Multi-agency Boards – Local Authority led

At a local level there are the multi-agency boards set out by statute including LSCBs and SABs whose roles are described in sections 3.1.1 and 3.1.4. There are also Health and Wellbeing Boards which have overall strategic responsibility for assessing local health and wellbeing needs in the joint strategic needs assessment (JSNA) and agreeing joint health and wellbeing strategies for each local authority area. They play

a vital role locally in identifying and ensuring that the needs of children and adults at risk of abuse or neglect are identified and addressed. The JSNA supports the commissioning of services so that effective coordinated help can be provided to those at risk and their families.

The exact relationship between LSCBs/SABs and Health and Wellbeing Boards is for local determination. However, it is important that the boards are complementary. The LSCB/SAB should not be subordinate to, or subsumed within, local structures that might compromise its separate identity and voice. NHS commissioners and providers are responsible for understanding these arrangements and ensuring that they are fully engaged and working effectively to support them.

5 Conclusion

The safeguarding of all those who are vulnerable is an enormous obligation for all of us who work in the NHS and partner agencies. Safeguarding children and adults at risk of abuse or neglect is complex, frequently under review and we must all take responsibility to ensure that it works effectively.

Safeguarding is everyone's responsibility. Fundamentally it remains the responsibility of every NHS organisation and each individual healthcare professional working in the NHS to ensure that the principles and duties of safeguarding adults and children are holistically, consistently and conscientiously applied with the needs of adults at risk of abuse or neglect at the heart of all that we do.

Partnership working is also key and it is vital that local practitioners continue to develop relationships and work closely with colleagues across their local safeguarding system to develop ways of working that are collaborative, encourage constructive challenge and enable learning in a sustainable and joined-up way.

NHS England will continue to seek assurance that the safeguarding arrangements across the health system are effective.

6 APPENDIX 1

Healthcare commissioners must have:
Designated Professional (DP) for safeguarding children and a safeguarding adults lead and lead for MCA - or arrangements to access advice from DP to support commissioning activity
Executive lead for safeguarding, effective policies and procedures, safer recruitment, training, supervision and reporting arrangements for safeguarding adults and children that link to local procedures for the LSCB/SAB
Arrangements to ensure services they commission are safe for children and adults at risk of abuse or neglect
Arrangements to ensure the health commissioning system as a whole is working effectively - disseminating policy and escalating key issues and risks

Primary care commissioners are required to:
Ensure Named GP/ Named Professional capacity is secured to support primary care services in discharging their safeguarding duties
Ensure arrangements are in place for training primary care professionals

Healthcare service providers must have:
Named doctor, named nurse and named midwife* or other named professional for safeguarding children
Named lead for safeguarding adults, MCA and Prevent
GP practices must have a named lead for safeguarding and MCA
Executive lead for safeguarding, effective policies and procedures, safer recruitment, training, supervision and reporting arrangements for safeguarding adults and children that link to local procedures for the LSCB/SAB
*** If maternity services are provided**

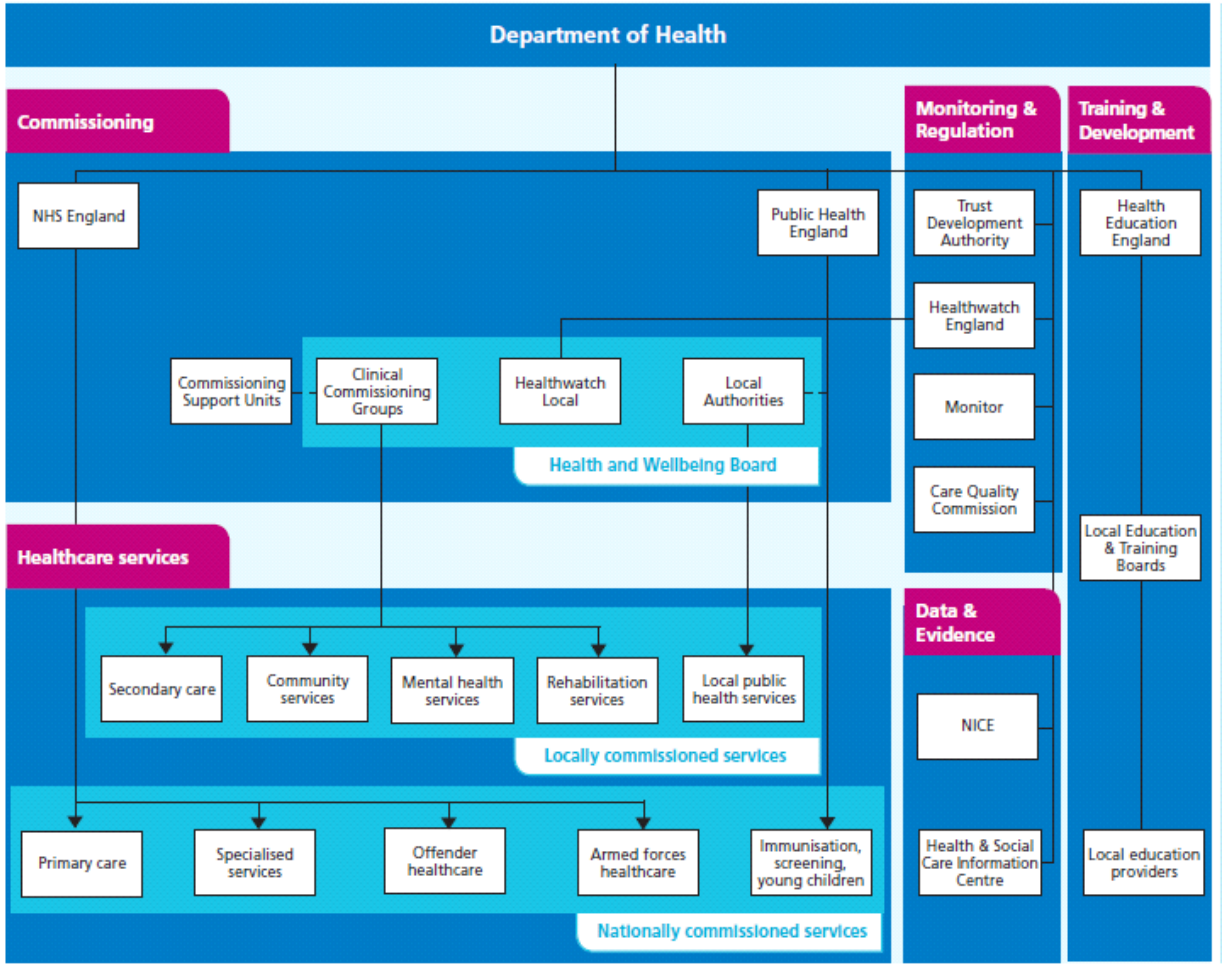


Figure 1: Summary of safeguarding duties

7 APPENDIX 2

7.1 How NHS England maintains oversight of safeguarding

NHS England's role in terms of safeguarding is discharged through the Chief Nursing Officer (CNO) who has a national safeguarding leadership role. The CNO is the Lead Board Director for Safeguarding and has a number of forums through which to gain assurance and oversight, particularly through the NHS England National Safeguarding Steering Group (NSSG). These groups and the governance arrangements are set out in figure 2 below.

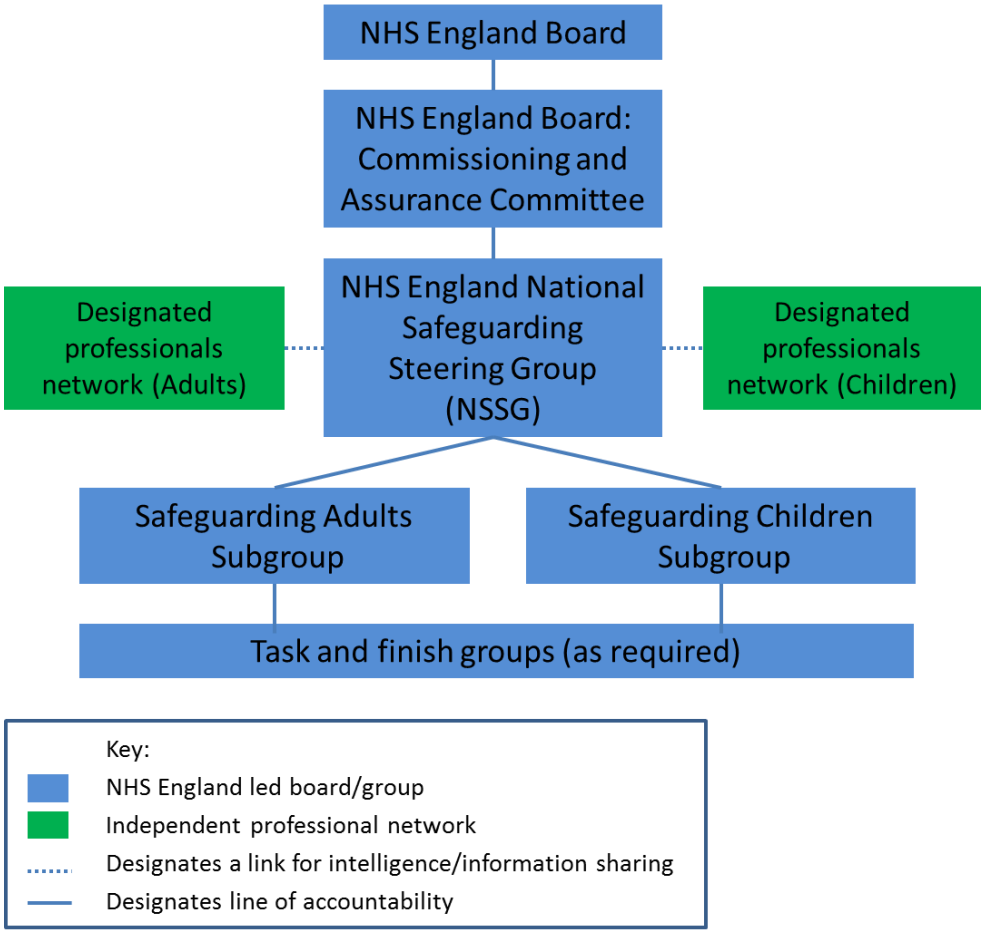


Figure 2: the Boards and Sub-groups for safeguarding

7.2 The NHS National Safeguarding Steering Group (NSSG)

The role of the NSSG is set out below. It discharges this through a range of temporary and permanent subgroups which focus on key issues using a risk-based approach. Membership of the NSSG includes representation from CCGs, provider trusts, and Designated/Named Professionals. The NSSG oversees and seeks assurance that agreed objectives and programmes of work are being met:

- Providing national leadership, support and advice in the delivery of the Accountability and Assurance Framework and continuing to revisit and challenge the safeguarding arrangements in place across the NHS system.

- Leading responsibility for policy on safeguarding and for overall assurance of the NHS safeguarding system including ensuring learning from, and taking action in response to, significant incidents.

- Adopting a shared learning approach, creating a repository for national best practice to be shared, and overseeing the delivery of the safeguarding leadership programmes.

- Providing national leadership, support and advice in the delivery of relevant recommendations from any national inquiries, investigations and reports.

- Ensuring that robust processes are in place to learn lessons from cases where children or adults die or are seriously harmed and abuse or neglect is suspected.

- Ensuring effective implementation across the NHS of national legislation and policies relating children and adults at risk of abuse or neglect.

- Identifying and taking forward action to respond to key priorities in relation to safeguarding adults and children, including but not limited to, preventing CSE (Child Sexual Exploitation), FGM (Female Genital Mutilation), Looked after Children, sexual violence domestic abuse and radicalisation (Prevent).

7.3 NHS England regions

Each NHS England region has a Regional Chief Nurse and a number of Directors of Nursing who have the leadership and governance role for safeguarding locally; setting direction, ensuring compliance with standards, policies and procedures, monitoring progress and managing risks. They involve, and work collaboratively with, other NHS England regional staff as required including commissioners, medical directors and those with a role in assuring the local system. The following section describes the roles and responsibilities for safeguarding at the regional level; however, it is for local discretion as to how these are actually discharged to suit local circumstances. Ultimately the Regional Chief Nurse is responsible for developing and implementing a local model that discharges all of the roles and responsibilities set out below:

- Providing assurance, via the National Safeguarding Steering Group (NSSG), to the NHS England Board on the effectiveness and quality of the safeguarding arrangements across the regional health system and determining whether these are meeting statutory duties.

- Disseminating national policy across the system.

- Escalating significant issues which may have system-wide relevance and/or require a national resolution to the National Safeguarding Steering Group

(NSSG). This includes any significant issues from serious case reviews, safeguarding adult reviews, domestic homicide reviews and other statutory processes.

- Convening a safeguarding network on a regular basis and ensuring significant issues which may have system-wide relevance are escalated, as appropriate, to quality surveillance groups and to the National Safeguarding Steering Group (NSSG).

- Ensuring effective arrangements are in place across the local NHS system in order to discharge safeguarding duties including information sharing, sharing best practice and embedding learning from incidents, as well as leading and defining improvement in safeguarding practice at a local level.

- Leading on delivering elements of the national safeguarding programme on behalf of the NSSG as appropriate.

- Ensuring effective systems are in place for responding to incidents of abuse and neglect of adults and children, making sure that when NHS England receives notification, a timely referral is made into either the local safeguarding adults or safeguarding children processes.

- Ensuring appropriate representation at LSCBs and SABs in the local area. This is for local determination using a risk-based approach. In agreeing local attendance arrangements the Regional Chief Nurse (or their nominee) will work closely with the LSCB/SAB chairs, CCGs and Designated Professionals to ensure any issues about the health system can be escalated. NHS England will only attend where there are specific concerns that require NHS England oversight or action, for example where an improvement board is in place. At other times NHS England will be represented by the Designated Professional or other agreed local representative with clear communication routes back to NHS England established.

- Ensuring NHS England staff are appropriately trained, supervised and competent to carry out their responsibilities for safeguarding.

- Ensuring safeguarding expertise is provided to support CCG assurance processes.

- Ensuring the provision of specialist safeguarding advice to NHS England commissioners, working with Designated Professionals as appropriate, to support them in commissioning services and monitoring contractors' performance, and to ensure compliance with safeguarding duties and the MCA. Where services are co-commissioned, arrangements must be agreed with the CCG as appropriate.

- Contributing safeguarding expertise to those maintaining the performers list and advising on any performance management concerns related to safeguarding.

- Working in partnership with the Local Education and Training Board (LETB) to highlight any safeguarding training needs and developing ways forward to meet these needs.

7.4 Safeguarding – Annual Assurance

The CNO is responsible for providing overall assurance to the NHS England Board on the effectiveness and quality of the safeguarding arrangements. Assurance is secured through an annual review process, the mechanism for achieving this is for local determination but the minimum requirements are set out below.

On an annual basis each Regional Chief Nurse will produce a report which provides assurance for their region across the following areas:

- The health commissioning system is working effectively to safeguard children and adults at risk of abuse or neglect.

- NHS England is meeting its specific safeguarding duties in relation to the services that it directly commissions.

- Robust processes are in place to learn lessons from cases where children or adults die or are seriously harmed and abuse or neglect is suspected.

- NHS England is appropriately engaged in the Local Safeguarding Boards and any local arrangements for safeguarding both adults and children, including effective mechanisms for LSCBs, SABs and Health and Wellbeing Boards to raise concerns about the engagement and leadership of the local NHS.

This report draws upon and critically assesses a range of intelligence and information from local sources including:

- Provider key performance indicators identified in the markers of good practice, section 11 audits and safeguarding adults assurance framework.

- Inspection findings.

- Statutory reviews that have taken place, including their findings and action plans.

- Regulation 28 reports[55].

- Intelligence from CCG and direct commissioning assurance processes.

- Views of Designated Professionals.

- Feedback from LSCB/SAB chairs.

[55] Paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and regulation 28 of the Coroners (Investigations) Regulations 2013, also known as reports to prevent future deaths or “PFD”.

- Contract monitoring processes.

- Complaints.

On an annual basis, the Head of Safeguarding, working closely with Regional Chief Nurses, will draw together an annual safeguarding assurance report which is reviewed and signed off by the National Safeguarding Steering Group. Any key findings are reported by exception to the NHS England Board Commissioning and Assurance Committee. The report has the dual purpose of providing assurance as well as enabling any themes, common issues, emerging trends and system-wide learning to be identified from across the health system.

Any issues identified through this process where a coordinated and/or system-wide response is needed, will be captured and monitored through the NSSG work programme and risk register. Where necessary, risks will be escalated via the governance route as set out in figure 2. Localised improvements are managed through local arrangements and infrastructure as appropriate.

North Yorkshire & Humber Emergency Preparedness Resilience and Response (EPRR) Assurance 2015-16

STATEMENT OF COMPLIANCE

Harrogate & District NHS Foundation Trust has undertaken a self-assessment against required areas of the NHS England Core Standards for EPRR v3.0.

Following assessment, the organisation has been self-assessed as demonstrating Full compliance level (from the four options in the table below) against the core standards.

Compliance Level	Evaluation and Testing Conclusion
Full	The plans and work programme in place appropriately address all the core standards that the organisation is expected to achieve.
Substantial	The plans and work programme in place do not appropriately address one or more the core standard themes, resulting in the organisation being exposed to unnecessary risk.
Partial	The plans and work programme in place do not adequately address multiple core standard themes; resulting in the organisational exposure to a high level of risk.
Non-compliant	The plans and work programme in place do not appropriately address several core standard themes leaving the organisation open to significant error in response and /or an unacceptably high level of risk.

Where areas require further action, this is detailed in the attached core standards improvement plan and will be reviewed in line with the Organisation's EPRR governance arrangements.

I confirm that the above level of compliance with the core standards has been or will be confirmed to the organisation's board / governing body.

Signed by the organisation's Accountable Emergency Officer

23/09/2015	15/09/2015
Date of board / governing body meeting	Date signed

Harrogate and District NHS
NHS Foundation Trust

Report to the Trust Board of Directors: 23 September 2015	**Paper No: 7.3**

Title	6 monthly report on progress against the recommendations of NCEPOD reports.
Sponsoring Director	Dr David Scullion
Author(s)	Mr David Lavalette
Report Purpose	To provide assurance to the Board of Directors

Key Issues for Board Focus:
The purpose of National Confidential Enquiries into Patient Outcome and Death (NCEPOD) is to assist in maintaining and improving standards of medical and surgical care.

This report clarifies the current studies and reports, includes the action plans that are currently being progressed to meet gaps in practice at HDFT based on NCEPOD recommendations. The involvement of the directorates and ownership of the gap analyses and action plans has been a concern for some reports in the past.

Related Trust Objectives	
1. Driving up quality	Yes
2. Working with partners	N/A
3. Integrating care	N/A
4. Growing our business	N/A

Risk and Assurance	This paper relates to the risks associated with failure to implement the recommendations of National Confidential Enquiries, and the associated assurance processes in place.
Legal implications/ Regulatory Requirements	Detail of participation in National Confidential Enquiries is required in Quality Accounts.

Action Required by the Board of Directors
To comment on the content of this report.

1. INTRODUCTION

The purpose of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) is to assist in maintaining and improving standards of medical and surgical care for the benefit of the public by reviewing the management of patients, by undertaking confidential surveys and research, and by maintaining and improving the quality of patient care and by publishing and generally making available the results of such activities. NCEPOD is independent of the Department of Health and the professional associations.

Each year, NCEPOD invites organisations or individuals to submit original study proposals for consideration as possible forthcoming studies. Proposals should be relevant to the current clinical environment and have the potential to contribute original work to the subject.

Once a topic has been identified an expert group will identify study themes and determine what questions need to be asked to develop clinical and organisational questionnaires. These are then sent to the NCEPOD local reporter to distribute to the clinicians.

NCEPOD local reporters act as a link between the non-clinical staff at NCEPOD and individual hospitals. The role includes compiling and sending datasets requested by NCEPOD and acting as a named contact for information sent by NCEPOD. The HDFT local reporter is Michael England, Governance Officer.

NCEPOD ambassadors support both NCEPOD local reporters and their fellow clinicians, working alongside NCEPOD. The HDFT Ambassador is Mr David Lavalette, Consultant Orthopaedic Surgeon.

In November 2014 NCEPOD were awarded the contract by HQIP to undertake the Child Health Clinical Outcome Review Programme (previously run as a part of Centre for Maternal and Child Enquiries (CMACE) and then more recently Royal College of Paediatrics and Child Health (RCPCH)). As a result NCEPOD will be undertaking an additional two studies over the three year contract which will focus on children and young people with complex neuro-disability and adolescent mental health. It is also anticipated that these studies will involve NCEPOD branching out into primary care and social care.

This report outlines Harrogate and District NHS Foundation Trust's response to studies and recommendations from NCEPOD. The reports and studies covered by this report are:

- Emergency & Elective Surgery in the Elderly Report: An age old problem
- Tracheostomy care: On the right trach?
- Alcohol related liver disease study: Measuring the Units
- Subarachnoid haemorrhage: Managing the flow
- Lower Limb Amputation: Working Together
- Gastrointestinal Haemorrhage: Time to get control
- Sepsis Study
- Acute Pancreatitis Study
- Provision of Mental Health Care in Acute Hospitals Study

2. HDFT GOVERNANCE ARRANGEMENTS

On the launch of a new study a study pack is sent to the local reporter. A case identification exercise is then undertaken. This is followed by clinical questionnaires which are sent to the clinicians responsible for a randomly selected number of patients care. Photocopied case-note extracts are also requested for a case note review. Administrative support is provided by the Directorate where needed. The local reporter is then sent an organisational questionnaire to complete with the help of relevant staff in order to obtain data on the provision of services in place at the Trust. The process is fully supported by the NCEPOD Ambassador. The Standards Policy describes the method for quality assuring the submission of organisational questionnaires to NCEPOD.

Previously Standards Group received reports following publication, and ensured a gap analysis of recommendations was defined and progress with action plans monitored. Following the review of the Trusts quality governance arrangements, receipt of a new report following publication is recorded on the standards log by the Deputy Director of Governance. Together with the NCEPOD Ambassador, an appropriate clinician is identified to review the report and lead the local work to respond to the recommendations.

Where possible, an appropriate working group or directorate board within the governance framework is identified to support the lead clinician. There is an expectation that these groups will ensure the recommendations are discussed in the appropriate fora in the Trust and that the lead clinician prepares a gap analysis to establish the Trust's position in relation to the recommendations, and an action plan to address any gaps in local performance compared to the recommendations. The lead clinician supported by the relevant directorate or working group is then required to progress the action plan. In the event of it proving impossible to action recommendations, the associated risks would be expected to be added to the appropriate risk register, and closed on the action plan.

A steering group or directorate board will also be identified to monitor progress.

NCEPOD reports are available on the intranet so that all staff can access them electronically.

3. REPORT METHODOLOGY

The preparation of this report has involved reviewing the standards log, with updates provided by the NCEPOD Local Reporter to confirm that the relevant organisational and clinical data has been prepared, reviewed and submitted.

Updates have also been requested from the appropriate groups and clinical leads regarding the preparation, review and progress of gap analyses and action plans for all relevant reports during the time period March 2015 – September 2015. The results of the latest gap analyses and action plans received for reports during this period are included to indicate where there is assurance of compliance, or progress towards compliance with recommendations, and where there are gaps in assurance.

NCEPOD STUDY AND REPORT SUMMARY

Study Name	Study pack received	Organisational data submission date	Organisational data validated by	Report published	Lead	Directorate	Working group	Monitoring group	Progress
Emergency & Elective Surgery in the Elderly Report: An age old problem	Sep-2010		AHL & RH	Nov-10	B Barron	Cross directorate	EC Board	IPSSG	Actions ongoing. Some update received
Tracheostomy care: On the right trach?	Nov-2012	Jan-13	AHL & RH	Jun-14	Dr C Sri-Chandana	EC			Action plan closed.
Alcohol related liver disease study: Measuring the Units	Dec-2012	Dec-12	AHL & RH	Jun-13	Dr G Sivaji	IC		IC Board	Actions ongoing. No update received
Subarachnoid haemorrhage: Managing the flow	Mar-2013	Mar-13	AHL & RH	Nov-13	Dr J Smith	Cross directorate		IPSSG	Actions ongoing. Updated action plan received
Lower Limb Amputation: Working Together	Mar-2013	Oct-13	RH & SW	Nov-14	L Hall	EC			Actions being progressed with York Teaching Hospital NHS Foundation Trust. Update received
Gastrointestinal Haemorrhage: Time to get control	Feb-2014	May- 14	RH/SW	June-15	Dr G Davies	IC	IC Board	IPSSG	Report being reviewed. No gap analysis or action plan received
Sepsis Study	Feb-2014	Nov- 14	RH/SW	Not yet published					All clinical and organisational data submitted The report is expected to be published in November 2015.
Acute Pancreatitis Study	Dec-2014	Sept- 15	RH/SW	Not yet published					All clinical and organisational data submitted
Provision of Mental Health Care in Acute Hospitals Study	June 2015	Not yet received		Not yet published					The Trust submitted in July 2015 a patient identifier spreadsheet following a data collection exercise for admitted adult patients coded for a diagnosis of specific mental health condition and/or patients detained under the mental health act and/or referred to psychiatric liaison. Organisational and clinical questionnaires to follow.

3.1. Current reports

3.1.1. Elective & Emergency Surgery in the Elderly: An Age Old Problem (2010): Update

This NCEPOD report highlights the process of care of elderly patients who died within 30 days of emergency or elective surgery. The report takes a critical look at areas where the care of patients might have been improved, from lack of input from Medicine for the Care of Older People to the level of pain relief provided. Remediable factors have also been identified in the clinical and the organisational care of these patients.

This report follows on from the NCEPOD Report Extremes of Age (1999) and reviews the care received by elderly patients undergoing surgery. The report makes a number of recommendations which are relevant to HDFT, falling into seven categories. Several of the recommendations cross cut with work streams relating to the National Falls and Bone health report.

At the last Standards Group meeting in May 2015 it was noted that a number of the outstanding actions relating to the elderly care physician pathway crossed over with the remaining actions from the National Emergency Laparotomy Audit action plan. It was agreed that this would be followed up with the Integrated Care Directorate.

A business plan is in development for a 2nd Surgical Geriatrician which is anticipated to enable the Trust to meet a number of the outstanding recommendations however there is still an outstanding action around the audits of delays to surgery.

The Improving Patient Safety Steering Group is required to monitor progress with the action plan and this is included in the forward plan. An update was requested in September but not received. This will be followed up in October 2015. The latest action plan is at appendix 1.

3.1.2. Tracheostomy Care: On the right trach? (2014)

This NCEPOD report highlights the process of care for patients who undergo a tracheostomy or a laryngectomy. The report takes a critical look at areas where the care of patients might have been improved. Remediable factors have also been identified in the clinical and the organisational care of these patients.

This report was published in June 2014 and received at Standards Group in July 2014. A lead was appointed and a gap analysis was undertaken and received by the group in October 2014 where it was agreed that the action plan would be progressed by the Critical Care Delivery Group.

A review of progress was received by Standards Group in May 2015 where it was noted that the remaining actions related to ongoing monitoring of staff training. It was agreed that this action plan could be closed on the standards database, but it was expected that tracheostomy training would be made essential training for staff in areas managing patients with tracheostomies (i.e. ITU/HDU, Lascelles Unit, Oakdale and Granby Wards). Progress would continue to be monitored by the Critical Care Delivery Group who would be provided with a quarterly training report by Workforce Development. Any concerns would then be escalated to the Elective Care Directorate Governance Group. The last action plan is at appendix 2.

3.1.3. Alcohol Related Liver Disease: Measuring the Units (2013)

This NCEPOD report highlights the process of care for patients who are treated for alcohol-related liver disease and the degree to which their mortality is amenable to health care intervention. The report takes a critical look at areas where the care of patients might have been improved. Remediable factors have also been identified in the clinical and the organisational care of these patients.

This report was published in June 2013 and received at Standards Group in July 2013. A gap analysis was received in February 2014, and the subsequent action plan reviewed at Standards Group in August 2014 and March 2015.

Although initially there were ongoing issues of engagement and ownership of this action plan it was agreed that the remaining actions from the *NHS Atlas Variation in Healthcare for People with Liver Disease* action plan should be amalgamated with the recommendations from the NCEPOD report and progressed as a composite action plan.

The majority of the remaining actions relate to the development of protocols by the Gastroenterology Team in conjunction with the Acute Care Physicians for the assessment, investigation and treatment of patients with alcohol related liver disease. An update to the action plan was requested at Standards Group in April and May 2015 but not received.

The Integrated Care Directorate Governance Group was identified to monitor progress, however no update has been received since it was last received by the Board in March 2015. The latest action plan is at appendix 3.

3.1.4. Subarachnoid Haemorrhage: Managing the flow (2013)

This NCEPOD report highlights the process of care for patients who are admitted with aneurysmal subarachnoid haemorrhage, looking both at patients that underwent an interventional procedure and those managed conservatively. The report takes a critical look at areas where the care of patients might have been improved. Remediable factors have also been identified in the clinical and the organisational care of these patients.

This report was published in November 2013 and was discussed at Standards Group in December 2013. A clinical lead was appointed and a gap analysis was received in April 2014. The action plan was reviewed in September 2014, January and March 2015.

Progress of actions was dependent upon a coordinated regional response which was being lead by Leeds General Infirmary. In January 2015 Standards Group were informed that the Yorkshire Regional Subarachnoid Haemorrhage Network had been established and progress was being made.

The Improving Patient Safety Steering Group is required to monitor progress with the action plan and this is included in the forward plan. An update was requested in September but deferred to October 2015. An updated action plan has been received and is at appendix 4.

3.1.5. Lower Limb amputation: Working together

This NCEPOD report highlights the process of care for patients aged 16 and over who undergo lower limb amputation. The report takes a critical look at areas where the care of patients might have been improved. Remediable factors have also been identified in the clinical and the organisational care of these patients.

This report was published in November 2014 and was discussed at Standards Group in December 2014 before being reviewed by the NCEPOD Ambassador to establish an appropriate lead.

As the vascular service is provided in an alliance with York Teaching Hospital NHS Foundation Trust an assessment of compliance was undertaken by the Lead Clinician for Vascular Surgery at York to include all Trusts involved in the network. An action plan has not been provided.

In response to the NCEPOD report and in line with the recommendations of the Vascular Society, a dedicated multidisciplinary clinic has been established which will include input from the Vascular Service, Endocrinologists, Trauma and Orthopaedic colleagues and other allied health professionals in order to ensure appropriate input from a multi professional team at the earliest opportunity for the patient. This is in additional to the current alliances services provided and will commence from 2nd November 2015 at HDFT for Harrogate patients. The establishment of this clinic represents an important improvement in the pathway of care for this group of patients.

3.1.6. Gastrointestinal Haemorrhage: Time to get control.

This NCEPOD report highlights the process of care for patients aged 16 years or older that were coded for a diagnosis of GI haemorrhage. The report takes a critical look at areas where the care of patients might have been improved. Remediable factors have also been identified in the clinical and the organisational care of these patients.

This report was published in June 2015 and added to the standards log. The report was to be reviewed by the NCEPOD Ambassador, Medical Director and Clinical Lead for Gastroenterology, to identify gaps in compliance against the recommendations from the report which will form an action plan to be progressed by the Integrated Care Directorate. The Improving Patient Safety Steering Group is due to request a gap analysis and action plan in October 2015.

4. CONCLUSIONS

The recommendations from all confidential enquiry reports and gap analyses have been reported annually to the Board of Directors for several years. This report clarifies the current NCEPOD studies and reports, and includes an update regarding the action plans that still need to be progressed to meet gaps in practice at HDFT based on the recommendations.

The involvement of the directorates and ownership of the gap analyses and action plans has been a concern for some reports and this has previously been reported to the Board.

It should be noted that the engagement of colleagues around data collection and submission has improved.

However the decommissioning of Standards Group has added another concern in that the monitoring of progress is now disseminated and requires the various identified groups and directorate boards to prioritise this role.

It is suggested that the role of the relevant directorate board is to ensure that the identified lead is supported to define and progress the required actions, to deliver the recommendations of the NCEPOD report, and that the Improving Patient Safety Steering Group monitors progress with all of the NCEPOD action plans. By having one group with oversight of all of the action plans it is hoped that assurance of progress can be improved.

5. APPENDICES

Appendix 1: Elective & Emergency Surgery in the Elderly: An Age Old Problem (2010): Current action plan

Appendix 2: Tracheostomy Care: On the right Trach? (2013)

Appendix 3: Alcohol Related Liver Disease: Measuring the Units (2013)

Appendix 4: Subarachnoid Haemorrhage: Managing the flow (2014)

5.1. Appendix 1: Elective & Emergency Surgery in the Elderly: An Age Old Problem (2010): Current action plan

NCPOD Action Plans - Care of the Elderly 'An Age Old Problem' and A review of peri-operative care of surgical patiens 'Knowing the risks'

\\ltserver1\elective care\Governance, Complaints and risks\NCPOD\Joint action plan - KTR and CofE

Action Plan	An Age Old Problem
Action Plan Owner	Beth Barron
Monitored by Improving Patient Safety Steering Group	Sep-2015

Action Plan						Progress Monitoring - 6 months - August 2012				
ID number	Issue	Initial Risk (H/M/L)	Action/s	Operational Lead	Target Date	Risk at review(H/M/L)	Progress	Further action/s	Operational Lead	Responsible Lead	Target Date
NCPOD Action Plan - An Age Old Problem											
1	Routine daily input from Medicine for the Care of Older People should be available to elderly patients undergoing surgery and is integral to inpatient care pathways in this population.	H	Proposal to be brought SMT and included in the planning process	Dr Hammond/Mr Conroy/Clinical Lead for Elderly Medicine	Mar-2012	H	• All hip fracture patients receive routine geriatric input. Elective orthopaedic & non-hip trauma patients have geriatric input on request, usually post-op. General surgery, urology & gynaecology don't receive any geriatric input unless a problem has arisen, often at the rehab stage. Funding would be required from Elective Care to Integrated Care for around 2 PA's to provide full surgical cover. • 28/03/14: Not possible to provide 2 PA cover between Elective and Integrated when Rebecca Leigh on annual leave. • 16/01/15: Business plan completed. Put forward as service priority for Elective Care DIrectorate. • 12/03/15: Meeting taken place between ICD & ECD to review the busines case for the additional geriatrician post. Identified that additional input required and business case reworded. Priority for ECD. - 07/05/15 further meetings between Elective and integrated, agreement that 2 PA's from integrated care come back in to elective care.	Based on decision to move two PA's back from integrated care to elective, the business case for additional orthogeriatrician time is to be updated with input from Orthogeriatrician and Orthopaedic Consultant. Remaining funding to be identified from increased achievement of BPT and a reduction in current cost pressure. 10/08/15 Business case updated to include transfer of PA's to Elective care. 2nd Consultanst Surgical geriatrician included in case is an 8 PA post with objectives set in relation to the assessment of elderly patients undergoing surgery. Business case to go through Elective Care board and through performance for reviewc omments and sign off	Beth Barron	J hammond	Oct-15
3	Comorbidity, disability and frailty need to be clearly recognised and seen as independent markers of risk in the elderly. This requires skill and multidisciplinary input including early involvement of Medicine for the Care of Older People	H	Appointment of orthogeriatrician. Ward rounds on all surgical wards by CoE physicians.	Dr Hammond/Mr Conroy/Clinical Lead for Elderly Medicine	Mar-2012	L	• A new full time elderly care physician post has gone out to advert that includes 2 PA's funded via Orthopaedic Best Practice tariff to ensure cover for Rebecca Leigh (orthogeriatrician) when on Annual Leave. • Discussions and agreements to still be had between Elective Care and Integrated care for the provision of Surgio-geriatric provision for a further minimum of 2 PA's to cover 2 ward rounds, MDT (2 wards) and a clinic for pre-operative assessment or follow ups. Further to the 2 PA's need to also look at cover for acute work • 28/03/14: Not possible to provide 2 PA cover between Elective and Integrated when Rebecca Leigh on annual leave. • 16/01/15: Business plan completed. Put forward as service priority for Elective Care DIrectorate. • 12/03/15: Meeting taken place between ICD & ECD to review the busines case for the additional geriatrician post. Identified that additional input required and business case reworded. Priority for ECD. 07/05/15 further meetings between Elective and integrated, agreement that 2 PA's from integrated care come back in to elective care.		Beth Barron	J hammond	Oct-15
6	Senior clinicians in surgery, anaesthesia and medicine need to be involved in the decision to operate on the elderly. Risk assessment must take into account all information strands, including risk factors for acute kidney injury.	H	Regular ward rounds by Care of Elderly Physician are not in place. This will be resolved with appointment of ortho-geriatrician / surgio-geriatrician which has been agreed between Elective and Integrated Care Directorates.	Dr Hammond/Mr Conroy.	Nov-2011	H	• Discussions and agreements to still be had between Elective Care and Integrated care for the provision of Surgio-geriatric provision for a further minimum of 2 PA's to cover 2 ward rounds, MDT (2 wards) and a clinic for pre-operative assessment or follow ups. Further to the 2 PA's need to also look at cover for acute work. • 28/03/14: Not possible to provide 2 PA cover between Elective and Integrated when Rebecca Leigh on annual leave. • 16/01/15: Business plan completed. Put forward as service priority for Elective Care DIrectorate. • 12/03/15: Meeting taken place between ICD & ECD to review the busines case for the additional geriatrician post. Identified that additional input required and business case reworded. Priority for ECD. 07/05/15 further meetings between Elective and integrated, agreement that 2 PA's from integrated care come back in to elective care.		Beth Barron	J hammond	Oct-15
2	All hospitals should address the need for mental capacity to be assessed and documented in the elderly on admission as a minimum standard.	L	Roll out of new forms for documenting capacity and best interests. Best Interest" training to be delivered to surgeons and nursing staff by October 2011	Janet Farnhill	Dec-2011	C	Dec 2011-MCA and best interest forms in use on all wards	No further action	Peter Hammond	Peter Hammond	Completed Dec-12

Action Plan						Progress Monitoring - 6 months - August 2012				
ID number	Issue	Initial Risk (H/M/L)	Action/s	Operational Lead	Target Date	Risk at review(H/M/L)	Progress	Further action/s	Operational Lead	Responsible Lead	Target Date
4	Medicine reviews need to be a regular daily occurrence in the peri-operative period. Input of both Medicine for the Care of Older People (MCOP) clinicians and an experienced ward pharmacist may greatly assist this process.	M	Aide memoire checklist introduced to prompt medical staff to undertake daily medication review on ward round. There is, however, reduced pharmacist input at weekends and on bank holidays. Review in October 2011 checklist efficacy at Surgical Board (three months after its implementation).Review weekend pharmacy provision.	Mr Conroy,Andrew Alldred	Dec-2011	C	Trust implementation of e-Prescribing will prompt daily medicines review. On going audits to be undertaken in surgery around the med chart access. 23/08/14: e-Prescribing now being used across the Trust. Issues identified with IT equipment malfunctioning, being slow to load and availability fo equipment. Ward rounds now also taking longer as a result of e-Prescribing.	Complete rollout of e-Prescribing	Emily Parkes	Andy Alldred	Completed Apr-13
5	Delays in surgery for the elderly are associated with poor outcome. They should be subject to regular and rigorous audit in all surgical specialities, and this should take place alongside identifiable agreed standards.	M	Delays to be monitored and audited for all surgical specialties. Process to commence October 2011.	Audit Leads for Surgical Specialties in Gynaecology, Urology, General Surgery and Orthopaedics.	Mar-2012	L	• Surgical Audit lead to define further audit programme for junior doctor(s) to complete. Audit to identify standards needed and the financial and time implications. • All patient who fail the best practice tariff are discussed at the Hip Fracture Group. - 07/05/15 request to John Simpson audit lead for GS, to alloctae audit with timescale.	Next Hip Fracture Group in August 2015. NEEDS FURTHER UPDATE	FY1/2 TBC	Jonny Hammond, General Manager	Jun-15
7	A fully resourced acute pain service (APS) is essential within the context of modern secondary care services.	M	Review of provision of the APS	Heather Lain / General Manager Elective Care	Mar-2012	M	There is an acute pain service available within the hospital however the ITU nurses and anaesthetic teams cross cover to ensure to minimise impact when the acute pain nurse is on A/L. The acute pain nurse is also providing training in pain management for ward based nursing staff and Critical care delivery group. Buisness case written and put forawrd as a Service Investment. Prioritised as Number 3 for the Elective Care Directorate for 2015/16.	Bunsiess case remains. Further review of role of the acute pain nurse being undertaken in relation to the priorities of the role and whether time can be released. This is being done with support of the Consultant Aneasthtetist lead for acute pain. Also being reviewed is whether the provision of a electronic tablet would improve the efficiency of the service and release time.	Jonny Hammond, Heather Lain, Mark Siminacz	Beth Barron	Oct-15
8	Post operative Acute Kidney Injury (AKI) is avoidable in the elderly and should not occur. There is a need for continuous postgraduate education of physicians, surgeons and anaesthetists around the assessment of risk factors for the development of AKI in the elderly surgical patient.	H	Renal physician to attend Surgical Audit meetings to identify how this can be included in Deanery programme.	Clinical Leads T&O, Urology and General Surgery	Mar-2012	C	Education programme for fluid mnagement has been developed in line with NICE guidance. Patient's now go through Pre-Assesment prior to proceedures to highlight any risks.	No further action	Simon Mawhinney / Karen Barnett	Peter Hammond	Completed Dec-12
9	Greater vigilance is required when elderly patients with non-specific abdominal symptoms and signs (diarrhoea, vomiting, constipation, urinary tract infection) present to the Emergency Department. Such patients should be assessed by a doctor with sufficient experience and training to exclude significant surgical pathology	M	Audit attendance in ED. Review surgical and urology middle grade rotas to assess availability for ED attendance. Review Surgical CAT and middle grades support.	Clinical Leads for ED/Surgery/Urology/DJL/John Smith	Oct-2011	C	A new Surgical Protocol has been developed for CAT to ensure fast response. A new Audit has been undertaken of this process throughout March and a meeting held 15 June to review. Clinical Lead in General Surgery signed up to process and quality indicators. Further audit taken place.	No further action	Simon Mawhinney / Jo Harding	Simon Mawhinne / Jo Harding	Completed Jul-12
10	Clear protocols for the post-operative management of elderly patients undergoing abdominal surgery should be developed which include where appropriate routine review by a MCOP consultant and nutritional assessment.	M	Clear protocols to be developed between surgery and medicine (Elective and Integrated Care Directorates)	General Managers in Elective and Integrated Care	Mar-2012	C	Review of the hip fracture handbook to see if it can be updated to become an acute abdo handbook. Handbook reviewed at Directorate Governance Group for agreement.	No further action	Peter Hammond	Peter Hammond	Completed Sep-12

5.2. Appendix 2: Tracheostomy Care: On the right Trach? (2013)

NCEPOD - On The Right Track Gap Analysis October 2014 - Dr C Sri-Chandana								Action Plan Progress Monitoring - 6 months Complete this for 6 month / end of year review						
ID number	Issue / Audit Finding / Theme	Indicator (if relevant)	Initial Risk (H/M/L)	Action/s	Operational Lead	Responsible Lead	Target Date	ID number	Risk at review (H/M/L or complete)	Progress on actions	Further action/s to ensure completion	Operational Lead (if changed)	Responsible Lead (if changed)	Target Date
1	Tracheostomy insertion should be recorded and coded as an operative procedure.		Low	To discuss accurate capturing of procedures across theatre and critical care with coding	C. Sri-Chandana	C. Sri-Chandana	01/12/2014	1	Complete	Discussion completed and tracheostomy care pathway ciruclated with coding. ITU consultants have been instructed to highlight care pathway in clinical notes to direct coders.				31/01/2015
3	Training programmes in blocked/displaced tubes/airways and difficult tube changes should be delivered in accordance with clinical consensus guidelines as stated by the National Tracheostomy Safety Project and the Intensive Care Society.		Medium	1) Programme of education to be formalised. 2) Particular focus on new staff induction.	R. Tuffin & M. Issott	R. Tuffin	Mar-15	3	Complete	Simulation Training prgramme timetabled: 1st Simulation session in March 2015 and then bimonthly				
5	Core competences for the care of tracheostomy patients, including resuscitation, should be set out by all Trusts using existing national resources available.		Medium	1) All ITU nursing staff to finish Step 1.competencies of the National Competency Framework for Adult Critical Care Nurses	M. Issott	C. Gill	30/03/2015	5.1	Low	Nursing staff now undertking step 1 critical care nursing national competencies. 1st 22 nurses will complete in October 2015 and the remain staff will complete by end of April	On going monitoring to ensure adoption of action acorss all ITU nursig staff			30/04/2016
			Medium	2) Incorporate resuscitation of patients with tracheostomies into ALS/BLS assessments undertaken as part of mandatory training.	N. West	N. West	30/03/2015	5.2	Complete	BLS hand-out modified to include a statement re tracheostomy management. Emergency tracheostomy algorithm added to folder stored on all resuscitation trolleys.				
12	If a cuffed tracheostomy tube is still required for a patient at the time of discharge from critical care, then there must be equipment and competences available on the ward for cuff pressure measurement.		Low	On going nurse education on wards regarding measurement of cuff pressures.	S. Blackburn	C. Gill	30/03/2015	12	Low	Mandatory training for nursing staff approved. Training programme formulated to include 1) completon of on-line package of traing from the National Trachestomy Safety Project 2) Hands on 3 hour senario based training sessions - sessions held quarterly. Next course 22 May 2015	Montioring attendance to ensure nursing staff are released to attend hands on sessions	D Hogg & S Cook	J Foster	31/07/2015
13	All Trusts should have a protocol and mandatory training for tracheostomy care including guidance on humidification, cuff pressure, monitoring and cleaning of the inner cannula and resuscitation.		Medium	Mandatory training for tracheostomy care for all nursing staff on wards caring for tracheostomy patients	TBA	J Foster	30/03/2015	13	Medium	Mandatory training for nursing staff approved. Training programme formulated to include 1) completon of on-line package of traing from the National Trachestomy Safety Project 2) Hands on 3 hour senario based training sessions - sessions held quarterly.Next course 22 May 2015	Montioring attendance to ensure nursing staff are released to attend hands on sessions	D Hogg & S Cook	J Foster	31/07/2015

ID number	Issue / Audit Finding / Theme	Indicator (if relevant)	Initial Risk (H/M/L)	Action/s	Operational Lead	Responsible Lead	Target Date	ID number	Risk at review (H/M/L or complete)	Progress on actions	Further action/s to ensure completion	Operational Lead (if changed)	Responsible Lead (if changed)	Target Date
16	Involvement of Speech and Language Therapy in critical care needs to be facilitated particularly for more complex patients and to assist clinicians with high quality communication strategies as well as day to day ward care and according to patient needs.		Low	Introduce the use of the communication board developed by the centre for international rehabilitation.	C. Sri-Chandana	C. Sri-Chandana	31/10/2014	16	Complete	Communication strategies already in existance e.g. Use of pen & paper, letter boards and ipads. Centre for international rehabilitation communication board has been brought to ITU MDT. Has been rolled out onto the ward area.		M. Issott	C. Sri-Chandana	31/03/2015
			Low	Involve Speech & Language Therapy	V. Davison	V. Davison	30/03/2015		Complete	All patients on ITU to have a swallow test done by the nurses. Anyone who fails that would be referred as per an agreed pathway to SALT. They will therefore capture all potential problems early. Also agreed patients who have been seen in the Critical Care Follow Up clinic who have problems attributable to previous tracheostomies will be referred directly to them as an out patient.				31/03/2015
17	Dysphagia reported in tracheostomy patients warrants ongoing and further study in terms of risk factors, identification and natural history.		Low	At follow up in follow up clinic, all patients who have had a tracheostomy to be asked about dysphagia symptoms.	L. Green	S. Holbrook	30/03/2015	17	Complete					
19	Bedside staff who care for tracheostomy patients must be competent in recognizing and managing common airway complications including tube obstruction or displacements and as described by the National Tracheostomy Safety Project algorithms.		High	1) Programme of education to be formalised and to included simulation training around trachesotomy senarios. 2) Particular focus on new staff induction.	M. Issott & R. Tuffin	R. Tuffin	30/05/2015	19	Low	Simulation Training prgramme timetabled and occurring monthly.	Monitoring of the training programme to ensure that sessions occur - risk that clinical activity may prevent sessions from happening.			30/05/2015
24	Multidisciplinary agreement about minimum airway assessments prior to decannulation needs to be established including availability of equipment and competences.		Medium	Informal processs already exists. To formalise process	W. Peat	C. Sri-Chandana	31/10/2014	24	Complete	Tracheostomies on ITU are well established at the time of decannulation. Consultant Anaesthetsist led discussions at daily MDT regarding management plan. ENT involvement only required in complex cases when formal input would be requested.				

5.3. Appendix 3: Alcohol Related Liver Disease: Measuring the Units (2013)

Composite Action Plan on Liver Disease:
A. NHS Atlas of Variation in Healthcare for People with Liver Disease Report 2013
B. NCEPOD Alcohol related liver disease study: Measuring the Units
Action Plan started September 2013
Owner Dr Ganesh Sivaji

ID number	Issue / Audit Finding / Theme	Initial Risk (H/M/L)	Action/s	Operational Lead	Responsible Lead	Target Date		ID number	Risk at review (H/M/L or complete)	Progress on actions	Further action/s to ensure completion	Operational Lead (if changed)	Responsible Lead (if changed)	Target Date
									Action Plan Review -					
B1	A multidisciplinary Alcohol Care Team, led by a consultant with dedicated sessions, should be established in each acute hospital and integrated across primary and secondary care.	Medium	1. To review requirement at HDFT and consider business case for service development. 2. To communicate need to commissioners if deemed appropriate 3. To add to Gastroenterology risk register if service development cannot be fulfilled	Gastroenterologists	James Goodyear	Oct-14			Complete	Added to gastroenterology risk register as no current service				
B2	Each hospital should have a 7-day Alcohol Specialist Nurse Service, with a skill mix of liver specialist and psychiatry liaison nurses to provide comprehensive physical and mental assessments, Brief Interventions and access to services within 24 hours of admission. (Medical Directors).	Medium	1. No current service. Actions as per B1	Gastroenterologists	James Goodyear	Oct-14			Complete	Added to gastroenterology risk register as no current service				
B3	Robust guidelines should be available to every unit admitting patients with alcohol-related liver disease. All physicians managing such patients should be familiar with those guidelines and trained in their use.	Medium	1. To develop clinical protocol for the assessment, investigation and treatment of patients with alcohol related liver disease link to Action A5 above	G Davies / G Sivaji / J Smith	G Sivaji	Oct-14			Medium	Dr Sivaji and Dr Smith currently drafting protocol		G Davies / G Sivaji / J Smith	G Sivaji	Mar-15
B4	All patients presenting with decompensated alcohol related liver disease should have blood cultures included in their initial investigations on admission to hospital. (All Doctors)	Medium	1. To include in clinical protocol as per actions A5 & B3	G Davies / G Sivaji / J Smith	G Sivaji	Oct-14			Medium	Dr Sivaji and Dr Smith currently drafting protocol		G Davies / G Sivaji / J Smith	G Sivaji	Mar-15
B5	If ascites is present in patients presenting with decompensated alcohol-related liver disease, a diagnostic ascitic tap should be performed as part of their initial assessment. Coagulopathy is not a contraindication to this procedure. (All Doctors)	Medium	1. To include in clinical protocol as per actions A5 & B4	G Davies / G Sivaji / J Smith	G Sivaji	Oct-14			Medium	Dr Sivaji and Dr Smith currently drafting protocol		G Davies / G Sivaji / J Smith	G Sivaji	Mar-15

ID number	Issue / Audit Finding / Theme	Initial Risk (H/M/L)	Action/s	Operational Lead	Responsible Lead	Target Date		ID number	Risk at review (H/M/L or complete)	Progress on actions	Further action/s to ensure completion	Operational Lead (if changed)	Responsible Lead (if changed)	Target Date
B6	Patients who present acutely with decompensated liver disease, and who drink alcohol at a potentially harmful level, should not be assumed to have alcohol-related liver disease. A full assessment to exclude all other potential causes of liver disease should be performed as soon as possible after admission to hospital. (All Doctors and Consultants)	Medium	1.To include in clinical protocol as per actions A5 & B5. 2. Patients should be transferred to the care of the Gastroenterologists to undertake investigation.	G Davies / G Sivaji / J Smith	G Sivaji	Oct-14			Medium	Dr Sivaji and Dr Smith currently drafting protocol		G Davies / G Sivaji / J Smith	G Sivaji	Mar-15
B7	A toolkit for the acute management of patients admitted with decompensated alcohol-related liver disease should be developed and made widely available to all physicians / doctors involved in the care of patients admitted to acute hospitals.	Medium	1. To include in clinical protocol as per actions A5 & B4	G Davies / G Sivaji / J Smith	G Sivaji	Oct-14			Medium	Dr Sivaji and Dr Smith currently drafting protocol		G Davies / G Sivaji / J Smith	G Sivaji	Mar-15
B8	All patients presenting to hospital services should be screened for alcohol misuse. An alcohol history indicating the number of units drunk weekly, drinking patterns, recent drinking behaviour, time of last drink, indicators of dependence and risk of withdrawal should be documented. (All Doctors)	Medium	1. Alcohol intake is recorded for all inpatient admissions in nursing documentation. 2. Screening undertaken for all high risk patients presenting to A&E and from September 2014 all patients presenting to CAT and all Gastroenterology outpatient appointments as part of local CQUIN for 14/15.	G Davies/J Smith/J Goodyear	G Sivaji	Oct-14			Complete					
B9	As recommended by NICE, assessment tools such as the Alcohol Use Disorders Identification Test (AUDIT) and the Clinical Institute Withdrawal Assessment – Alcohol, revised (CIWA-Ar) should be readily available for use by all health care professionals who should be competent in their use. (Medical Directors and Clinical Directors)	Medium	1. Audit C tool to be made available for use?	Gastroenterologists	James Goodyear	Oct-14			Complete	Audit C tool now in use in A&E, Gastroenterology and CAT				

ID number	Issue / Audit Finding / Theme	Initial Risk (H/M/L)	Action/s	Operational Lead	Responsible Lead	Target Date		ID number	Risk at review (H/M/L or complete)	Progress on actions	Further action/s to ensure completion	Operational Lead (if changed)	Responsible Lead (if changed)	Target Date
B10	Alcohol withdrawal scales should be used, as suggested in NICE guidance, to guide treatment decisions to prevent the alcohol withdrawal syndrome. (All Doctors)	Medium	1.To include in clinical protocol as per actions A5 & B5.	G Davies / G Sivaji / J Smith	G Sivaji	Oct-14			Medium	Dr Sivaji and Dr Smith currently drafting protocol		G Davies / G Sivaji / J Smith	G Sivaji	Mar-15
B11	Treatment for alcohol withdrawal should be tailored to the individual patient. The presence of encephalopathy, or other features of liver disease, can make the administration of sedatives inappropriate and may indicate the need to consider transfer to a higher level of care. (All Doctors and Consultants)	Medium	1.To include in clinical protocol as per actions A5 & B5.	G Davies / G Sivaji / J Smith	G Sivaji	Oct-14			Medium	Dr Sivaji and Dr Smith currently drafting protocol		G Davies / G Sivaji / J Smith	G Sivaji	Mar-15
B12	All patients admitted with decompensated alcohol related liver disease should be seen by a specialist gastroenterologist / hepatologist at the earliest opportunity after admission. This should be within 24 hours and no longer than 72 hours after admission to hospital. (Consultants).	Medium	1.To include in clinical protocol as per actions A5 & B5.	G Davies / G Sivaji / J Smith	G Sivaji	Oct-14			Medium	Dr Sivaji and Dr Smith currently drafting protocol		G Davies / G Sivaji / J Smith	G Sivaji	Mar-15
B13	Trusts should ensure that all patients admitted with alcohol-related liver disease receive early specialist input from a gastroenterologist / hepatologist and a specialist practitioner in alcohol addiction. (Medical Directors and Clinical Directors).	Medium	1. Patients will currently be seen by a Gastroenterologist 2. Currently no specialist alcohol practitioner. To consider as per action B1	Gastroenterologists	James Goodyear	Oct-14			Complete		Lack of specialist alcohol team added to gastroenterology risk register. Patients will be reviewed by consultant gastroenterologist.			Mar-15
B14	All patients with alcohol-related liver disease and a history of current alcohol intake, in excess of recommended limits, should have thiamine (oral or intravenous) administered on admission to hospital. (All Doctors).	Medium	1.To include in clinical protocol as per actions A5 & B5.	G Davies / G Sivaji / J Smith	G Sivaji	Oct-14			Medium	Dr Sivaji and Dr Smith currently drafting protocol		G Davies / G Sivaji / J Smith	G Sivaji	Mar-15

ID number	Issue / Audit Finding / Theme	Initial Risk (H/M/L)	Action/s	Operational Lead	Responsible Lead	Target Date		ID number	Risk at review (H/M/L or complete)	Progress on actions	Further action/s to ensure completion	Operational Lead (if changed)	Responsible Lead (if changed)	Target Date
B15	In patients with decompensated alcohol-related liver disease and deteriorating renal function, diuretics should be stopped and intravenous fluid administered to improve renal function, even if the patient has ascites and peripheral oedema. (All Doctors)	Medium	1.To include in clinical protocol as per actions A5 & B5.	G Davies / G Sivaji / J Smith	G Sivaji	Oct-14			Medium	Dr Sivaji and Dr Smith currently drafting protocol		G Davies / G Sivaji / J Smith	G Sivaji	Mar-15
B16	As for all patients, patients with alcohol-related liver disease should have accuate monitoring of fluid balance. Systems to ensure accurate monitoring of fluid balance should be in place in all Trusts. (Medical Directors and Nursing Directors)	Medium	1.To include in clinical protocol as per actions A5 & B5.	G Davies / G Sivaji / J Smith	G Sivaji	Oct-14			Medium	Dr Sivaji and Dr Smith currently drafting protocol		G Davies / G Sivaji / J Smith	G Sivaji	Mar-15
B17	NICE recommends that a nutritional assessment of all patients should be made within the first 48 hours of admission (CG32). This should include patients with alcohol-related liver disease. (All Health Care Professionals)	Medium	1. Currently liver disease triggers an automatic referral to dieticians as part of the nutritional screening tool. However nutritional screening tool compliance is limited. To continue to monitor as part of Nutrition Group 2. Dietitians are able to provide assessment within 48hrs Monday to Friday	Ali	Jill Gale	Oct-14			Complete					
B18	In line with NICE guidance, unless contraindicated, all patients with alcohol-related liver disease, who present with gastrointestinal bleeding, should be offered antibiotics and terlipressin until the outcome of their endoscopy is known. (All Doctors and Consultants)	Medium	1.To include in clinical protocol as per actions A5 & B5. 2. To develop UGIB protocol?	G Davies / G Sivaji / J Smith	G Sivaji	Oct-14			Medium	Dr Sivaji and Dr Smith currently drafting protocol		G Davies / G Sivaji / J Smith	G Sivaji	Mar-15
B19	Deterioration in renal function in patients with liver disease should not be assumed to be due to the hepatorenal syndrome, as other potential causes are often present and should be actively excluded. (All Doctors and Consultants)	Medium	1.To include in clinical protocol as per actions A5 & B5.	G Davies / G Sivaji / J Smith	G Sivaji	Oct-14			Medium	Dr Sivaji and Dr Smith currently drafting protocol		G Davies / G Sivaji / J Smith	G Sivaji	Mar-15

ID number	Issue / Audit Finding / Theme	Initial Risk (H/M/L)	Action/s	Operational Lead	Responsible Lead	Target Date		ID number	Risk at review (H/M/L or complete)	Progress on actions	Further action/s to ensure completion	Operational Lead (if changed)	Responsible Lead (if changed)	Target Date
B20	Escalation of care should be actively pursued for patients with alcohol-related liver disease, who deteriorate acutely and whose background functional status is good. There should be close liaison between the medical and critical care teams when making escalation decisions. (Consultants)	Medium	1.To include in clinical protocol as per actions A5 & B5. 2. To review CCOT outreach escalation criteria	G Davies / G Sivaji / Chris Gill	G Sivaji	Oct-14			Medium	Dr Sivaji and Dr Smith currently drafting protocol		G Davies / G Sivaji / J Smith	G Sivaji	Mar-15
B21	All patients presenting to acute services with a history of potentially harmful drinking, should be referred to alcohol support services for a comprehensive physical and mental assessment. The referral and outcomes should be documented in the notes and communicated to the patient's general practitioner. (All Doctors)	Medium	As per action B1 as currently no service at HDFT	Gastroenterologists	James Goodyear	Oct-14			Complete	Lack of service added to gastroenterology risk register				
B22	All deaths due to alcohol-related liver disease should be reviewed at a local morbidity and mortality, clinical governance meeting to ensure that lessons are learned and to give assurance that high quality care is being provided. (Consultants)	Medium	1. Deaths to be reviewed by Mortality Review Group	MORG		Oct-14			Complete	All deaths are currently reviewed by MORG members	Agreement from Consultant Gastroenterologist to present all alcoholic liver disease deaths at MORG meeting			01/03/2015

5.4. Appendix 4: Subarachnoid Haemorrhage: Managing the flow (2014)

NCEPOD SAH April 2014							Action Plan Progress Monitoring - Update september 2015						
ID number	**Issue / Audit Finding / Theme**	**Initial Risk (H/M/L)**	**Action/s**	**Operational Lead**	**Responsible Lead**	**Target Date**	**ID number**	**Risk at review**	**Progress on actions**	**Further action/s to ensure completion**	**Operational Lead (if changed)**	**Responsible Lead (if changed)**	**Target Date**
O1	Formal networks of care should be established. linking all secondary care hospitals receiving subarachnoid haemorrhage patients to a designated regional neurosurgical/neuroscience centre.	Low	Formal links already in place with LGI and Leedsneurosurgery.com. These need to be incorpartaed into common care pathway. There is still scope to agree criteria for referal with Leeds and responsibility for furtehr imaging ie CTA	Dr J Smith			O1	Complete	We have now forming a local network to drew a ccommon response to all NCEPOD SAH issues. This is being co-ordinated by Mr Ross, Neurosurgeon in LGI and the first meeting is in October - There will not be any further development of these pathways locally until a regional approach is dicted.	Meetings are now established and regular and will develeope to include audit and M&M			
O2	All hospitals should undertake regional audit or multi-disciplinary team meetings, in order to share learning that could improve the care provided to aneurysmal subarachnoid haemorrhage patients.	Low	No regular audit has been undertaken. First initial updit has been initiated. Alter and complete initial audit and set tine for annual re-audit. It would be difficult to organise MDT - rolling audit a better option.	Dr J Smith			O2	Complete	First audit done and results awaited - plan yearly audit of target number. Suggest this is a rolling audit to be completed by CAT junior Doctor allocated on a yearly basis. Nature of audit likely to be dictated by regional response	Yearly on-going SAH audit. Likley to feed into regional data			
O3	The availability of interventional neuroradiology services should be such that hospitals can comply with the 'National Clinical Guideline for Stroke' stating that patients should be treated within 48 hours of their aneurysmal subarachnoid haemorrhage.	Low	Baseline data needs to be obtained via audit. Transfer to Leeds is usually pormpt but the service is not consistent.	Dr J Smith			O3	Low	Inherent variability in transfer - usually within target - will need to be monitored via annual audit. Formal criteria will need to be finalised with regional approach.	Yearly on going SAH audit. Likely to remain ongoing low risk. The condition of this is likely to remain unchnaged for the forseebale future. Low risk however as base line service is excellent.			Jul-2015
S1	The clinical presentation of aneurysmal subarachnoid haemorrhage should be highlighted in primary and secondary care education programmes for all relevant health care professionals, including the guidelines for the management of acute severe headache published by the College of Emergency Medicine.	Medium		Dr J Smith			S1	Complete	Headache included in both ED and CMT training programs. Common presntation core competency in ACCS and CMT				
S2	All patients presenting with acute severe headache in a secondary care hospital should have a thorough neurological examination performed and documented. A CT scan should be performed immediately in this group of patients as defined by the 'National Clinical Guideline for Stroke'.	Medium	This should be standard practice but documentation of such needs to be auditted. Need agreement from radiology on avaialbility of cross sectional imaging both in and out of hours.	Dr J Smith			S2	Medium	Deviation in out of hours CT scanning of low risk presentation needs to be explored. May need to allow case by case variation and dicussion with on call radiology. Likely to remain low risk. High risk factors for acute severe headaches developed	It is accepted in regional network that ?SAH should be imaged within one hour- contacted Dr sapherson - need a formal but reasoned approach to out of hours scanning here with inclusion criteria - should be done 3 months then will move to COMPLETE	Dr J Smith / Dr D Sapherson		Nov-2015
S3	Standard protocols for the care of aneurysmal subarachnoid haemorrhage patients in secondary care should be developed and adopted across formal networks. These should cover, as a minimum, initial assessment and diagnosis, management, referral, transfer to a neurosurgical/neuroscience centre and subsequent repatriation to secondary care, including rehabilitation. These protocols should take into account existing guidelines where relevant.	Medium	This is not in place although aspects are available there is no universal protocol. This should include multiple patient entry points (ED and AMU), Initial management and risk assessment; agreements for cross sectional imaging both in and out of hours; agreement on suitability of referal to tertiary centers, requirement for supported transfer, agreement on criteria for re-location from tertiary care and rehabilitation	Dr J Smith			S3a	Low	Secondary care pathway bundle being developed by J Smith in HDFT. Drafted	For ratification by network. These pathways are being ratified in sections - it is liely to take another year to complete in all but risk would be low rather than medium on matrix	Dr J Smith / SAH network group		2016
							S3b	Low	Others in the network are developing the other care pathways	Network to ratify the entire set of protocols / pathways	SAH network group		2016
S4	All patients diagnosed with a subarachnoid haemorrhage should be commenced on nimodipine immediately as recommended in the 'National Clinical Guideline for Stroke', unless there are contraindications to its use.	Medium	This is not current initial practice. Nimodipine is not available on the wards or within the Emrgency Department	Dr J Smith			S4	Low	Nimodipine is now stocked in ED, CCU and AMU Fountains. Its use will be highlighted in guidelines	Need to audit usage in annual audit			Jul-2015
P1	Organ donation rates following fatal aneurysmal subarachnoid haemorrhage should be audited and policies adopted to increase the frequency with which this occurs.	Low	Occurs under the unbrella of organ transplation on going audit - needs to be flagged as specific issue	Dr J Smith			P1	Complete	This is included as part of on going organ donation audits				

Harrogate and District NHS
NHS Foundation Trust

Report to the Trust Board of Directors: 23 September 2015	Paper No: 10.0

Title	Financial Position
Sponsoring Director	Director of Finance
Author(s)	Finance Department
Report Purpose	Review of monthly financial position

Key Issues for Board Focus:

The Trust reported a year to date deficit of £140k in July, £926k behind plan. The position had deteriorated in July with an adverse variance of £372k for the month. This instigated a discussion at SMT August in relation to recovery plans.

During August and early September, directorates have developed a series of actions to address this position. Without any action, the Trust would have ended the financial year with a £1,147k deficit. The plans developed to date to recover this position equate to £2,652k. Applying a risk adjustment to these plans would improve the position by £2,069k, resulting in a surplus of £868k. This is still behind the plan of £1.8m.

The financial position in August was an adverse variance against plan of £123k, resulting in a variance to date of £1,049k.The plan for August was a deficit of £635k, due to the activity drop planned for the month. Activity and income were in line with the reduced plan, but expenditure was ahead of plan.

Related Trust Objectives	
1. Driving up quality	Yes
2. Working with partners	Yes
3. Integrating care	Yes
4. Growing our business	Yes

Risk and Assurance	There is a risk to delivery of the 2015/16 financial plan if budgetary control is not improved. Mitigation is in place through regular monthly monitoring, and discussions on improving this process are ongoing.
Legal implications/ Regulatory Requirements	

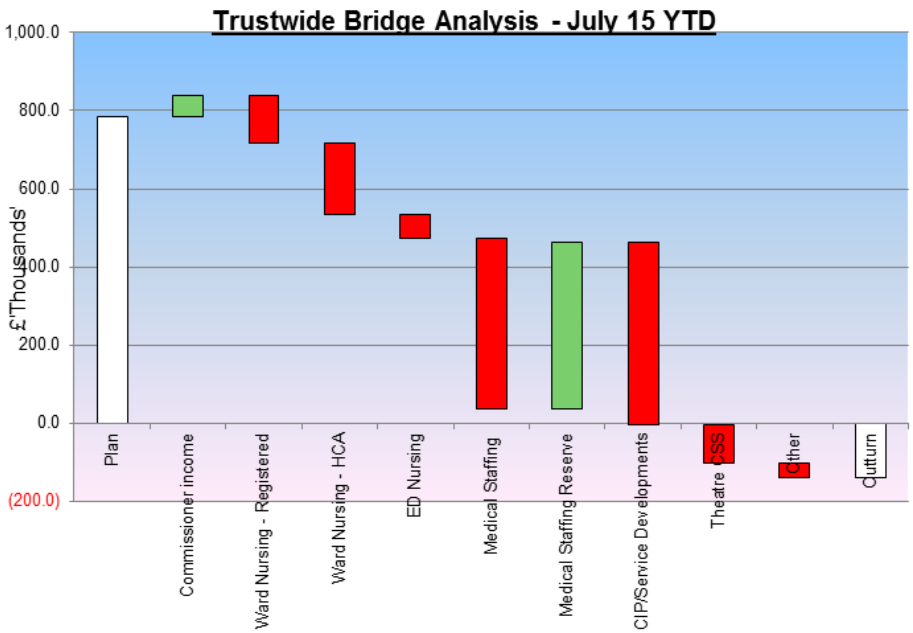
Action Required by the Board of Directors

The Board of Directors is asked to note the contents of this report

2015/16 Financial Position at July

July Financial Position

- In August 2015, SMT discussed the following financial position for the year to July -



» The Trust reported a deficit of £140k, £926k behind plan.

» This was against the internal target the Trust set at the start of the year in order to fund service developments and provide greater resilience to the current, challenging financial environment.

» The position had deteriorated in July with an adverse variance of £372k to plan. Commissioner income was balanced in month, however, favourable performance in previous months had offset significant adverse expenditure variances.

» The key expenditure variances relate to ward nursing, medical staffing, ED staffing, Theatre consumables and CIP performance, as demonstrated in the bridge diagram on the left. There are also a number of smaller issues were beginning to accumulate.

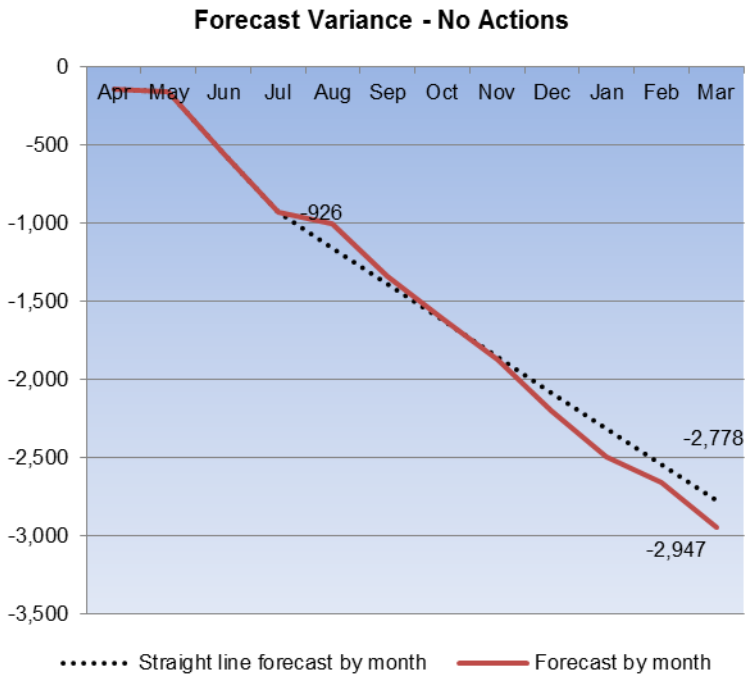
» Despite being so significantly overspent on medical staffing (£438k), the Trust planned a significant contingency in this area

- As well as the deterioration in month and items mentioned above, a number of concerns were raised in relation to the following elements –
  - The CIP position for 2015/16, and the concern in relation to the delivery needed to fund developments / service pressures
  - Expected issues in relation to medical staffing which were potentially going to increase the overspend in this area over and above the planned contingency
  - The impact of winter pressures
  - Planning for 2016/17 CIP
- All of this resulted in the need to further review directorate positions, producing recovery plans in order to return the Trust to the planned financial position. Further work was requested on 2016/17 CIP planning which will be discussed at SMT in October.

2015/16 Forecast Outturn

The figures below outline the forecast position based on performance to July **without** any actions being put in place. This would result in a deficit of **1,147k**, £2,947k behind plan.

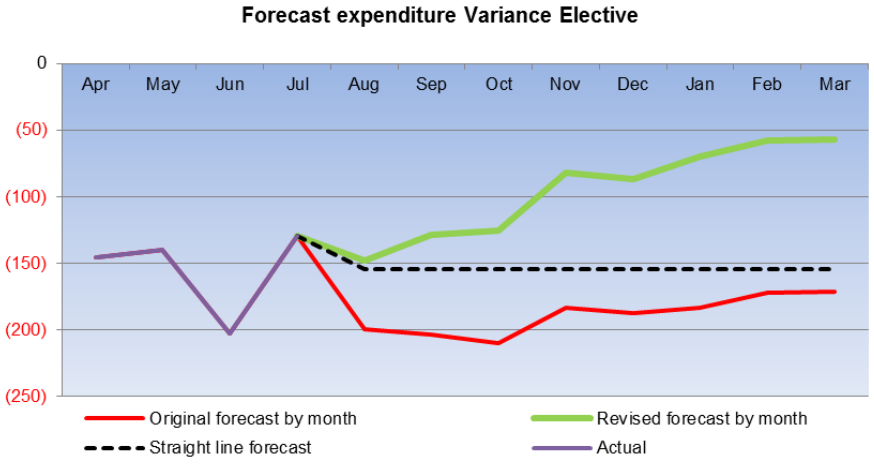
£'000s	July YTD	Forecast
- Expenditure Variance		
Elective	-619	-2,132
Integrated	-502	-1,726
UCCC	-399	-982
Corporate	-282	-629
Central	901	2,704
Total Expenditure Variance	**-901**	**-2,764**
- Income Variance	**-25**	**-183**
Total Variance	**-926**	**-2,947**
Surplus/Deficit	**-140**	**-1,147**



The forecast is based on directorate expectations, factoring in agreement in relation to main commissioner contracts and phasing reserves at a similar rate to the first 4 months of the year. This is slightly worse than the straight line forecast as demonstrated above.

2015/16 Recovery Plans – Elective Care

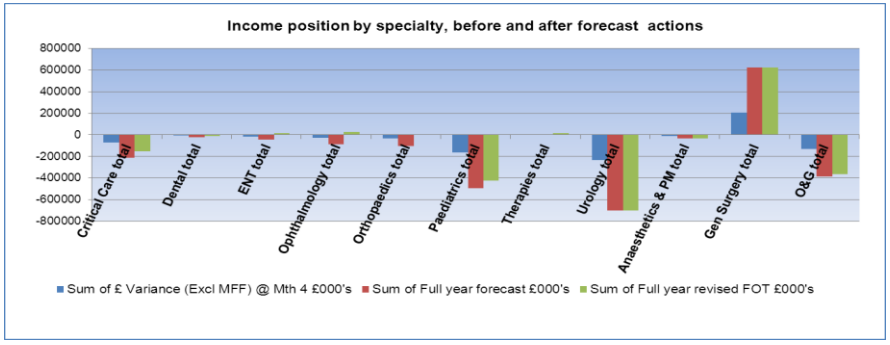
- **Expenditure**



	£000's
Overspend as at Month 4	-£621.0
amended)	-£2,131.7
Value of recovery actions	£756.5
Revised Forecast overspend	**-£1,375.3**

- **Income**

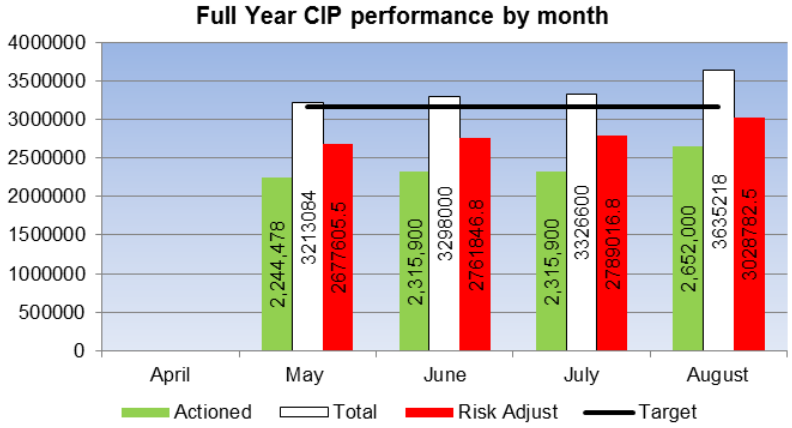
	£000's
Under recovery as at Month 4	**-£502**
FOT (pro rata)	**-£1,505**
Value of recovery actions	**£450**
Revised Forecast overspend	**-£1,055**



Key Actions

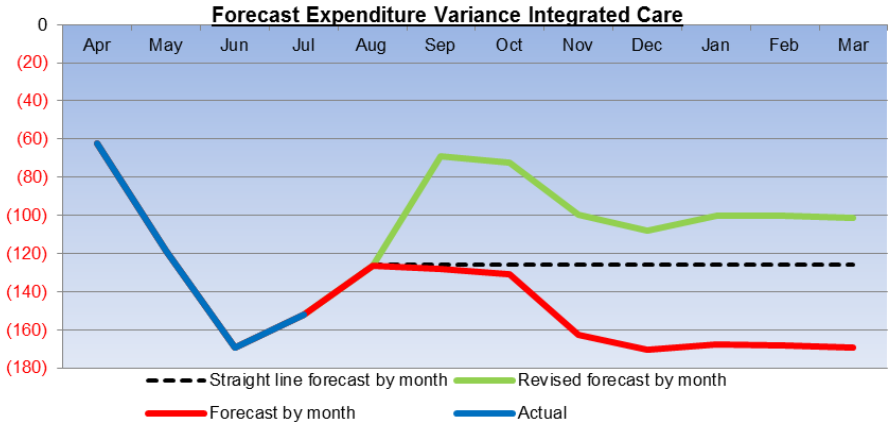
1. £400k of CIP actions (230k low risk), including Ophthalmology cons post, further BCSP, 7th Gen Surgeon BC, WLI achievement (38k)
2. £110k Ward initiatives around sickness, specials
3. £60k Medical staff cost reduction through appointment of MG in Oct.
4. £115k income increase on F/Us through Ophthalmology agency role. £100k Orthopaedic improvement forecast. £120k increase on ITU/HDU from winter activity levels.

- **CIP**



2015/16 Recovery Plans – Integrated Care

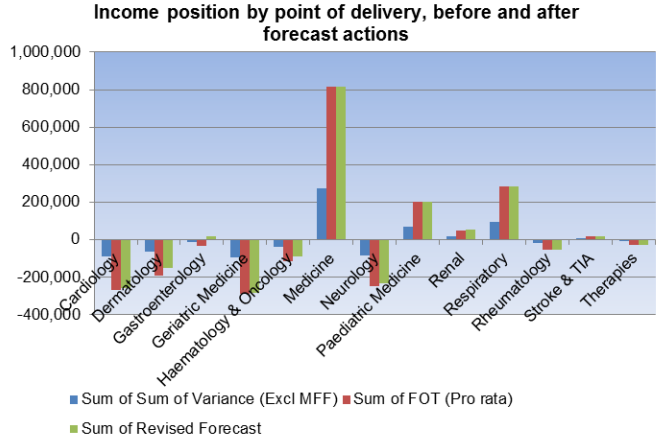
- **Expenditure**



	£000's
Overspend as at Month 4	-£502.3
Straight line forecast	-£1,506.9
Forecast Outturn	-£1,725.7
Value of recovery actions	£446.7
Revised Expenditure Forecast	**-£1,279.0**

- **Income**

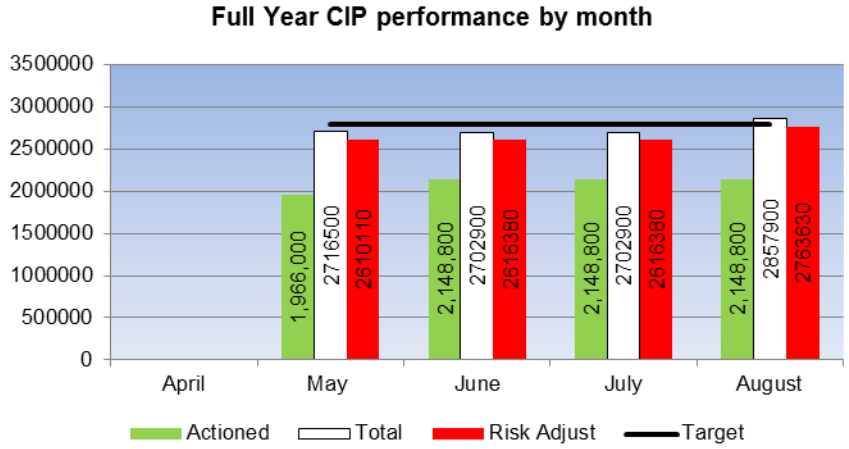
	£000's
Over recovery as at Month 4	**£78**
FOT (pro rata)	**£233**
Value of recovery actions	**£145**
Revised Forecast	**£378**



Key Actions

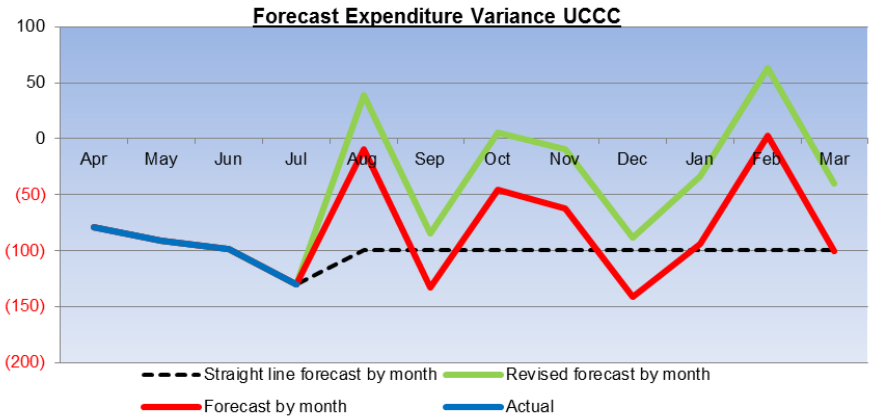
1. Medical Staffing overspend to decrease as a result of consultant cover in a number of areas and recruitment to junior doctor roles.
2. Planning gap in relation to CIP closed with focus on delivery moving forward.
3. A number of schemes have been put in place to improve the income position, ranging from additional job planned clinics (both consultant and nursing) as well as capacity from appointments mentioned in point 1.

- **CIP**



2015/16 Recovery Plans – UCCC

- **Expenditure**



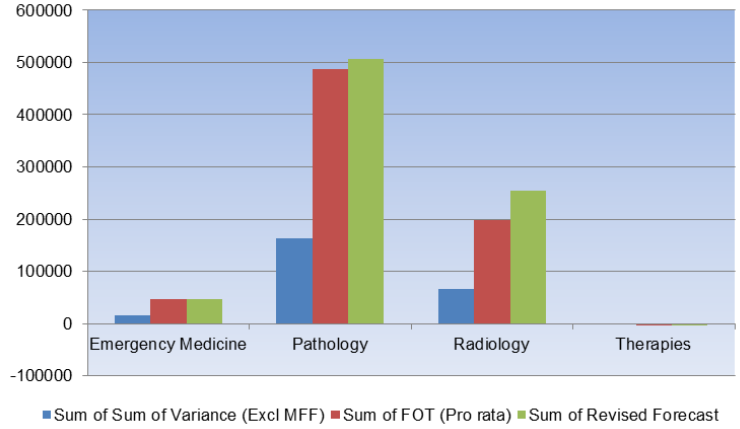
	£000's
Overspend as at Month 4	-£399.3
Straight line forecast	-£1,197.92
Forecast Outturn	-£981.7
Value of recovery actions	£434.5
Revised Expenditure Forecast	**-£547.2**

Key Actions

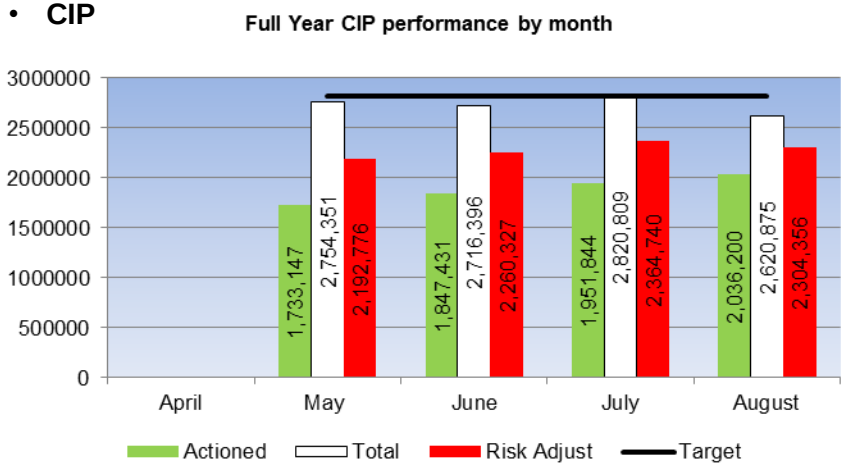
1. Reduce expenditure in relation to ED medical staffing. In particular addressing middle grade HR issue and locum/agency spend for foundation year doctors.
2. Benefit of retirement from January
3. Continue to undertake activity related to Fast track Income at minimum cost
4. Budget position for reablement and BCF to be addressed, however, this will be offset by a number of posts being recruited into.

- **Income**

	£000's
Over recovery as at Month 4	**£345**
FOT (pro rata)	**£1,035**
Value of recovery actions	**£76**
Revised Forecast	**£1,111**

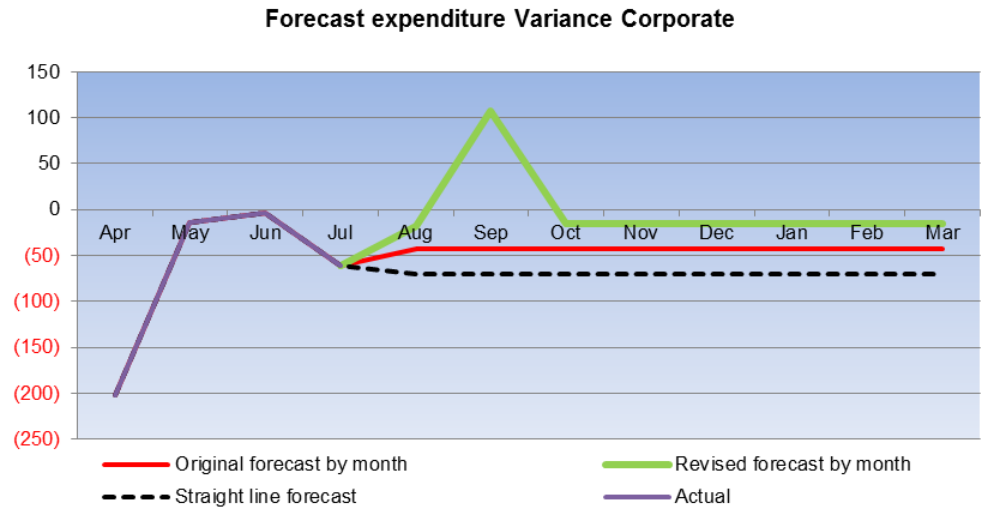


- **CIP**



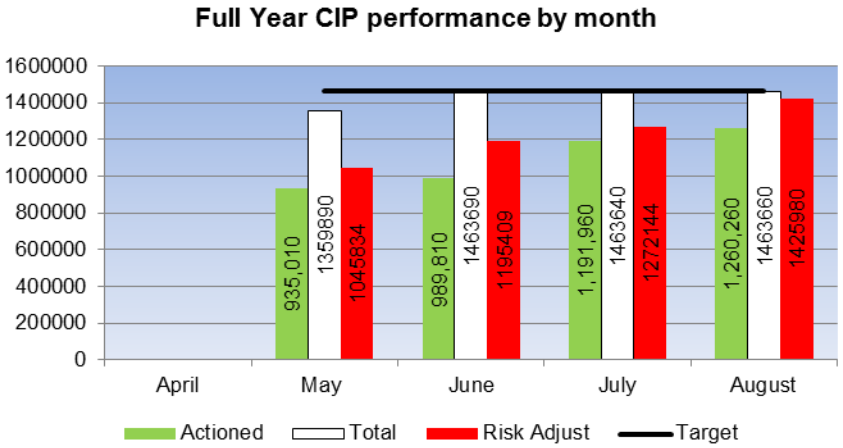
2015/16 Recovery Plans – Corporate Services

- **Expenditure**



	£000's
Overspend as at Month 4	-£281.7
Straight Line Forecast	-£845.2
Forecast Outturn	-£628.7
Value of recovery actions	£342.8
Revised Forecast overspend	**-£285.9**

- **CIP Performance**



Key Actions

1. Correct Accruals in relation to Carbon Energy Fund and reforecast energy usage
2. Maintain current pay expenditure in relation to hotel services
3. Capitalise pay expenditure in relation to IT projects
4. Reclaim of costs in relation to tender

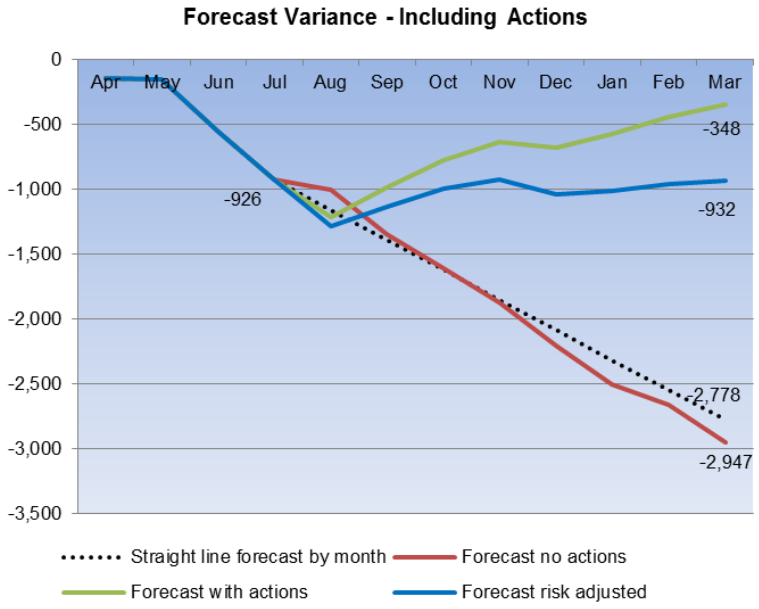
2015/16 Recovery Plans – Combined Position

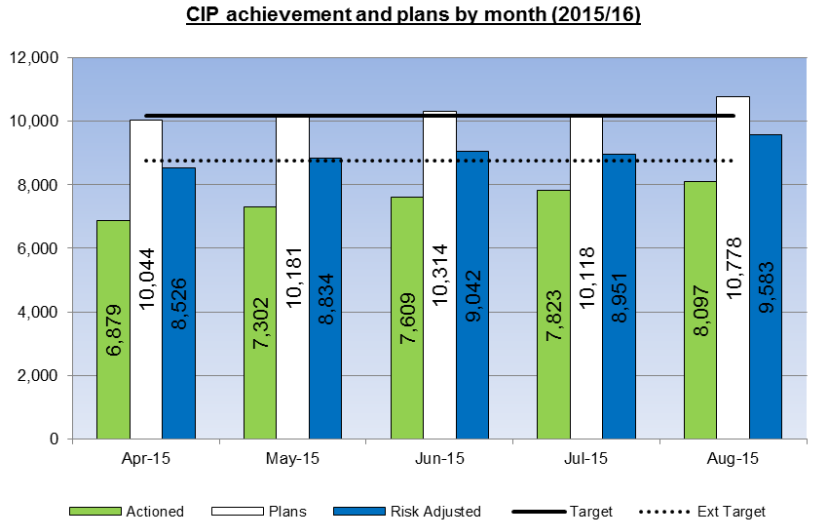
Summary Of Recovery Plan Actions

- The recovery plans outline an expected improvement of £2,652k in total. Using the same risk adjusted methodology as used for CIP schemes this total reduces to £2,069k.
- As well as the recovery plans, there is the profiling of reserves to consider. The forecast below includes all major reserves being phased into the position on a monthly basis.

£'000s	Elective	Integrated	UCCC	Corporate	Total	Risk Adjusted Total
Expenditure Variance at Month 4	-621	-502	-399	-282	-1,804	-1,804
Pro rata full year	-2,132	-1,726	-982	-629	-5,468	-5,468
Value of recovery actions	756	447	435	343	1,980	1,532
Revised Expenditure Variance Forecast	**-1,375**	**-1,279**	**-547**	**-286**	**-3,487**	**-3,936**
Income Variance as at Month 4	-502	78	345	0	-79	-79
Pro rata full year	-1,505	233	1,035	0	-237	-237
Value of recovery actions	450	145	76	0	672	537
Revised Income Variance Forecast	**-1,055**	**378**	**1,111**	**0**	**434**	**300**
Total Impact of Recovery	**1,207**	**592**	**511**	**343**	**2,652**	**2,069**

- The actions described would therefore result in a surplus of £1,452k, £348k behind plan. This is dependant on all plans being actioned at the level described and no unexpected cost pressures occurring.
- Using the risk adjusted methodology would result in a surplus of £868k, £932k behind plan.





2015/16 Financial Position to date & next steps

August Financial Position

- The financial position in August was an adverse variance against plan of £123k, resulting in a variance to date of £1,049k.
- The plan for August was a deficit of £635k, due to the activity drop planned for the month. Activity and income were in line with the reduced plan, but expenditure was ahead of plan.
- The key areas are those highlighted last month, namely ward nursing, medical staffing and CIP delivery.
- The focus of the financial recovery planning and delivery of CIP in 15/16 remains unchanged, and it is vital that the actions identified already start now.

Next Steps

- The recovery planning work is a good start to financial recovery – these actions need to be delivered.
- The actions identified will be monitored for delivery each month through Finance & Activity reviews.
- Further work is still required - the current plans if delivered will result in a year end position of £348k behind plan. This position provides greater pressure next year, and provides little resilience against any winter pressures in excess of plan.

Report to the Trust Board of Directors: 23 September 2015	**Paper No: 11.0**

Title	**Workforce and Organisational Development Update**
Sponsoring Director	Director of Workforce and Organisational Development
Author(s)	Director of Workforce and Organisational Development
Report Purpose	To provide a summary of performance against key workforce matters

Key Issues for Board Focus:

This report provides information on the following areas:

a) Workforce Performance Indicators
b) Training, Education and Organisational Development
c) Service Improvement and Innovation

Related Trust Objectives	
1. Driving up quality	Through the pro-active management of workforce matters, including recruitment, retention and staff engagement
2. Working with partners	By working with NHS England and the Yorkshire and Humber LETB on standards of education, training and leadership at the Trust
3. Integrating care	By the delivery of multi-disciplinary learning and development interventions. Also, via service innovation and improvement initiatives
4. Growing our business	By ensuring we have the right number of staff with the right skills in place to continue with the delivery of high quality services

Risk and Assurance	Any identified risks are included in the Directorate and Corporate Risk Registers
Legal implications/ Regulatory Requirements	Health Education England and the Local Education and Training Board have access to the Trust's workforce data via the Electronic Staff Records system. Providing access to this data for these organisations is a mandatory requirement for the Trust

Action Required by the Board of Directors

The Board is asked to **note** the update on matters specific to Workforce, Training and Education, Service Improvement and Innovation and Organisational Development.

Key Messages for September 2015

a) Junior Doctors contract negotiations

The British Medical Association (BMA) has announced they will not be re-entering negotiations over the proposed contracts for junior doctors. The proposed revision of the whole pay system includes:

- higher rates of basic pay
- a standard 40 hour week and a lower cap of no more than 72 hours work in any seven consecutive days
- higher rates of pay for night work in return for more hours paid at standard rates
- Improved pension benefits.

New contracts were due to be issued for new employees commencing in post on or after 1 August 2016. Further details are awaited from NHS Employers.

b) Team Development Task and Finish Group – New Models of Care

The task and finish group will project manage and support the identification, commissioning, development, delivery and management of the Team Development programme for the teams working in the Integrated Hubs. This group will work closely with the already established Integrated Teams Task & Finish Group and be accountable to the New Models of Care Delivery Group.

The group will provide visibility and assurance of the projects delivery and enable an organisational view of the number of projects and the resource impact for delivery. Terms of reference for the group have been drafted for approval at the first meeting of the group taking place this month.

c) Attendance

Overall sickness absence remains below Trust target and the previous year's figures at 3.62%.

Most notable has been the change in the absence levels related to stress, anxiety and depression. Over the three month period May to July; there has been a significant decrease in absence due to these reasons. This period corresponds to the running of the Trust-wide programmes aimed at improving staff resilience and tackling stress, so indications suggest that this has been effective. Traditionally the number of days' absence due to stress, anxiety and depression reasons has been at levels between 18% and 25% which is reflected nationally. In July levels at this Trust dropped to 16%.

d) Schedule 15 – Consultant Contract

Following a recent meeting of the Trust's Local Negotiating Committee, a local agreement has been reached regarding Schedule 15 of the consultant contract. This makes the requirement clear for future incremental and pay threshold progression. This agreement will be circulated to Directorates in the near future. This makes pay progression conditional on an employee not being on a disciplinary or capability pathway, having completed all their mandatory and essential skills training, having had an annual appraisal and a signed job plan from within the last 12 months. This is a significant development and harmonises pay

progression arrangements between medical and non-medical staff and helps with developing a culture of personal responsibility. Job plans include specific objectives the achievement of which are linked to pay progression.

e) Deanery update

Health Education Yorkshire and the Humber visited the Trust in February 2015. Subsequently the Trust was issued with a report on their findings regarding the quality of education received by trainee doctors in Medicine, Surgery and Obstetrics and Gynaecology, measured against the General Medical Council's standards for training. The Directorates have eight conditions to meet and below is the current position on those that require attention.

Elective Care Directorate Update

Condition	Date Due	Summary	Evidence submitted by Directorate and condition met?
1	30/06/15	Appropriate supervision in clinics – Elective Care to produce a copy of supervision framework, confirmation that unsupervised clinics have ceased. Evidence and result of monitoring.	Draft supervision framework developed for approval by Elective Care/Integrated Care Directorates.
3	31/07/15	Review consultants supervision with regards to workplace based assessments.	Draft supervision framework developed for approval by Elective Care/Integrated Care Directorates.
6	31/05/1	Improvements in surgical handover.	Awaiting approval of evidence submission by HEYH.

Integrated Care Directorate Update

Condition	Date Due	Summary	Evidence submitted by Directorate and condition met?
1	30/06/15	Appropriate supervision in clinics – Integrated Care to produce a copy of supervision framework, confirmation that unsupervised clinics have ceased. Evidence and result of monitoring.	Draft supervision framework developed for approval by Elective Care/Integrated Care Directorates.
2	30/04/15	Increase in Gastroenterology Consultant Ward Time and submission of rotas illustrating increase.	Awaiting approval of evidence submission by HEYH.
6	31/05/15	Improvement in medical handover.	Awaiting approval of evidence submission by HEYH.

f) Effective rostering

The Business case presented for Oceans Blue has been approved. The aim of the business case is to improve and provide assurance that rostering in ward areas is safe, efficient and effective. A significant amount of work has been undertaken in this area already with the Trust performing well against our own safe staffing recommendations. However, a recent internal audit highlighted a number of areas which required improvement and provided limited assurance.

Directorates have implemented a number of changes however, there remains a gap in the information available to support the rostering process.

The Trust will be implementing a pilot for a system called Barnacles, supplied by Oceans Blue, to address this issue. The Barnacles system will ensure robust time balances, coherent information across RosterPro, the Trust's Electronic Staff Record and budget reports as well as a greater level of management information. It also removes duplication in a number of areas.
It is estimated that the system will provide approximately £100k of actual savings against ward nursing expenditure. If these savings are achieved then the system could continue at ward level or be expanded to a number of areas across the Trust.

g) Health Education England - Training in Smaller Places Task and Finish Group

I have been accepted to serve on this national task and finish group as the primary New Cavendish Group representative. The group has been established in response to the Kirkup report in to the failings at University Hospitals Morecambe Bay NHS Foundation Trust with the action that a review be carried out of the opportunities and challenges to assist such units in promoting services and the benefits to larger units of linking with them. The task group is being established to explore issues around, for example, service, curricula and quality, and produce a report on these areas. The group is chaired by Professor N Kumar, Director of Education and Quality at NHS Health Education (NE) England with the first meeting today, Wednesday 23 September 2015.

h) Update on the Measles/Mumps/Rubella Screening Project

Attached at Appendix A is an update on the above project previously requested by the Board of Directors for the September 2015 meeting.

Appendix A

BOARD OF DIRECTORS' MEETING – SEPTEMBER 2015

UPDATE ON THE MEASLES/MUMPS/RUBELLA SCREENING PROJECT

History:

Screening of immunity to Rubella has been routinely undertaken for many years in healthcare workers (although up to 12 – 15 years ago it was common to accept employees' verbal history of satisfactory screening during pregnancy rather than seeking documentary evidence of testing). Health clearance for serious communicable diseases: New healthcare workers (Department of Health, 2007), published in 2008 set out standards for screening evidence of immunity to Measles, Mumps and Rubella (MMR) for staff new to the NHS (in addition to pulling together guidance regarding screening for other communicable diseases such as TB, Varicella zoster, Hepatitis B and C, and HIV). The guidance applies to workers who have regular direct contact with patients (including relevant ancillary workers) and those who are exposed to patient samples such as laboratory workers. Acceptable evidence is specified as:

- Evidence of x2 doses of MMR vaccine
  OR
- Blood test results confirming immunity to Measles and Rubella

The guidance does not include any requirement to test Mumps immunity when there is no evidence of MMR vaccination, and the Trust Director of Infection Prevention and Control agreed that it was not necessary to include this.

The Occupational Health service at the Trust has applied this standard to new staff joining the Trust, and any staff changing job role who come to our attention, since the latter months of 2008.

In November 2008 an entry was made in the HR Risk Register regarding risk of pre-existing staff being non-immune and identifying that additional staff resource would be required in order to undertake a systematic review of records in order to update all staff to the standard. Ad hoc updating of individuals attending the department for other reasons was commenced however was a slow and random process.

In 2013 outbreaks of Measles infection were reported nationally. The risk level recorded in the Risk Register was revised and agreement was given to allow funding for additional nurse hours in Occupational Health to commence a more systematic review of staff immunisation records with the aim of updating all relevant pre-existing staff to the current standard for Measles/Mumps/Rubella.

A process was devised whereby following review of the individual's record and identification of outstanding items, they are sent a letter to explain the project and what their individual outstanding requirements are. This was backed up by a copy of a letter from both Chief Nurse and Medical Director supporting the project. When blood tests

are required a sample request form is included to facilitate convenient local sample collection where possible and avoid the need for attendance in person at Occupational Health (attendance is of course required for any vaccinations).

In addition to checking recorded evidence of Measles/Mumps/Rubella immunity, the opportunity is taken to also check any other outstanding immunisation requirements.

Initially a decision was taken to utilize existing occupational health part-time and bank nurses who were willing to work additional hours from late 2013 (subsequently with additional support from bank administrative staff) on the basis that they already understood the requirements and were familiar with our occupational health records systems this reducing need for training. However, over time it became clear that their availability was not consistent and without regular input the project failed to progress in a timely manner. It also became clear that in some cases staff did not respond promptly to comply with the request to take action to ensure their record is updated thus adding to the time required to track progress and delaying completion.

Therefore a decision was made to seek a nurse with experience of relevant immunisation programmes and electronic records (to facilitate rapid induction to the project) who could be available to work more hours on a regular basis in order to progress the project to completion.

Up to end of July 2015, the time dedicated to the project equated to 10.5 weeks full time equivalent and 69% of hospital based patient facing staff records had been confirmed as up to current standards.

Current position:

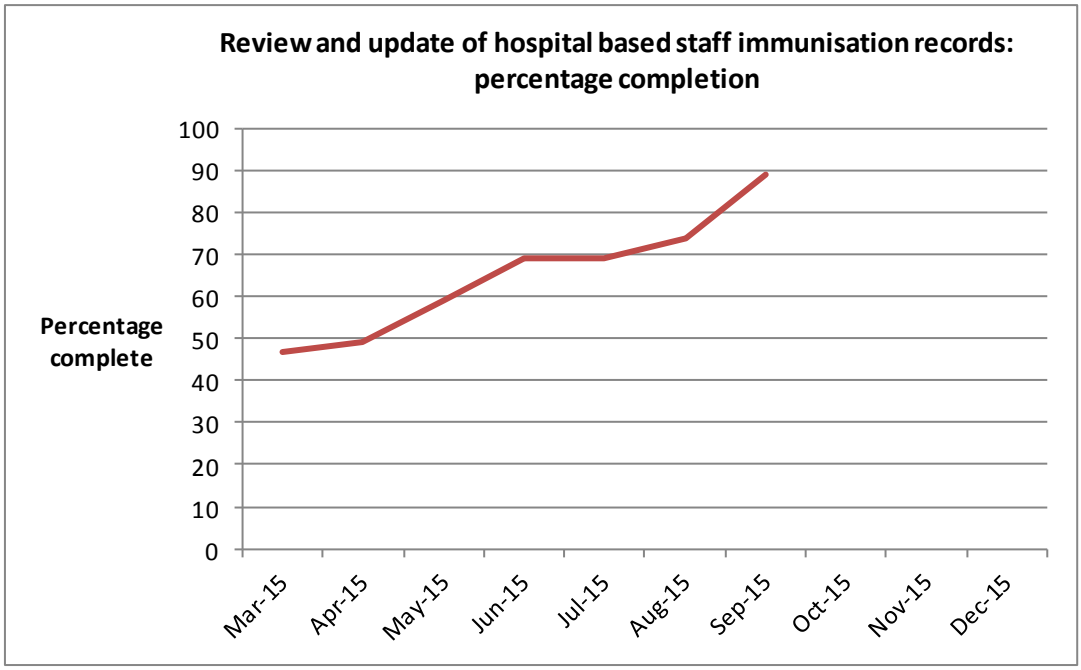
Further registered nurse support began working solely on the project from the beginning of August 2015; she has been able to work 34.5 hours per week. Consistent time spent on this work is now showing improved progress: by 1 September 2015 89% of hospital based patient facing staff had been confirmed as up to the required standard.

The tables below show the current data as of 1 September 2015 relating to hospital based staff and progress to date with attaining completion of updates.

4128 total record lines in employee list (includes bank, multiple post holders etc)	
2900 identified as HDH based: 624 identified as not applicable to date (567) 523 identified as not patient facing roles = **1753 for review** (1810)	70% of total
1561 marked as complete up to date immunisation record (1345)	**89%** of those requiring review (74%)

Numbers in parentheses represent data from last update report dated 10 August 2015.

It is planned that the Hospital specific update will be completed by 31 December 2015.



Preparation is underway to commence review of community staff records. This will involve arranging transfer of previous occupational health records held by York Hospital NHS Foundation Trust Occupational Health Service for those who transferred from North Yorkshire & York Primary Care NHS Trust to Harrogate and District NHS Foundation Trust in 2011 under the Transferring Community Services process to ensure that the immunisation records held in Harrogate are complete and up to date. Notification of the intent to arrange this transfer has been disseminated by email via Daily Bulletin and Middle and Senior Managers to ensure that relevant staff are aware and have opportunity to object to this transfer of their personal data. The Trust Data Protection Officer has approved this process. These records will be transferred after 7 September 2015, when an exercise to transfer relevant immunisation information into the Harrogate occupational health system and tracking for this MMR update project will be required.

In addition, review of records for non-patient facing staff for whom vaccination is recommended for their own safety e.g. laboratory and sterile services staff, will commence as time allows from early September.

Heather Singleton
Occupational Health Manager

September 2015

Quality Committee
Minutes
Wednesday 5 August 2015, 2.00 – 4.00 pm, The Atrium, Trust HQ

Members present:

Mrs L Webster	Non-Executive Director (Chair)
Mr N McLean	Non-Executive Director
Professor S Proctor	Non-Executive Director
Dr R Tolcher	Chief Executive
Mr P Marshall	Director of Workforce and Organisational Development
Mrs A Leng	Head of Risk Management
Dr K Johnson	Clinical Director, Elective Care Directorate
Mrs J Crewe	Operational Director, Acute & Cancer Care Directorate (representing Mr Alldred)
Mr P Nicholas	Deputy Director of Performance and Information (representing Mr Harrison)
Mrs A Mayfield	Deputy Chief Nurse (representing Mrs Foster)

In attendance:

Mrs S White	Corporate PA (minutes)

No	Item	Actions
1.	Welcome and apologies Apologies were received by the Record Taker prior to the meeting from Mr A Alldred Clinical Director, Acute and Cancer Care Directorate, Mrs J Foster, Chief Nurse, Mr R Harrison, Chief Operating Officer, Dr D Scullion, Medical Director and Dr S Wood, Deputy Director of Governance.	
2.	Minutes of the Last Meeting and Matters Arising The minutes of the meeting held on 1 July 2015 were approved as a correct record. There were no matters arising.	
	Objectives The Quality Committee's objectives had been discussed at the previous meeting, along with how assurance would be gained and success measured. In relation to CQC readiness, it was felt that this could be an agenda item, looking at one of the five questions from the Assurance Framework Self-Assessment each month, including differences across the directorates, and over the course of the year each question would be looked at at least twice. Evidence of what is being done around this would also be collected. Dr Wood would be asked to add the five questions to the Forward Plan, starting with the first next month.	*S White to speak to Dr Wood*
	Action Log Minute Ref: 4 - Follow up with Dr H Moss for date when the Clinical Effectiveness Policy and Strategy will come to Quality Committee for ratification.	*S White*
	Minute Ref: 3 -Terms of Reference – approved by Board on 22 July 2015 following minor amendment.	
	Minute 6: GP OOHs - Action Plan brought forward from September	*Dr Wood*

meeting.
Minute 7: Self-Assessment Process – remains outstanding to be discussed at SMT.
Minute 8: Future meetings – dates and venues confirmed for 2015.

4. Dashboards

Integrated Dashboard

This dashboard was received and taken as read. Mr McLean commented on the fact that the Quality Committee sees the dashboard after the Board of Directors. It was confirmed that the Quality Committee meetings had been timed to follow the Board meetings so that the Quality Committee could be asked to have a closer look at any areas of concern raised by the Board and report back. Equally the Quality Committee could also escalate any areas of concern to the Board at its next meeting.

It was agreed the main focus for the Quality Committee would be on the areas highlighted as 'reds' and 'ambers' to look at and understand issues that might lie beneath these. A log would be maintained of the different areas looked at and the frequency. However there would still be intermittent scrutiny of the 'green' rated sections in order to highlight areas which could still offer quality improvements. *S White*

In terms of the Red, Amber, and Green (RAG) ratings, the Quality Committee considered whether it would be appropriate for them to have any input into the criteria for the ratings. It was noted explanations were provided at the end of the report and it was agreed that the Quality Committee should comment on quality aspects only. Mr Marshall felt it would be valid for the Quality Committee to review the ratings. It was suggested that the first action would be to raise this at the next Senior Management Team (SMT) meeting, for this team to review the tolerance levels, specifically relating to quality. Mr Nicholas agreed to pick this up with Mr Harrison and to bring back the outcome to the next Quality Committee after this. *Mr Nicholas Mr Harrison*

Professor Proctor commented that she felt the narrative of HSMR was too crude and more detail was required in order to gain assurance. It was questioned whether it misleading rating this 'green'?

In relation to the Infection Control Section and the comments related to C.diff rated as 'amber', Mrs Webster commented that she felt this should be 'red' in view of the current position. Mr Nicholas advised that the report was produced at the end of June and the fourth case of C. diff had occurred at the end of July.

Mr McLean said he would expect a direction of travel indicator on all 'reds' e.g. C.diff – and the relationship between staff behavioural risk in relation to hand hygiene. The Quality Committee to seek assurance from the Director of Infection Prevention and Control on what is happening. *S White to contact Richard Hobson*

Mrs Crewe advised that the appropriate Clinical Director would respond to those queries at the meeting whenever they were able to, especially if a report has been to the Board the previous week and an issue raised there,

they should be able to respond to the Quality Committee. Dr Johnson commented that Clinical Directors rely on their Operational Directors keeping them up to speed and may need to refer to them to provide an up-to-date position.

Quality and Safety Dashboard

This dashboard was received and taken as read. Mrs Webster asked if there were any concerns or comments. Mr McLean commented that more narrative on the analysis as to actions to be taken and timeframe would be helpful, e.g. infection control did not provide sufficient information. Mr Nicholas confirmed that all Directorates have had the opportunity to supply narrative for their individual areas and to obtain updates from their teams as to actions being taken.

Mr Nicholas explained that the Quality and Safety Dashboard provides a breakdown by wards. Reports are prepared on a monthly basis, at the end of the month; therefore the report does not provide the latest position. Verbal updates could therefore be given at the Quality Committee meetings.

It was noted the number of Grade 3 pressure ulcers was not showing any reduction.

It was noted that incident reporting had been discussed at the Board of Directors' meeting and what an indication of a healthy culture of reporting should look like e.g. lots of no or low harm reporting is a good indication. It was also necessary to see the number of reports of moderate and severe harm against the total. It was felt that the narrative needed to explain what we believe is happening, with feedback to be brought to the next meeting if this was not possible at the time.

Mrs Mayfield referred to hand hygiene audits and actions being taken to drive up compliance. It was noted that whilst compliance is good the actual amount of audits undertaken is not as good. Dr Johnson suggested consideration be given by the Infection Control Team to whether this was the most effective way of ensuring people wash their hands - could it be made easier for people to comply? It was agreed this would be raised with the Director of Infection Prevention and Control when he attends the Quality Committee meeting.

Professor Proctor noted that all indicators are graded and provide a lot of information about certain aspects, but do not tell the Quality Committee anything about Community Services and Maternity and suggested referring this to the SMT for a proposal regarding these two areas. Dr Johnson reported that there is a monthly Maternity dashboard which contains a wide spectrum of information, some of which is required by the CCG. In terms of Community Services, Mrs Crewe advised that there is limited information already and it would not be difficult to produce this in a dashboard format. It was agreed that Dr Johnson would circulate the Maternity Dashboard, before the next meeting, to enable the Quality Committee to consider if it would be helpful to receive this in the future. Mrs Crewe agreed to send any information the Committee could be looking at in advance of the next meeting.

Mr Harrison

Dr Johnson/ Mrs Crewe

It was noted that information on these two areas is also received at the Operational Delivery Group (ODG). Mrs Crewe reported she would be drafting a report for SMT and for scrutiny by the Quality Committee in September.

Mr Marshall noted that in relation to the Family and Friends Test and variances, the aim was to have a consistent approach to compliance across all areas to provide a fair reflection. The figures on the Quality Dashboard in relation to this area were generally very good, with only one or two very slight spikes which may not be a cause for concern, but the Quality Committee need to be aware of any issues.
Dr Johnson pointed out that it is necessary to look at the comments to understand what is going on. In the case of maternity services, she highlighted the factors that can affect the answers: it's an emotional time, care during birth is one-to-one but then the level of care changes, currently there is refurbishment work taking place.

It was agreed that Directorate Boards need to consider how to promote the message that the Family and Friends Test needs to be completed on a consistent basis – learning from what others are doing really well. Mrs Crewe and Dr Johnson to feedback this message to their directorates, and Mr Harrison would be asked to take this back to ODG. *Mrs Crewe/Dr Johnson/ Mr Nicholas*

It was noted the Quality and Safety Dashboard is cascaded within directorates and issues taken forward by Directorate Boards or Quality and Governance Groups, comments are also fed-back to staff.

As this report is no longer to be part of the Board Pack it was agreed that going forward the Quality Committee would spend more time reviewing this dashboard, However to receive greater assurance it would be helpful if the narrative could be expanded to enable a better understanding of variances in data and in particular where there is a highlighted issue to provide appropriate narrative to show that it is being addressed. *Executive Directors*

5. <u>New Items and Hot Spots</u>
Mrs Webster asked if there were any issues in relation to quality not highlighted in the dashboards that members of the Committee were aware of.

Dr Johnson highlighted an issue in relation to a significant increase in requests for scans, as a result of new guidance from SaBiNE (Saving Babies in North England) and a level of anxiety from staff about missing things - doing all we can to prevent stillbirth. This was creating pressure on the radiology department.
This had been identified as a cost pressure for the directorate, as there was no money within the contract for scans if low risk on the pathway. Some agency screening was being provided in the interim and a business case was being looked at, in addition to considering other options around these scans and other staff being trained to do this.
As this was a cost risk rather than a quality risk it was agreed that this would be picked up outside the meeting. However it would be flagged up at Board during the Quality Committee update section. *Mrs Webster / Dr Johnson*

Mr Nicholas reported that the number of cases of C. diff had risen to 7. Twelve is our threshold for the year to 31 March 2016. Information on this 7th case was awaited but it looked like a community case –a specimen not taken within first 72 hours - a RCA would be undertaken. It was agreed that this was a worrying situation. What was particularly important to note was that to date investigations show there had been no evidence of transmission from patient to patient.

Mrs Crewe reported that community services were under pressure from increasing activity levels and staffing issues, including a number of unfunded posts, and the workforce were very stretched. A number of actions were being taken to address the issues. As a consequence the commissioner had been advised that activity would have to be capped, to ensure the service remained safe, as the Trust could not continue putting more hours of work into the service and not being paid for this as it posed a financial risk to the organisation.

Dr Tolcher joined the meeting at this time.

6. Update on GP Out Of Hours (GPOOH) Clinical Safety

Mrs Crewe presented an action plan which was taken as read. She apologised that the Committee had received this without any covering paper of explanation. Mrs Crewe said the action plan provided a level of assurance of actions being taken and noted there had been an improvement of performance particularly in relation to urgent face-to-face contacts. It was noted that actions being taken forward fell under three main headings:-

- Changes to direct booking process to be brought in, to improve timeliness in seeing patients. This was being tested at the moment and due to go live on 5 September in Harrogate. The system would link into the Emergency Department (ED) so they could see the same booking system and would be used in ED when GP OOHs is more appropriate for a patients needs. It was expected efficiencies and improved productivity in the service would result. Evidence from other areas suggests this improves performance around National Quality Requirements (NQRs).

- An increased level of scrutiny in relation to NQRs to understand some of the behaviours and culture in the GP OOHs service which potentially affects timeliness of when patients are seen, including addressing specific individual issues in respect of timeliness and any limitations to the service as a whole. GP OOHs staff have been made more aware of the importance of NQRs and now receive a dashboard, and NQRs are highlighted at team meetings. There will also be audits around staff understanding and to see if there has been a change.

- Clinical Effectiveness audit results are to be shared across the team. A recommendation from a Serious Incident Requiring Investigation (SIRI) in GP OOHs was for clinician led, regular audits of telephone conversations, to ascertain the quality of our telephone conversations; as the SIRI had identified this was not at the expected level and as a

result additional training in respect of communications has been put in place. Other audit recommendations had been around documentation. The clinical lead had also looked at timeliness of patient follow up response and residential home visits. Finally some new policies have been looked at to improve how we deal with patients who we find we can't make contact with.

Mr McLean asked about the status of the GPs concerned were they working in GP surgeries or just OOHs? Mrs Crewe advised that in Harrogate many are part of our existing GP community. Mrs Crewe was also asked if the issues we are concerned with are typically from local GPs, she confirmed that it was a mixture of both, however, predominantly it is where we have GPs working for us from locum agencies and therefore harder to hold to account. Expectations of them are made very clear and they would not be engaged again if they did not meet these.

It was noted that the GPOOHs Action Plan was not completely 'green' as there were still some outstanding actions. Dr Tolcher said she would expect to see a timeframe for achieving these outstanding actions included in the longer-term. However it is possible that it will be very difficult to get all of these elements to a green rating as the NQR levels are set externally.
If it is the case that we will not achieve 'green' status, then appropriate assurance needs to be provided to this committee that we are confident that the service is safe.

Mrs Webster asked if the Trust could be fined if the standard was not met and Dr Tolcher advised that there is no fine, but this is a poorly commissioned service.

Mr Marshall commented that an audit on this would be helpful. The GPOOHs action plan would be going to the Board of Directors in September and it was agreed that it would come back as an agenda item to the Quality Committee in November. *S White*

Mrs Crewe concluded that there was confidence that the results shown on the dashboard would improve over the next six months as a result of these actions.

7. Quality Improvement Priority Update - Communications

Acute and Cancer Care Directorate

A paper from the Acute and Cancer Care Directorate was received and taken as read. It set out how the baseline had been identified, using information from complaints as a benchmark, and provided details of the work the Directorate was doing to try and address the issues around communication. It was noted that this Directorate is very disparate and does not receive a large number of complaints. Some of the actions being taken to improve communications included:

- Training and developing communication skills for staff, including using 'Every Patient Every Time' and 'Barbara's Story' to highlight the importance to staff of good communications
- Collating patient feedback from all areas of the Directorate and identifying where improvements could be made

- Increasing the use of technology to improve recording of information and patient safety
- Information boards used in wards and department to display key messages
- Quarterly Patient Experience report shared and cascaded within directorate.

It was agreed it was a very helpful paper. Professor Proctor queried how directorates share the learning so a similar issue does not happen in another directorate. Mrs Crewe said this would be shared at Directorate Board and across the Directorate, if it related to patient safety; it would be shared at ODG. It is also discussed at the Learning from Patient Experience meeting chaired by Mrs Foster. In addition, the quality governance leads in directorates meet and share quality reports.

<u>Elective Care Directorate</u>
Dr Johnson apologised that there was no paper and instead gave a verbal report on the actions being taken in the Directorate to improve communication. It was recognised that poor communication is often close to the heart of a complaint. Some of the actions being taken to highlight and improve communications included:

- Circulation of quality report to Quality Board, this is also cascaded to all members of Quality of Care Teams (QCTs), along with other learning from complaints
- Patient story at the beginning of meetings which provides a very powerful message
- Work was on-going to improve the structure of QCTs and trying to address the issue of medical staff attendance which is disproportionate as it is very much nurse focused.

Dr Johnson noted that communication can deteriorate when staff are under pressure and noted the resilience training and support from HR that was in place for staff. There was immediate access to self-refer to the Occupational Health Department when staff need this. Mrs Webster asked if Mr Marshall was aware of the numbers taking this up and he advised that this is not monitored but he could bring an update to the next meeting. The Trust recognises the importance of healthy, happy staff and the importance of ensuring they feel valued and treated equally. It was noted that patient feedback is overwhelmingly positive. *Mr Marshall*

A discussion was held about how we could know that Communications are improving. Dr Tolcher applauded the work that Acute and Cancer Care Directorate had done in using patient feedback.
Using PALs feedback was important to ensure that things are being 'nipped in the bud' and that there is shared learning from complaints between Directorates. The messages coming through from PALs are extremely important.

Quality Assurance now highlight 3 top quality messages and encourage each ward to have a theme of the month.

The effectiveness and success of the actions being taken would be measured by the changes seen as a result and capturing patient feedback.

A high level indicator would be a fall in complaints relating to communication. There would be many more non-tangible benefits as communication within teams forms the bedrock of safe care.

Integrated Care Directorate

No report had been received and it was agreed that a written report would be requested to be circulated to the Quality Committee members prior to the next meeting. *Dr Hammond*

8. Items for Forward Plan

This was considered and it was agreed:-

- To invite Richard Hobson to attend September's meeting, if available, to report on Infection Control specifically C.diff concerns.
- Quality Priority Update: Patient Flow – reports to September meeting.
- Integrated Care Directorate to be asked for an interim report on Communication in line with the schedule of reporting.
- Annual Information Governance update – October, with final March – anything for September?
- Patient Experience Report to be received in September.
- Staff, Family and Friends report in April.
- Well Led Review – may be later than planned.
- Clinical Effectiveness Policy and Strategy from Dr Moss – date to be agreed and added to Forward Plan.

9. New Reports Received

The log of reports was received and it was noted that this lists the reports from external bodies, visits, and inspections etc. which have recommendations relevant to HDFT and that have been received by Dr Wood. The report details the dissemination process to key staff for reviewing and developing action plans, and groups within the governance framework to support and monitor progress with meeting the recommendations.

This was an opportunity for the Quality Committee to ask for further assurance if they felt it necessary about the completeness of the reports included, actions being taken in relation to specific reports, and assurance about the process. It was agreed that Dr Wood would be asked to explain the standards showing as 'red' at the next meeting. *Dr Wood*

10. Items to escalate to Board of Directors
    - Impact of cost pressures from additional maternity scanning requests activity.
    - Putting agreed actions in place in response to SIRIs.

11. Any Other Business

There were no further items of business.

12. Reflection on Meeting
    - Noted that if we had kept the quorum status to include Integrated Care then we would not have been able to hold the meeting today as a representative from the Integrated Care Directorate should attend these

meetings. This would be followed up by Dr Tolcher *Dr Tolcher*

- Significant time spent on the dashboard, next time there would be three reports to receive, but agreed there would be more time to discuss purely quality issues.
- Agreed helpful discussions.

13. Next meeting
Wednesday 2 September 2015, 2.00 pm, Boardroom, Trust HQ

Apologies were noted from Professor S Proctor.

Harrogate and District NHS
NHS Foundation Trust

MINUTES OF THE AUDIT COMMITTEE MEETING
Held on 21 May 2015
Farndale Meeting Room, Harrogate District Hospital

Present:	Mr C Thompson	Non-Executive Director (Chair)
	Prof S Proctor	Non-Executive Director
	Mrs M Taylor	Non-Executive Director
In Attendance:	Mr J Coulter	Finance Director & Deputy Chief Executive, HDFT
	Mr A Forsyth	Interim Head of Corporate Affairs, HDFT
	Mr T Morrison	Head of Financial Accounts, HDFT
	Mr J McKie	Deputy Director of Finance, HDFT
	Dr S Wood	Deputy Director of Governance, HDFT
	Mr T Watson	Internal Audit Manager, NYAS
	Mr A Smith	Senior Manager, KPMG
	Mrs C Partridge	Director, KPMG.
	Miss K Anderson	Audit Committee Secretary, NYAS
	Dr R Tolcher	Chief Executive, HDFT [item 8(ii)]

1 Apologies for Absence and Attendance

Apologies for absence were received from Mr Ward, Non-Executive Director, Mrs Kemp-Taylor, Head of Internal Audit, NYAS and Dr C Hall, Deputy Medical Director, HDFT.

Mr Thompson welcomed Mrs Taylor who has joined the Audit Committee in her capacity as new Non-Executive Director.

2 Declaration of Interests

No declaration of interests.

3 Minutes of Previous Meetings

(i) Audit Committee Meeting held on 7 May 2015

Dr Wood requested re-wording on page 4 regarding the Quality Account to read 'Mr Ward enquired if there was any significant difference in the requirements for the Quality Account'

The minutes of the 7 May 2015 Audit Committee meeting were approved as an accurate record of the meeting held subject to the amendment above.

4 Action Points

See separate Action Point document for progress against actions.

5 Matters Arising

There were no matters arising from the minutes of the previous meeting.

6 Clinical Assurance

(i) Quality Account

Dr Wood stated that the document had been through significant proof reading and additional areas

had been included in light of the comments raised by KPMG, to ensure it was an accurate document covering all aspects of Quality activity in 2014/15. She highlighted the additional information in terms of the outstanding Internal Audit control weaknesses, which are reflected in the Annual Governance Statement, work around community equipment and details on the ambulance handovers both requested by the CCG.A short section on the 2014 National Inpatient Survey results had also been included as the results have now being received. Dr Wood concluded that all outstanding indicator data had now been included.

Prof Proctor said the narrative was clear and commended Dr Wood and those involved. Mr Thompson agreed and formally thanked everyone involved in the Quality Account for their hard work in preparing the Report.

The Quality Account was recommended to the Board of Directors.

7 Governance

(i) Review Staff Registers of Interests and Gifts and Hospitality

Mr Forsyth summarised that the Trust has a robust and proactive system of reporting interests and gifts and hospitality. He said that departments have been chased which has resulted in receiving retrospective declarations and added that people are aware of and compliant with the Standards of Business Conduct Policy. Mr Thompson agreed it is a very comprehensive report which provides assurance to the Audit Committee.

Prof Proctor enquired what the threshold for reporting declarations is. Mr Forsyth confirmed it is £50.

The Staff Registers of Interests and Gifts and Hospitality was noted.

(ii) Review Audit Committee Annual Report (Final)

Mr Thompson stated that amendments had been made as per discussions held at the Audit Committee meeting held on 7 May and that delays in finalising the report were around ensuring there were appropriate consistency between the Audit Committee Annual report and the External Audits report. Mr Smith explained that the report is referred to in KPMGs audit report to state that it is consistent with their findings and opinion.

The Audit Committee Annual report was approved.

8. Financial Management

(i) Consideration of going concern

Mr Thompson stated that the appropriateness of preparing the accounts on a going concern basis was formally considered at the March Audit Committee meeting and at the Accounts Review Meeting. He added that a paper regarding going concern would be taken to the end of May 2015 Board of Directors meeting next week.

Mr Coulter said the Trust had just submitted its annual plan and as part of that submission, statements were signed to say that the Trust will be financially stable for the next five years.

Mr Thompson proposed that the Audit Committee recommend the approval of Financial Statements and the Annual report on the basis of going concern.

(ii) Review of Annual Report

Dr Tolcher summarised that the Annual Governance Statement (AGS) sets out arrangements and assurances the Trust has in place within its framework for internal control. It sets out everyone's responsibilities under the Trust's new governance framework and the groups that work within the

organisation to deliver on those responsibilities. She added that the document includes a summary of current key risks to the Trust, both strategic and corporate.

Dr Tolcher stated that the Trust had conducted a self-assessment against the Monitor Licence and CQC compliance requirements, which has shown the Trust to have robust systems in place for governance. Whilst no significant concerns to report have been highlighted in the AGS she asked the Audit Committee to note the caveats on the final page which flag up outstanding control weaknesses arising from the work undertaken by Internal Audit throughout the year. Dr Tolcher concluded that a considerable amount of work had been undertaken to close risks and that this will be followed up further.

Dr Wood noted that she was aware of an new risk on the Corporate Risk Register and asked whether the Annual Governance Statement should reflect that, given the risk had been escalated after the year end. Mr Smith confirmed that the document should reflect both current and future risks, therefore if the additional risk is considered significant then it should be included in the statement.

Mr Coulter added that the Chair and Chief Executives statements, tabled at the meeting, have been added to the Annual Report and that KPMG have conducted a review of the document. Mr Smith stated that the review is on-going and whilst the key areas have been reviewed and no issues have been identified the annual report is subject to a final full review. Mr Coulter added that an updated report including all areas of the annual report, including KPMG's full review would be available for next week's Board Meeting. He added that KPMGs audit opinion needs to be inserted into the Annual Report.

Mr Thompson sought and received approval to approve the Annual report, subject to agreed changes, and recommend to the Board of Directors for formal approval.

Dr Tolcher and Dr Wood left the meeting.

(iii) Review of Final Trust & Charitable Annual Accounts

Trust Accounts

Mr Thompson noted that the Trust Annual Accounts had been to the Audit Committee previously and had been discussed at length with all comments dealt now reflected.

The Final Trust Annual Accounts were approved subject to the changes noted above.

Charitable Accounts

Mr Morrison highlighted that he was waiting for confirmation from External Audit as to the correct act to note, this will now be changed to reference the Charities Act of 2011.

The Final Charitable Annual Accounts were approved subject to the changes noted above.

Mr Mckie and Mr Morrison left the meeting.

(iv) Review of Losses and Special Payments

Mr Coulter explained that a more detailed report, reconciliation and account categorisation were included in the paper this time. He went on to add that some of the losses are made up of a large number of items for example prescription charges; other balances mainly relate to dentures and glasses. He said that outstanding balances have been reconciled with the ledger. Mrs Taylor commented that the £26,000 total losses were minimal for a year.

The Losses and Special Payments paper was noted.

9. Internal Audit and Counter Fraud

(i) Review of Counter Fraud Annual Report

Mr Moss explained that the self-review tool, which requires organisations to review compliance with provider standards, had been introduced last year. He added that overall the Trust scored as Green which is an improvement from last year's Amber score. The Trust had fully met 18 of the standards, partially met 5 of the standards and recorded a neutral response against one standard. He hoped that the work planned for the next year would ensure the Trust is fully compliant with all standards.

Mr Moss stated that various methods had been used throughout the year to inform and involve the Trust staff such as; face to face presentations, the Trust open event, an e-learning package and information on wage slips/staff bulletin.

During 2014/15 the Counter Fraud Team have liaised with a number of agencies to assist in countering fraud, including the Home Office, North Yorkshire Controlled Drug Local Intelligence Network, Regional Local Counter Fraud Specialists Forum and the Regional Counter Fraud Managers' Group meetings.

Mr Moss added that the Anti-Fraud, Bribery and Corruption Policy had been revised and includes additional information on the Fraud Act, Bribery Act and gives examples of frauds Trust staff may potentially encounter. He added that it is explicit in terms of the roles and responsibilities of staff.

Mr Moss stated that the Trust is undertaking the National Fraud Initiative (NFI) this year. He added that employees were notified about participation in the NFI via wage slips, Team Brief and the Intranet. The Trust was found to be compliant with the NFI Security policy's requirements with no duplicate payments found for the creditor exercise within the organisation. He said that they are currently reviewing the payroll matches which may lead to some investigation work.

Mr Moss explained that the Counter Fraud team had received twelve referrals, which is one more than last year. Working whilst on sick leave is the most prevalent fraud at the Trust and a trend across the NHS.

Mr Moss summarised two of the investigations listed in the report:

Prescribing Investigation – NYRT/12/00078
Mr Moss stated that this related to a Locum Doctor falsifying prescriptions and the LCFS' had provided witness statements to the General Medicine Council (GMC). A hearing will take place in August and the Trust's Medical Director is aware of the case.

Timekeeping Referral – 69565
Mr Moss explained that this case related to an employee who is alleged to routinely arrive late and leave early. This case has been referred back to HR and a disciplinary hearing is due to take place in June.

Prof Proctor enquired if Trust staff found to be working whilst on sick leave, were working elsewhere in Harrogate. Mr Moss confirmed they were found to be working mostly in Harrogate and Leeds. Prof Proctor asked what level of awareness there is across the Health sector, in particular care homes and also in the private sector. Mr Moss said that awareness was good in the public sector which should ensure any public sector cases are picked up. He explained that it is more difficult to identify staff who work within the private sector, because the private sector do not take part in the exercise.

Mr Thompson commented he was surprised that the NFI exercise was not run more frequently given the previous successes. Mr Moss said that the Cabinet Office are proposing real time matches, which will identify these issues on a regular basis.

Mr Thompson asked that after the recent Stepping Hill incident, and the individual providing false references, does Mr Moss expect a purge in this area. Mr Coulter replied that pre-employment

checks are part of the Internal Audit programme and that the Trust has a robust system in place. Prof Proctor commented that it will be at least two years until an independent review will be published, so for now the Trust should ensure that the pre-employment checks process is robust. Mr Watson confirmed that Pre-Employment checks had been covered this financial year and controls in place were generally operating well.

The Counter Fraud Annual Report was approved.

10. External Audit

(i) External Audit ISA 260 report and Letter of Representation

Mr Thompson thanked the Finance team and voiced his appreciation for their hard work and dedication in completing the financial statements and Annual report. He also thanked KPMG for the work they had done.

ISA 260 Charity Accounts
Mr Smith stated that the audit of the charitable accounts had been completed and there were no audit differences or issues to note.

Mr Smith said that KPMG is satisfied with the Annual Report disclosures and confirmed there are no issues in financial statements therefore the charitable fund accounts have been given a clean opinion.

ISA 260 Trust Accounts
Mr Smith explained that an outstanding balance for Leeds North CCG had been highlighted in the report because of its material value. Mr Thompson stated that given the amount, he was surprised the Audit Committee were not previously made aware of it. Mr Coulter explained that all Trusts make estimates of income and expenditure and the difference of £0.8 million is in terms of the difference between the Trust's expectation of activity delivered and that of Leeds North CCG. He added that he is confident the amount is collectable, and discussions are being held with Leeds North CCG to resolve the issue. Mr Morrison added that differences on the agreement of balances only become apparent when the draft accounts are submitted centrally and the Trust is then made aware of differences with counterparts' estimates.

Mr Thompson requested the Audit Committee be updated for assurance purposes. Mr Coulter added that the Trust will have a more accurate picture by the July Board meeting and assured the Audit Committee that the Trust had followed the same year-end process as usual.

ACTION: Mr Coulter to keep the Board informed of the progress with resolving the difference and to provide a summary of impact to the July Board Meeting.

Mr Thompson sought reassurance that it was still appropriate for the Audit Committee to approve the accounts with this outstanding difference.

Mr Smith added that it would not be unusual for the Audit Committee to approve the accounts and assurance can be taken from KPMGs review of all material accounting estimates.

The Audit Committee noted the outstanding balances.

Mr Smith stated that in terms of use of resources, KPMG found no issues. They reviewed correspondence with Monitor and CQC, plus reports from external agencies and inspector bodies and the Annual Governance Statement. He concluded that based that work, KPMG are satisfied they can provide a clean use of resources conclusion.

Mr Smith said that KPMG will be issuing an unqualified opinion on the financial statements. He explained that KPMG had highlighted some presentational issues which have now been addressed and their review of the annual report is on-going. Work on the annual report would be concluded soon, and comments fed back to the Trust prior to the Board meeting.

Mr Smith concluded that KPMG are happy with the review of the Remuneration Report, Annual Governance Statement and the Annual Audit Committee Report.

Mrs Partridge thanked the Finance team for their co-operation and for providing information when required.

Letters of Representation

Mr Thompson sought and obtained approval from the Audit Committee to recommend and endorse the draft representation letters to the Board of Directors for signing.

(ii) External Audit's Review of Quality Account

Mr Smith stated that KPMG had reviewed the content of the report against Monitor's and the Department of Health requirements and that it had been checked for consistency against specified documentation. He added that a few items had been identified in the Board of Directors minutes which have now been included in the Quality Account

Mr Smith confirmed that regarding the indicator data, he was assured it was in line with the reported data. He commented that he had not had sight yet of the CQC Inpatient Survey as it had not yet been released to the Trust, the Quarter 4 Hospital Intelligence Monitoring Report or feedback from the Health and Wellbeing Board. Mr Smith stated that if they are unable to review these, it will not change their opinion, they will just have to state in their report that these areas were not covered as part of the review.

Mr Smith added that the Trust are required to publish Emergency Readmission data from the Health and Social Care Information Centre (HSCIC), but noted that the data is out of date and from 2013/14.

Incomplete pathways within 18 weeks
Mr Smith stated that KPMG had reviewed the data and were giving it a limited assurance opinion in respect of this indicator. He clarified that the limited assurance opinion meant there was limitation of scope and not areas of concern as you might find in a limited assurance Internal Audit opinion.

Mr Smith explained that the data reported by the Trust to NHS England is not strictly in line with National definition. He added that the Trust should be reporting unadjusted time for incomplete pathways however has been reporting an adjusted position. Analysis by the Trust has shown that this inflates performance by 0.5% and does not created a difference in reported performance.
Mr Coulter confirmed that reporting had been amended to report in line with national definitions from1st April 2015.

Emergency readmissions within 28 days of discharge
Mr Smith stated that although the indicator is supposed to be against 28 days, the Trust reports against 30 days which is the same for most providers. He explained that no issues were found and this indicator was given a limited assurance opinion. Mr Thompson enquired whether there would be a significant difference if the Trust reported against the 28 days. Mr Smith explained that the indicator comes from HSCIC and their information is up to 18 months out of date.

62 day Cancer Referrals
Mr Smith confirmed that no issues were found during testing and no opinion was needed as this was not a mandated indicator.

For clarity, Mr Coulter requested for KPMG to include a description of what a limited assurance opinion is in the narrative of the External Audit report.

ACTION: Mr Smith to include a description of limited assurance opinion in the External Audits report on the Quality Account.

(iii) Review of External Audit's Representation Letter (Draft)

(iv) Confirmation of External Audit Independence

Mr Thompson thanked KPMG for the declaration of objectivity (included under item 10(i) above). He agreed that KPMG have appropriate controls in place to ensure they are able to operate on an independent basis.

External Audit's independence was noted.

11. Standing Items

(i) Audit Committee Timetable

Prof Proctor said that as the Trusts' new governance structure comes into place in June, the Standards Group items will need a closure date of May, and the new groups will need adding to the timetable.

ACTION: Mr Watson to liaise with Dr Wood regarding the new groups.

Mr Thompson noted that Prof Proctor is a member of the new Quality Committee and asked whether it would still be appropriate for the Audit Committee to review the minutes to gain assurance on the overall governance structures in place across the Trust. Prof Proctor said that there will be a transition period, so it may be appropriate to receive the minutes for the September and December Audit Committee meetings and then review the position in the new financial year. Mr Thompson added that he expected the Quality Committee to review all sub committee meeting minutes, so that the Audit Committee would not need to. Prof Proctor confirmed the Quality Account would review sub committee minutes and would provide assurance to the Audit Committee over this process.

12. Any Other Business

There was no other business.

13. Date, Time & Venue of Next Meeting

8 September 2015 Farndale Meeting Room, Harrogate District Hospital

- 09.00 – 09.30 Pre-Meet for Audit Committee Members
- 09.30 – 12.30 Audit Committee