Board of Directors public - 25 October 2017 - all documents

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Harrogate and District
NHS Foundation Trust

The meeting of the Board of Directors held in public will take place on
Wednesday 25 October 2017
Boardroom, Harrogate District Hospital, HG2 7SX

Start: 9.00am Finish: 12.30pm

AGENDA			
Item No.	**Item**	**Lead**	**Paper No.**
9.00am – 10.50am			
1.0	**Welcome and Apologies for Absence** *To receive any apologies for absence: Mrs Maureen Taylor*	Mrs S Dodson, Chairman	-
2.0	**Declarations of Interest and Register of Interests** *To declare any interests relevant to the agenda and to receive any changes to the register of interests*	Mrs S Dodson, Chairman	2.0
3.0	**Minutes of the Board of Directors meetings held on 27 September 2017** *To review and approve the minutes*	Mrs S Dodson, Chairman	3.0
4.0	**Review Action Log and Matters Arising** *To provide updates on progress of actions*	Mrs S Dodson, Chairman	4.0
Overview by the Chairman		Mrs S Dodson, Chairman	-
5.0	**Bi-annual review of Strategic KPIs** *To receive the report for comment*	Dr R Tolcher, Chief Executive	5.0
6.0	**Report by the Chief Executive Including the Integrated Board Report** *To receive the report for comment*	Dr R Tolcher, Chief Executive	6.0 6.1
7.0	**Report by the Finance Director to include:** – **Financial Recovery Plan Monitoring** – **CIP Monthly Update** *To receive the report for comment*	Mr J Coulter, Deputy Chief Executive/ Finance Director	7.0
10.50am – 11.00am – Break			
11.00am – 12.30pm			
8.0	**Report from the Chief Operating Officer** *To receive the report for comment*	Mr R Harrison, Chief Operating Officer	8.0

9.0	**Report by the Director of Workforce and Organisational Development** *To receive the report for comment*	Mr P Marshall, Director of Workforce & Organisational Development	9.0
10.0	**Report from the Chief Nurse, including Annual Efficiency Programme Quality Impact Assessment** *To receive the report for comment*	Mrs J Foster, Chief Nurse	10.0
11.0	**Report from the Medical Director** *To receive the report for comment*	Dr D Scullion, Medical Director	11.0
11.1	**Guardian of Safe Working Hours Quarterly Report** *To receive the report for comment*	Dr D Scullion, Medical Director	11.1
12.0	**Oral Reports from Directorates** *12.1 Planned and Surgical Care* *12.2 Children's and County Wide Community Care* *12.3 Long Term and Unscheduled Care*	 Dr K Johnson Clinical Director Dr N Lyth, Clinical Director Mr A Alldred, Clinical Director	 - - -
13.0	**Committee Chair Reports** *13.1 To receive the report from the Finance Committee meeting held 12 October 2017.* *13.2 To receive the reports from the Quality Committee meetings held 4 October 2017.*	Mrs L Webster, Non-Executive Director / member of the Finance Committee Mrs L Webster, Non-Executive Director / Quality Committee Chair	13.1 13.2
14.0	**Infection Control Update** *To receive the report for comment*	Dr Jenny Child, Director of Infection Prevention and Control	14.0
15.0	**Business Planning Update** *To receive the report for comment*	Mr J Coulter, Deputy Chief Executive/ Finance Director	15.0
16.0	**Other matters relating to compliance with the Trust's Licence or other exceptional items to report, including issues reported to the Regulators** *To receive an update on any matters of compliance:*	Mrs S Dodson, Chairman	-
17.0	**Any other relevant business not included on the agenda** *By permission of the Chairman*	Mrs S Dodson, Chairman	-
	Board Evaluation	Mrs S Dodson, Chairman	-
Confidential Motion – the Chairman to move: *Members of the public and representatives of the press to be excluded from the remainder of the meeting due to the confidential nature of business to be transacted, publicly on which would be prejudicial to the public interest.*			

Harrogate and District NHS Foundation Trust

BOARD OF DIRECTORS – REGISTERED DECLARED INTERESTS
October 2017

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 Company Secretary

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 of Red Kite Learning Trust – multi-academy Trust
Dr Ros Tolcher	Chief Executive	1. Specialist Adviser to the Care Quality Commission 2. Member of NHS Employers Policy Board (Vice Chair). 3. Harrogate Ambassador on behalf of Harrogate Convention Centre
Mr Jonathan Coulter	Deputy Chief Executive/ Finance Director	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 2. Charity Trustee of Acomb Methodist Church, York
Mr Phillip Marshall	Director of Workforce and Organisational Development	1. Member of the Local Education and Training Board (LETB) for the North
Mr Neil McLean	Non-Executive Director	Director of: - Northern Consortium UK Limited (Chairman) - Ahead Partnership (Holdings) Limited - Ahead Partnership Limited - Swinsty Fold Management Company Limited - Acumen for Enterprise Limited
		None

Laura Robson	Non-Executive Director	
Dr David Scullion	Medical Director	1. Member of the Yorkshire Radiology Group
Mrs Maureen Taylor	Non-Executive Director	None
Mr Christopher Thompson	Non-Executive Director	1. Director – Neville Holt Opera 2. Member – Council of the University of York 3. Chair – Audit Yorkshire Consortium
Mr Ian Ward	Non-Executive Director	1. Non-Executive Director of : • Charter Court Financial Services Limited, • Charter Court Financial Services Group Limited, • Exact Mortgage Experts Limited, • Broadlands Finance Limited • Charter Mortgages Limited. In respect of the five companies above, Mr Ward is Chairman of the Remuneration Committee and Chairman of the Nominations Committee. Also, for each of them, he is a member of the Board Risk and Audit Committees. 2. Non-Executive Director of Newcastle Building Society and a member of the Group Risk Committee. Also, he is Chairman of its subsidiary company, Newcastle Systems Management Limited and a Director of Newcastle Financial Advisers Limited. 3. Member, Leeds Kirkgate Market Management Board
Mrs Lesley Webster	Non-Executive Director	None
Mr Andrew Alldred	Clinical Director LTUC	None
Dr Kat Johnson	Clinical Director PSC	None
Dr Natalie Lyth	Clinical Director CCCC	None
Dr David Earl	Deputy Medical Director	1. Private anaesthetic work at BMI Duchy hospital
Dr Claire Hall	Deputy Medical Director	1. Trustee, St Michael's Hospice Harrogate
Mrs Joanne Harrison	Deputy Director of W & OD	None
Mr Jordan McKie	Deputy Director of Finance	1. Familial relationship with NMU Ltd, a company providing services to the NHS
Mrs Alison Mayfield	Deputy Chief Nurse	None
Mr Paul Nicholas	Deputy Director of Performance and Informatics	None

Harrogate and District
NHS Foundation Trust

Report Status: Open

BOARD OF DIRECTORS MEETING

Minutes of the Board of Directors' meeting held in public on
Wednesday 27 September 2017 9.00am in the Boardroom at Harrogate District Hospital.

Present:
Mr Jonathan Coulter, Deputy Chief Executive/Finance Director
Mrs Sandra Dodson, Chairman
Mrs Jill Foster, Chief Nurse
Mr Robert Harrison, Chief Operating Officer
Mr Phillip Marshall, Director of Workforce and Organisational Development
Mr Neil McLean, Non-Executive Director
Dr David Scullion, Medical Director
Mrs Maureen Taylor, Non-Executive Director
Mr Chris Thompson, Non-Executive Director
Dr Ros Tolcher, Chief Executive
Mr Ian Ward, Non-Executive Director
Mrs Lesley Webster, Non-Executive Director

In attendance:
Mr Andrew Alldred, Clinical Director for Long Term and Unscheduled Care
Dr David Earl, Deputy Medical Director
Dr Kat Johnson, Clinical Director Planned and Surgical Care
Dr Natalie Lyth, Clinical Director for Children's and County Wide Community Services
Mrs Katherine Roberts, Company Secretary (minutes)
Mrs Angela Schofield, Chairman Designate

Patient Story

Prior the meeting the Board heard a patient story from the family of a 14 year old patient who had received care on Woodlands Ward. The family had a poor experience of communication with some staff and felt that the quality of care had suffered because the admission was at a weekend. The family had been told that as a teenager it was not possible to be treated on the Nidderdale (adult women) ward, however they felt it had been inappropriate to be placed on the Children's ward. On a third visit to the hospital the family had an improved experience. Throughout the treatment nursing staff had been caring and supportive. The family had been unclear how to raise concerns at the time of their experience.

All members of the Board of Directors expressed their apologies to the family for their experience.

Mrs Foster explained the Trust usually sought patient choice as to whether teenagers are placed on a children or an adult ward. It was extremely regrettable that in this case the family had not been given a choice. She noted that for smaller hospitals such as

Harrogate which do not have teenage wards, it is a dilemma where teenage patients should be placed.

The Board reiterated their apologies and committed to making a difference as a result of the family's experience.

After the family had left the meeting Mrs Dodson invited the Board to share their reflections on the story.

Dr Tolcher said treatment of teenage patients in the right setting was a known issue for the Trust. She also felt the story revealed an issue for patients getting access to the right services when an immediate diagnosis was not clear. In these situations staff could improve on how they explained the complexity of the care plan to patients and be clear about which team would take clinical leadership. 'You matter most' should be at the fore for all clinicians.

Dr Johnson said her team had developed a poster explaining how patients can raise concerns during their care so that these can be addressed as early as possible.

Mrs Foster noted the Youth Forum had attended the Emergency Department in a mystery shopper exercise. This had revealed young people did not feel they were addressed directly. There was a question as to whether all clinical teams were ensuring young people are involved in decisions about their care.

Mr Harrison expressed concern about the handover of care on a Friday. This was a known fault of the 'surgeon of the week' model because the surgeon on call did not keep patients over the weekend. There needed to be a shared care protocol between children's and surgical services. He also noted that the Trust had moved a long way on providing radiological services at weekends, but not all clinical colleagues appeared to be aware that these service were available.

Mrs Webster said the Trust's quality priorities included an ambition to improve communication. Teams needed to reflect and think differently how they communicated with patients and families, in order to facilitate the resolution of issues before they reached the complaint stage.

Mrs Dodson said she wanted to empower clinicians to approach patients when it is clear they are unhappy, and enquire what is not right.

ACTION: Sandra Dodson to write to the family and thank them for attending the Board. The letter should include some replications from the Board's reflections. In addition it should include an invitation to join the Trust's Youth Forum.

1.0 Welcome and Apologies for Absence

Mrs Dodson expressed a very warm welcome to Mrs Angela Schofield, Chair Designate.

She noted that apologies had been received from Ms Laura Robson, Non-Executive Director.

Mrs Dodson welcomed observers to the meeting, this included the NED Insight programme delegates Ruth Irving and Jasmeet Narang, and Mr Paul Widdowfield (Communications and Marketing Manager).

2.0 Declarations of Interest and Board Register of Interests

There were no declarations of interest relevant to items on the agenda.

Mr Thompson noted he was now chair of Audit Yorkshire, the Trust's internal Audit consortium.

ACTION: Mrs Roberts to update the Board of Directors register of interest.

3.0 Minutes of the meetings of the Board of Directors on 26 July 2017

The draft minutes of the meeting held on 26 July 2017 were approved with one amendment.

Mr Harrison noted minute 5.19 required an amendment to clarify the Trust's PAS system limited the number of comorbidities recorded to 12 while the new HRG4+ formula permitted more than 12 comorbidities to be recognised.

ACTION: Mrs Roberts to update the minutes from 26 July 2017.

APPROVED:
The Board of Directors approved the minutes of the meeting held on 26 July 2017 as an accurate record of proceedings.

4.0 Review of Action Log and Matters Arising

4.1 Completed actions 4, 50 and 52 were noted.

4.2 With regards to action 50 Mr Harrison noted an ongoing issue regarding NHS Property Services (NHSPS) fire risk assessments. He confirmed the Trust was waiting for NHSPS to confirm completion of all compartmentalisation reviews, this was likely to take some time due to the volume of properties. Mr Harrison provided reassurance that the properties concerned were low risk, in many cases the Trust occupied only one or two rooms. The Trust's 'Providing a Safe Environment Group' would monitor progress.

4.3 Mr McLean queried whether the same process would be undertaken with local authorities where the Trust had staff based. Mr Harrison confirmed this was the case but noted these premises included staff but no patients.

4.4 It was agreed this action would have a new completion date of January 2017, it would be shown as amber on the action log. Following a query from Mr Thompson it was noted fire risk assessments are renewed on a two yearly basis. A process for receipt of assurance was in place via the Audit Committee and Quality Committee through SALUS (health and safety) audits.

4.5 There were no other matters arising.

APPROVED:
The Board of Directors agreed actions 4, 50 and 52 were closed.

Overview by the Chairman

Mrs Dodson noted the importance of receiving a patient story to focus the remainder of the Board meeting on the Trust's vision of 'Excellence Every Time'..

In considering the financial recovery plan the Board would be seeking to confirm that it was robust and resilient. The financial recovery plan was essential in order to ensure the Trust kept delivering high quality care. In addition the challenges of recruiting and retaining staff would be an underpinning theme. It was clear from the meeting papers that Trust staff were stretched and showing signs of tiredness.

Mrs Dodson encouraged all members of the board to be robust, realistic and honest about how much could be delivered. She noted the Trust had been invited to attend a meeting with NHS Improvement on 10 October 2017 to discuss the recovery plan and emphasised the importance of demonstrating transparent clear plans were in process and the Board as a whole had coalesced around what needed to be done to recover the financial position whilst maintaining quality of care.

5.0 Report by the Chief Executive (excluding finance) and Integrated Board Report

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

5.2 Dr Tolcher noted operational performance and pressures in the system. Although largely on plan there were increasing signs of distress. It was a challenge to deliver the right staff, occupancy and flow rates. The Trust aimed to keep beds closed in order to save on agency costs but the result was high occupancy rates which made it more difficult to maintain high quality patient experience.

5.3 She noted Referral to Treatment targets had also been a challenge. In month the Trust had hit the target of 92%, the reduced performance was partly due to reduced activity due to the sterile services department (SSD) operating off site. She reported that activity in September was back on plan and therefore it was expected performance would recover.

5.4 Dr Tolcher confirmed her report included details of recent strategic developments, this included detail about the Health and Care Partnership (HCP – formally referred to as the Sustainability and Transformation Partnership, STP). She reflected the drive behind the HCP had changed; Accountable Care Systems were an increasing focus from national teams. The Trust had concerns about the slow pace of change and development of strategic thinking in Harrogate.

5.5 The Trust had recently received a letter from NHS Improvement directing the Trust to start participating in a pathology network across West Yorkshire and Harrogate. Although work on a West Yorkshire and Harrogate network had already commenced the timescales outlined by NHS Improvement were very challenging. The Board agreed to delegate authority to the Chief Executive, Chairman and Medical Director to approve the Trust's response to NHS Improvement. It was noted the issue would be discussed further during the private section of the Board due to confidential commercial implications.

5.6 Mr Coulter noted the drive for STP areas to have shared performance standards and shared financial control total.

5.7 Mr Alldred sought further information about the potential footprint of the

Accountable Care System. Dr Tolcher said the Accountable Care System (ACS) appeared to replace the current HCP area, West Yorkshire and Harrogate. Based on emerging models elsewhere, such an ACS would work alongside six local place-based Accountable Care Partnerships. The concept of ACS/ACP needs further discussion in Harrogate where the model has previously been unacceptable to local partners.

5.8 Mr McLean expressed concern there was a risk the Harrogate system would be left behind the pace of other areas. He queried whether the Trust could apply any pressure to help the Harrogate place regain momentum compared with other areas. Dr Tolcher said in order to take the discussions forward she had organised for the Chief Executive and Finance Director of the CCG and Trust to meet with the HCP leadership. Mr Coulter reported discussions about the joint recovery plan were ongoing between the CCG, Trust and regulators. He noted that as a result of this the CCG may be subject to more formal intervention and which would force further movement.

5.9 Dr Lyth expressed concern that although the STPs aligned well for acute services this did not work as effectively for other services, for example children's services. It was important such services did not become invisible in any new STP structures. Mr Harrison provided reassurance the Trust had engaged in the STP areas in which services are delivered.

5.10 Mr Thompson noted the pressures on the Trust's community care teams. He expressed a desire for further visibility to the Board about pressures on community care teams.

5.11 Mr Ward queried why there had been a sustained increased in delayed transfers of care (DTOC) and higher levels of patients medically fit for discharge. He asked why the Trust's levels remained above others and the national average and who had ownership. Dr Tolcher said the answer was complex. It was often the case that patients needed to wait for assessments before packages of care could be agreed. Other patients would have to wait for a place in a care home of their choice. Within Harrogate there was a capacity shortfall, this was the result of the relatively high cost of care in Harrogate and the workforce challenges which lay behind this. She noted that the metrics used by the NHS varied from those used by local authorities. As a result North Yorkshire County Council had invested in the care sector in areas other than Harrogate. Mr Harrison confirmed he had executive ownership of this area and Mr Alldred delivered operationally and it was monitored by the local A&E Delivery Board. Mr Alldred provided reassurance the Trust was doing everything possible to address the challenge of DTOC but capacity in the local system was a real concern.

5.12 Mrs Webster queried whether it would be possible for the Trust to influence national targets, which appeared to be increasingly difficult to deliver within existing resources. Dr Tolcher said harmonisation between the NHS and local authority measurements would be helpful. She reflected that all partners in the system work for the best outcome for the local population. It was difficult to justify people remaining in acute hospital beds because this was worse for them.

5.13 Mr Harrison reported there had been short term issues in the stroke service which necessitated a two week divert to York; services had returned on 25 September 2017. The issues related to a sudden deterioration in the number of stroke trained nursing staff which had compromised the ability to deliver thrombolysis. The position was forecast to improve further in October 2017. He noted the long term future of the stoke service was

included within the ongoing HCP hyper-acute stoke services consultation and review.

5.14 Mr McLean expressed concern about the current resilience of the Trust's stoke service. He emphasised that the regional review should not stop the Trust making important decisions. Dr Tolcher confirmed a hot spot review had been undertaken and would be reviewed by the executive directors on 28 September 2017. She agreed the Trust needed to make progress and reach any necessary local decisions. Where these changes would impact on neighbouring Trusts the whole system impact would need to be considered. Mr Harrison noted stroke was one of the critically required services the Trust was commissioned to deliver. The service could not be altered unless there was agreement by the CCG following consultation of patients. Mrs Dodson noted the Trust could decide to temporarily close a service based on safety. Mr Harrison added this had been the first time the stoke service had been diverted, it had not been a decision taken lightly. It was agreed this matter should be discussed again by the Board in December 2017.

ACTION: Mrs Roberts to include stroke hotspot on the Board forward plan for December 2017.

5.15 Mr Thompson drew attention to theatre utilisation rates and expressed his concerns about performance. Although summer was the correct time of year to complete the work, he queried whether on reflection there was anything to learn from the refurbishment of the sterile services department. Dr Tolcher agreed there would be a post implementation review. She explained that although productivity had improved part way through programme it had not been recovered fully.

5.16 Mrs Webster expressed concern about the increasing level of falls. Mrs Foster agreed there had been an increase on the figures for 2016/17, she confirmed root cause analysis reviews had been undertaken and found seven out of eight falls had been unavoidable. Mrs Foster said she was meeting the Trust's Falls Coordinator to ensure all possible actions were being taken. Mrs Webster expressed concerns about the reliability of falls sensor, Mrs Foster confirmed she was undertaking a review to ensure the equipment was well maintained by the Trust.

APPROVAL:
The Board of Directors:

- **noted the strategic and operational updates.**
- **noted progress on risks recorded in the BAF and Corporate Risk Register and confirm that progress reflects the current risk appetite.**
- **endorsed use of the Trust's seal as detailed in the Integrated Board Report.**
- **received and noted the contents of the report.**
- **delegated authority to the Chief Executive, Chairman and Medical Director to approve the Trust's response to NHS Improvement regarding pathology networks.**

ACTIONS:

- **Chief Executive, Chairman and Medical Director to approve the Trust's response to NHS Improvement regarding pathology networks.**
- **Mrs Roberts to include stroke hotspot on the Board forward plan for December 2017.**

6.0 Finance Report including Financial Recovery Plan and CIP update

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

6.2 Dr Tolcher provided a summary of the current financial position. Actions taken during month five had achieved a run rate improvement of £319k against a planned improvement of £466k, as a result the financial deficit year to date was £5.2m. The Trust's NHS Improvement 'use of resources' rating remained at three. In support of the finance report, Dr Tolcher noted that Mr Coulter had re-circulated to the Board a copy of the full financial recovery plan which had been agreed in August 2017.

6.3 Dr Tolcher acknowledged that the forecast through to the end of the year was a slowly improving deficit until month eleven, but it would be within the gift of the Trust to achieve a positive position in month twelve. In order to achieve this, it would be essential for the Trust to deliver on planned cost improvement programmes (CIPs), drive income and sustain the planned level of expenditure.

6.4 Dr Tolcher said there had been evidence the financial recovery actions had started to achieve traction, this included theatre session switches and extra theatre sessions. In addition extra outpatient sessions had been scheduled and new outpatient templates were in use.

6.5 Mr Thompson said it was important to recognise the risk assessed financial forecast did not demonstrate the Trust would achieve a surplus.

6.6 Mr McLean queried whether the Trust should adjust the full year financial plan to reflect the risk adjusted position. Mr Coulter explained that in order to do this the Trust would have to follow a formal protocol with NHS Improvement, the plan could only be amended on a quarterly basis. It was expected this issue would be discussed at the meeting with NHS Improvement on 10 October 2017. Before considering a year-end position adjustment NHS Improvement would seek assurance from the Board that all possible actions have been taken. He noted the importance of being transparent with NHS Improvement about the Trust's financial position and the action being taken as a response.

6.7 Mr Ward said September 2017 would be an important month in demonstrating the organisation could achieve the figures forecast. He queried the level of activity the Trust had undertaken to date during September 2017. Mr Coulter reported that as of 25 September 2017 activity would translate into £600k more income than August. As a result the in-month deficit would be £450k against a position of £900k in July 2017.

6.8 Mrs Taylor noted the significant adjustment forecast during March 2018, she queried how the financial position would improve to such a degree in month. Mr Coulter explained this would be the result of increased activity in March 2018 and the introduction of an Alternative Service Delivery Model. Mr Ward noted Easter would fall into March in 2018, Mr Coulter confirmed this had been included within the planning.

6.9 Mrs Webster queried why figures included within the September 2017 report had not been adjusted to reflect the under-achievement during August 2017; how could the Board gain assurance how this gap would be achieved. Mr Coulter confirmed it was not his intention to adjust the plan; rather performance would be monitored against the plan. Dr Tolcher expressed concern that it would be poor governance to alter the financial plan after each month this would provide a false sense reassurance. Mrs Webster agreed

and suggested a rolling adjustment total would be helpful. Mr Harrison explained the Executive Team had identified mitigations to address the shortfall through alternative delivery plans. It was agreed the financial report should include further narrative to explain underachievement of the plan. It was agreed this detail was required only for actions which were off-track in order to provide assurance about actions being taken to address the position. Mr McLean suggested the report could be amended to include actual benefit of recovery actions and aggregate variance.

ACTION: Mr Coulter to review format of the finance report in light of comments received from members of the Board.

6.10 Referring to the Senior Management Team minutes Mrs Taylor sought assurance about progress to schedule additional outpatient sessions. Dr Tolcher explained this referred to new orthopaedic outpatient work, which would become embedded once a new trauma and orthopaedic locum joined the Trust. She noted the negative impact of the 'consultant of week' model, there had been varied views about the model between consultants. Dr Johnson noted the potential gap between the financial recovery plan and the reality of having clinicians engaged in and willing to support the actions necessary. Mr Coulter commented this was an example of the time some actions took to come to fruition.

6.11 Mr Coulter drew attention to proxy measures which had provided confidence about the Trust's future spending; these included a significant reduction in recruitment activity. It was reported the new sterile services department (SSD) would open on 27 September 2017, this was a very positive development. Mr Coulter noted all financial recovery actions had been quality impact assessed; some actions had been rejected as a result.

6.12 Mr Coulter confirmed the Trust's financial plan had been shared with the CCG; there had been full transparency about the Trust's recovery actions. Mrs Taylor noted the impact of a change in the CCG paying the Trust in 12^{ths} rather than 10^{ths} as agreed within the 2017/18 contract. She noted North Yorkshire CCGs were outliers because they waited to pay Trusts until performance had been reconciled and adjusted. Concern was expressed about the financial position of the CCG and whether this presented a risk to the Trust should the CCG have insufficient funds to pay the Trust.

6.13 In light of historic issues with productivity in theatres Mr McLean sought assurance the financial recovery actions could be delivered and appropriate staffing levels would be available to consistently enable surgeons to do the work required. Dr Tolcher said that she recognised there had been a national issue with recruitment; however the theatre staffing strategy was well advanced. Dr Johnson agreed the Trust would soon realize benefits of the new approach, but it would be unrealistic to expect to see an improvement very quickly due to national issues. Mr Harrison said there had been early signs of improvement but the new strategy was not yet fully embedded. It was confirmed the new theatres structure had been appointed to, in addition additional band five staff had been appointed which had reduced staffing gaps. Mr McLean and Mr Ward expressed concern about whether the staffing issues had been adequately reflected in the risk adjusted financial plan. Dr Scullion agreed the totality of risk in delivering the required activity was high; he confirmed he felt reassured by the progress achieved during recent weeks.

6.14 In conclusion following receipt of the finance report Mrs Dodson invited the Board to reflect on their feelings about the Trust's financial position. She emphasised the importance of the whole Board having clarity. Mr Thompson said he was reassured by what he had heard during the meeting, the additional granularity he had sought had been

provided. Mr Ward said he supported the Board's position. Mr McLean expressed concern that with winter approaching it was likely adverse events would happen and impact negatively on the financial recovery actions. Mrs Webster said she had no doubt the Trust was concentrating on the correct areas, the challenge would be timing and landing the position within the remaining months of the financial year. Mrs Taylor said the quality of information provided was good and sufficient. She agreed the areas being addressed were the correct ones, the focus would move to delivering these.

APPROVED:
The Board of Directors received the finance report, noted the financial position and the actions being taken to improve the current situation.

ACTIONS:
- **Mr Coulter to review format of the finance report in light of comments received from members of the Board.**

7.0 Review of Treasury Management Policy

7.1 Mr Coulter reminded the directors the Treasury Management Policy required annual approval by the Board. Mr Thompson confirmed the policy had been considered by the Audit Committee.

7.2 Members of the Board approved the Treasury Management Policy

APPROVED:
The Board of Directors approved the Treasury Management Policy.

8.0 Report from the Chief Operating Officer

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

8.2 Mr Ward suggested the activity table included within the report should be expanded to include activity levels in the Trust's community services. Mr Harrison agreed to consider this further; he noted a potential solution could be inclusion of the community services OPEL (operational pressure escalation level) framework; OPEL had been developed recently to demonstrate pressures on community services -an appropriate measure to include within the report.

8.3 Mr McLean asked if there was a problem with the Carbon Energy Fund benefits realisation. Mr Harrison explained the Trust's contract with Imtech was very well written and robust. As a result the Trust had been able to levy monthly fines for the performance failings.

8.4 Mr Thompson noted the Trust's positive results in the recent national cancer survey. In addition he sought further information about the process to address the small number of concerns highlighted by the survey results. Mrs Foster confirmed an action plan was being prepared, this would be monitored by the Learning from Patient Experience Group and the Long Term and Unscheduled Care Directorate Board.

8.5 Mrs Webster noted outpatient activity was behind plan, she queried whether this was the position sought by the Trust. Mr Harrison explained it would be acceptable for the Trust to be behind on follow-up outpatient activity, subject to performance being ahead of

plan on new outpatient appointments. Mr Alldred provided reassurance processes were being put in place to ensure no clinical concerns had been lost as a result of reduced activity on follow up outpatient appointments. Dr Johnson explained this potential risk had been reported to the Quality Committee, she noted the importance of clinicians flagging urgent follow-up appointments to ensure these were prioritised.

8.6 Mrs Taylor expressed concern that administration delays had contributed to 62 day cancer standard breaches. Mr Harrison confirmed this had not been a recurrent issue; as a result procedures had been reviewed to ensure they were robust. Staffing levels were being monitored closely and considered through the established vacancy control process.

APPROVED:
The Board of Directors received and noted the contents of the report.

9.0 Emergency Preparedness, Resilience and Response (EPRR) Report

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

9.2 Mr Harrison confirmed he was the Executive Director accountable for the Trust's compliance with EPPR standards. He noted the national standards recommended Trusts should also allocate a Non-Executive Director.

9.3 Following discussion it was determined a Non-Executive Director would not be allocated to hold the EPRR portfolio for the organisation. Mr Thompson commented on the professionalism of the team leading on EPPR, he said he did not believe appointment of a Non-Executive Director would add value for the organisation. The Board agreed they were assured by existing governance processes

APPROVED:
The Board of Directors:
- **approved the EPRR Statement of Compliance**
- **delegated responsibility for signing the statement to Mr R Harrison, Chief Operating Officer/Accountable Emergency Officer for the Trust**
- **agreed a Non-executive Director would not be allocated to hold the EPRR portfolio for the organisation**

10.0 Report by the Director of Workforce and Organisational Development to include an update on the Clinical Workforce Strategy

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

10.2 Mr McLean noted job planning and appraisal rates were behind target. Mr Marshall explained consultants had been alerted to the job planning requirement and would be issued with letters explaining pay would be withheld if job plans were not completed on time. The Trust had listened to feedback that the appraisal process was time consuming as a result had developed an appraisal on a page which would be quicker for staff to complete. Mr Alldred provided reassurance about the position in the LTUC department, he asserted the actual compliance level was better than the data suggested. Dr Tolcher noted the importance of job plans and appraisal processes to ensure staff resources were used productively.

APPROVED:

The Board of Directors:

- **Noted items included within the report.**
- **Endorsed the recommendation of the Senior Management Team to sign the Time to Change Employer Pledge.**

11.0 Report from the Chief Nurse

11.1 The report had been circulated in advance of the meeting and was taken as read. There were no questions.

APPROVED:
The Board of Directors:

- **Confirmed they were assured by the monitoring of nurse recruitment and retention and the governance process for assuring safe staffing levels**
- **Noted the reporting of Director Inspections and Patient Safety Visits**
- **Confirmed they were assured of progress toward the Trust pressure ulcer target**
- **Noted the increase in numbers of complaints received by the Trust in August.**
- **Acknowledged the work to improve standards for mothers and babies**
- **Noted the Review of Whistle Blowing arrangements**

12.0 Freedom to Speak Up Guardian Update

12.1 It was noted this report would be presented to the Board on a six monthly basis.

12.2 Mrs Webster suggested a picture of the Freedom to Speak Up Guardian, Dr Sylvia Wood, should be added to communications about freedom to speak up, in order that staff would recognise her.

APPROVED:
The Board of Directors received and noted the contents of the report.

13.0 Report from the Medical Director

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

13.2 Dr Scullion reported on initial findings from the mortality review of care of the elderly had not identified any areas of concern. The full findings would be shared with the Board when the final report was completed.

13.3 It was noted Dr Alison Layton would soon step down from her role as Clinical Director for the Yorkshire and Humber Clinical Research Network. It was agreed Mrs Dodson would write to Dr Layton and expressed thanks on behalf of board.

13.4 Dr Johnson noted the results of the national cataract survey; she reported the Trust had decided to adopt a new method of anaesthesia which, while recognised as safe and widely used elsewhere, might result in a small increase in the average complication rate. The new approach would bring the Trust in line with other NHS providers and would be more efficient, resulting in reduced waiting times for patients. It was noted clinical opinion about the technique was divided, and individual surgeons would be able to choose their preferred method.

13.5 Mr Thompson noted the HSMR rate had increased to 107.6 for the rolling period

ending June 2017.

APPROVED:
The Board of Directors:

- **Noted compliance for the year 2016/17 with the medical revalidation annual Statement of Compliance with regulatory procedures.**
- **Received and note the Learning from Deaths policy.**
- **Noted joint academic posts with the University of Leeds and Leeds Teaching Hospitals NHS Trust are being considered further.**

ACTIONS:

- **Mrs Dodson to write to Dr Alison Layton and express the Board's thanks for acting as Clinical Director for the Yorkshire and Humber Clinical Research Network.**

14.0 Medical Revalidation and Appraisal Statement of Compliance

14.1 Dr Scullion explained this was annual statement which the Trust was required to submit to NHS England. He expressed thanks to Dr Lavalette and Andrew Forsyth for their assistance in preparing the report.

APPROVED:
The Board of Directors endorsed and approved the Medical Revalidation and Appraisal Statement of Compliance.

15.0 Learning from Deaths Policy

15.1 Dr Scullion explained the Learning from Deaths Policy was part of a new process developed by the Trust. It had been discussed over many months. He expressed thanks to the many people who had supported develop of the policy. Mrs Webster noted her involvement in developing the policy, she explained the policy overlapped a number of other policies and was intended to support learning.

15.2 Following a suggestion from Mr Thompson it was agreed the first sentence should be amended to soften the tone.

APPROVED:
The Board of Directors approved the Learning from Deaths Policy.

ACTIONS:

- **Dr Scullion to revise the first sentence in the Learning from Deaths Policy.**

16.0 Oral Reports from Directorates

16.1 Planned and Surgical Care Directorate

16.1.1 Dr Johnson reported the Trust was engaged with ongoing conversations with The Leeds Teaching Hospitals Trust about a maternity alliance. It was reported this development would potentially result in up to 500 additional births at HDFT. Dr Johnson noted the Trust did not currently comply with the better births agenda because mothers were not offered a midwife led unit within HDFT. It was agreed maternity services were essential to the sustainability of the Trust, it was

suggested a longer term strategy was required to address the future direction of the service.

16.1.2 Gastro services remained a hot spot, a report would be presented to the director team in October and an update would be provided to the Board at a future meeting.

16.2 Children's and County Wide Community Services Directorate

16.2.1 Dr Lyth reported the directorate was very busy as the result of bids for new services, a number of external inspections, and actions to manage implications of the Trust vacancy freeze.

16.2.2 Multiple bids for children's services contracts had been submitted within a period of ten weeks. As a result teams within the directorate had been placed under significant pressure.

16.2.3 Dr Lyth confirmed the Trust had responded to an independent inquiry into child sexual exploitation. In line with requirements the submission had not been shared with partner organisations.

16.2.4 It was noted the Trust vacancy freeze had proved difficult for the directorate to manage in services which operated over a wide geographical patch.

16.3 Long Term and Unscheduled Care Directorate

16.3.1 Mr Alldred reported the acute oncology locum appointed by the Trust had given back word. Dialogue was ongoing with Leeds and York to ensure the service remained sustainable.

16.3.2 Conversations regarding the GP Out Of Hours services continued to develop. Hambleton, Richmondshire and Whitby CCG had confirmed they would not issue a Prior Information Notice (PIN), the position for Harrogate and Rural Districts CCG remained unclear.

16.3.3 The Trust's cancer strategy was three years old and would be refreshed. This process would include engagement with the public, patients and clinicians.

16.3.4 Planning for winter was underway and an 'every hour matters' week was planned in January 2018.

17.0 Committee Chair Reports

Mrs Dodson welcomed reports from the Board's committees.

17.1 Report from the Finance Committee meeting held on 5 September 2017

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

17.1.2 Mrs Taylor confirmed the committee had discussed the place in which the financial recovery plan could be best monitored, it had agreed this should remain with the Board of Directors. This was because the Board meetings included the full complement of skills and experience to actively monitor the plan; in particular it

would be important the Clinical Directors were included in these discussions.

17.2 Report from the Quality Committee meeting held on 2 August and 6 September 2017

17.2.1 Mrs Webster explained that due to technical difficulties it had not been possible to issue a written report. She provided a verbal update on meetings of the Quality Committee held in August and September 2017.

17.2.2 Over two meetings the Quality Committee had received reports seeking assurance on the quality of care for patients receiving end of life care in their chosen location. In the short term the Committee was assured that the quality of care was safe. The Committee considered this work was concluded. It is noted that a longer term business case was in preparation to extend palliative care and this ongoing work would be reported to Board via the Chief Nurse report, from work being scrutinised via the End of Life Care Group, the Improving Fundamental Care Steering Group and the Senior Management Team.

17.2.3 Recent cannula care audits had provided strong evidence the Trust's procedures were adequate and safe. This will be reported to the Audit Committee.

17.2.4 Assurance was also received about the trinity ward and minor injuries unit at Ripon Hospital.

17.2.5 Mrs Webster reported a number of hot spots had been identified by the committee. These included a case of Carbapenemase Producing Enterobacteriaceae (CPE) within the Trust. The organisation's policy had been reviewed in light of the case and was unchanged.

17.2.6 As a result of actions to alter the management outpatient appointments in support of the Trust's financial recovery, a potential risk to patients requiring urgent follow-up appointments had been identified.

17.3 Report from the Audit Committee meeting held on 7 September 2017

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

17.3.2 Mrs Dodson expressed concerned regarding item 8; post project evaluations. Mr Thompson agreed this continued to be an area of concern. Members of the committee had made this an issue at meeting, it was made explicit Mr Thompson was "getting grumpy". The Board agreed the Audit Committee should be robust in pushing for timely post project evaluations.

18.0 Council of Governors minutes of the meeting held 3 May 2017

18.1 The minutes were noted.

19.0 Other matters relating to compliance with the Trust's Licence or other exceptional items to report, including issues reported to the Regulators

19.1 It was reported the Trust would meet with NHS Improvement on 10 October 2017 to discuss the financial position.

19.2 The September 2017 return to NHS Improvement had been submitted in accordance with the deadline set by NHS Improvement.

20.0 Any other relevant business not included on the agenda

There was no other business.

21.0 Board Evaluation

Mrs Dodson reflected that the meeting had included a good balance of the patient story, strategy, financial matters and routine governance.

Dr Tolcher said she was pleased the Board's conversations had returned to patients and quality.

Mr Ward expressed a view chairing of the meeting was almost perfection. Mr McLean agreed it had been a good effective meeting.

It was agreed it was preferable for the patient story to be included at the start of the meeting. It was noted it would be helpful for the Board to receive an annual report which included thematic actions taken following patient stories. The new Chairman Mrs Schofield agreed to consider this issue further.

22.0 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 12.25pm.

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Harrogate and District NHS Foundation Trust

HDFT Board of Directors Actions Schedule as at October 2017
Completed Actions

This document logs actions completed since the previous Board of Director meeting. Completed items will remain on the schedule for three months and then be removed.

Item Description	Director/ Manager Responsible	Date of completion/ progress update	Confirm action Complete
Additional information to be included in the IBR relating to readmissions of older people. Update on reducing readmissions in older people to be submitted to the September Board meeting (8.9)	Mr A Alldred, Clinical Director	July 2017	Complete – Revised IBR presented in September 2017
IBR to be reviewed by a small group post April 2017.	Mrs S Dodson, Chairman	July 2017	Complete – Revised IBR presented in September 2017
Consider how the Integrated Board Report would capture improved efficient within theatres	Mr Coulter, Director of Finance & Mr R Harrison, Chief Operating Officer	July 2017	Complete – Revised IBR presented in September 2017
Review KPIs included within the Integrated Board Report.	Non-Executive Directors, Mr Coulter, Director of Finance & Mr R Harrison, Chief Operating Officer	July 2017	Complete – Revised IBR presented in September 2017
Financial plan to be risk assessed and be re-presented to Board meeting in July.	Mr Coulter, Director of Finance	July 2017	Complete – presented to the Board in private session in August 2017
Register of Interests to be updated to reflect new interests for Dr Tolcher and Mr Ward.	Katherine Roberts, Company Secretary	August 2017	Complete – interests added in August 2017
Add 'human factors' training to a future Board development session.	Katherine Roberts, Company Secretary	September 2017	Complete – session planned for autumn 2017
A recommendation paper to be submitted to Board on the Trust's substantive nursing workforce requirements.	Mrs J Foster – Chief Nurse	September 2017	Complete - update included in Chief Nurse report
Assurance to be provided to July meeting of the Board that fire risk assessments are up to date for all sites occupied by the	Mr R Harrison, Chief Operating Officer	July 2017	Complete - September 2017, update included

Item Description	Director/ Manager Responsible	Date of completion/ progress update	Confirm action Complete
Trust.			within COO report, further monitoring through SALUS audits
Chief Operating Officer report should inter-provider transfer data in a chart format	Mr R Harrison, Chief Operating Officer	September 2017	Complete - September 2017, included within COO report.
Mrs Roberts to update the Board of Directors register of interest to reflect Mr Thompsons declaration regarding Audit Yorkshire.	Mrs K Roberts, Company Secretary	September 2017	Complete - September register updated
Sandra Dodson to write to the family and thank them for attending the Board. The letter should include some reflections from the Board's reflections. In addition it should include an invitation to join the Trust's Youth Forum.	Mrs Dodson, Chairman	October 2017	Complete – October 2017
Chief Executive, Chairman and Medical Director to approve the Trust's response to NHS Improvement regarding pathology networks.	Dr Tolcher, Chief Executive Mrs Dodson, Chairman Dr Scullion, Medical Director	September 2017	Complete - September 2017
Mrs Dodson to write to Dr Alison Layton and express the Board's thanks for acting as Clinical Director for the Yorkshire and Humber Clinical Research Network.	Mrs Dodson, Chairman	September 2017	Complete – October 2017
Dr Scullion to revise the first sentence in the Learning from Deaths Policy.	Mrs Dodson, Chairman	September 2017	Complete - September 2017
Mrs Roberts to include stoke hotspot on the Board forward plan for December 2017.	Mrs K Roberts, Company Secretary	September 2017	Complete – October 2017
Quality Committee to seek assurance about concerns raised about end of life care services.	Mrs Webster, Non Executive Director / Jill Foster, Chief Nurse	September 2017	Complete – October 2017
Mrs Roberts to update section 5.19 of the minutes from of 26 July 2017	Mrs K Roberts, Company Secretary	September 2017	Complete – October 2017
Mr Coulter to review format of the finance report in light of comments received from members of the Board.	Mr J Coulter, Deputy Chief Executive and Finance Director	October 2017	Complete – October 2017

Harrogate and District NHS Foundation Trust

HDFT Board of Directors Actions Schedule – Outstanding Actions as at October 2017

This document logs items for action from Board of Directors meetings which remain outstanding. 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.

Ref	Meeting Date	Item Description	Director/Manager Responsible	Completion date	Detail of progress
46	May 2017	During the planned Finance Committee self-assessment, consideration would be given to the committee's terms of reference and ensuring an appropriate balance of focus on short term financial management and longer term strategic issues	Mrs Maureen Taylor, Chair – Finance Committee	December 2017	
49	June 2017	Sentinel Stroke National Audit Programme; following completion of 'hot spot' review, action plan will be presented.	Mr R Harrison, Chief Operating Officer	December 2017 (date adjusted by Board in September 2017)	
53	July 2017	Strategic review of the gastroenterology service to be completed and considered by the Senior Management Team. Further updates would be provided to the Board through Dr Johnson's verbal update to the Board.	Dr Kat Johnson, Clinical Director Planned and Surgical Care	October 2017	

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Date of Meeting:	25th October 2017	**Agenda item:**	5.0
Report to:	Board of Directors		
Title:	Strategic KPIs Report		
Sponsoring Director:	Dr Ros Tolcher, Chief Executive		
Author(s):	Ms Rachel McDonald, Head of Performance & Analysis Mrs Samantha McLachlan, Assistant Planning Manager		

Report Purpose:

Decision		Discussion/ Consultation	✓	Assurance	✓	Information	✓

Executive Summary:

The presentation of the indicators contained within this report have been updated and amended in line with the discussion at the Board Strategy Day in July 2017.

The Board of Directors are asked to note that:

- There is continued positive external validation of the Trust's performance;
- The Trust continues to perform well on national patient and staff surveys with the latest published A&E patient survey placing the Trust joint 1st out of 137 participating Trusts;
- Further work is needed to understand our current incident reporting ratio of high/low risks incident - the latest published data shows a small improvement but the Trust remains in the bottom 25% of Trusts nationally;
- The Trust's financial position remains a significant risk, with the year to date position a deficit of £5,575k. The Trust is therefore behind on both the income and I&E surplus / deficit strategic trajectories;
- Delivery of the IT Strategy milestones via the WebV project is progressing and the project will be back on track during Quarter 3;
- More action to undertake over the next year in terms of catchment population and out of Harrogate activity, as part of local and West Yorkshire STP discussions.

Related Trust Objectives

To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓

Key implications

Risk Assessment:	Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF# 1: risk of a lack of medical, nursing and clinical staff; BAF# 2: risk of a high level of frailty in local population; BAF# 9: risk of failure to deliver the operational plan; and BAF# 12: external funding constraints.
Legal / regulatory:	None identified.
Resource:	Not applicable.
Impact Assessment:	Not applicable.
Conflicts of Interest:	None identified.
Reference documents:	None.

Action Required by the Board of Directors:

The Board of Directors are asked to receive and note the content of the report.

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Harrogate and District NHS Foundation Trust

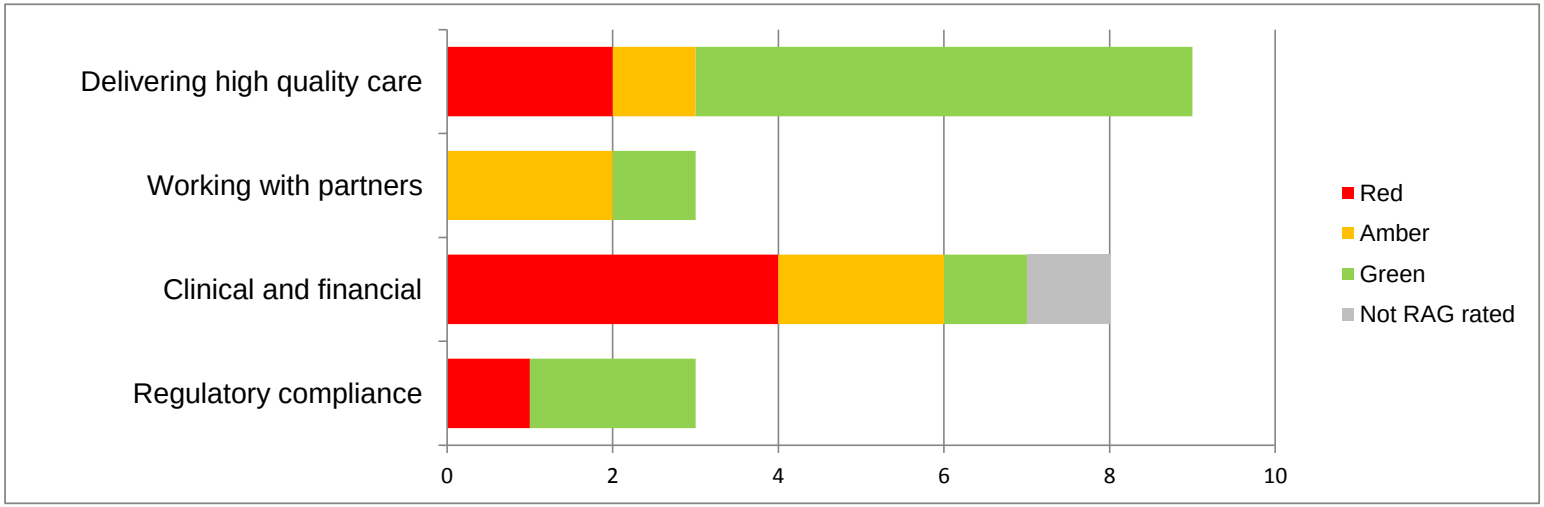
Strategic Key Performance Indicators

September 2017

The presentation of the indicators contained within this report have been updated and amended in line with the discussion at the Board Strategy Day in July 2017.

Key issues to note:

1. There is continued positive external validation of the Trust's performance;
2. The Trust continues to perform well on the national patient and staff surveys with the latest published A&E patient survey placing the Trust joint 1st out of 137 Trusts;
3. Further work is needed to understand our current incident reporting ratio of high/low risks incide - the latest published data shows a small improvement but HDFT remains in the bottom 25% of Trusts nationally;
4. The Trust's financial position remains a significant risk, with the year to date position a deficit of £5,575k. The Trust is therefore behind on both the income and I&E surplus / deficit strategic trajectories.
5. Delivery of the IT Strategy milestones via the WebV project is progressing and the project will be back on track during Quarter 3;
6. More action to undertake over the next year in terms of catchment population and out of Harrogate activity, as part of local and West Yorkshire STP discussions.



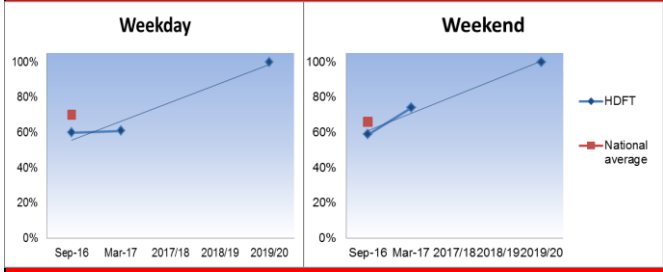
Board of Directors Strategic KPIs report - September 2017

NHS Harrogate and District NHS Foundation Trust

Delivering high quality care

Patient safety

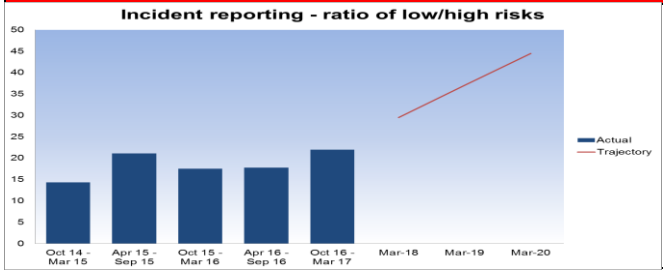
Emergency admissions receiving senior reviews within 14 hours of admission to hospital



All emergency admissions should receive a clinical assessment by a senior clinician as soon as possible, but at the latest within 14 hours of admission to hospital. Trusts should be achieving this for 100% of patients by 2019.

The results opposite came from the last case note reviews undertaken in September 2016 and March 2017. The overall proportion of patients seen and assessed by a suitable senior clinician within 14 hours of emergency admission was 61% in March 2017, a minor improvement on the previous audit but remaining below both the most recently published National and North England averages.

Reporting culture - Ratio of high/low risks.

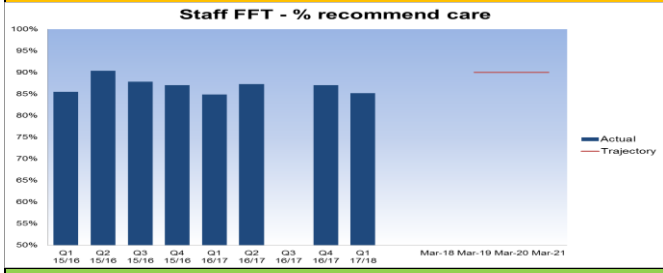


A large number of reported incidents but with a low proportion classified as causing significant harm is indicative of a good incident reporting culture. The latest published national data (for the period October 16 to March 17) shows that Acute Trusts reported an average ratio of 39 no harm/low harm incidents for each incident classified as moderate harm, severe harm or death (a high ratio is better). HDFT's local reporting ratio for the same period was 22, an improvement on the last publication. However the Trust remains in the bottom 25% nationally.

HDFT aspires to be in line with the 2016/17 national average by March 2019.

Patient experience

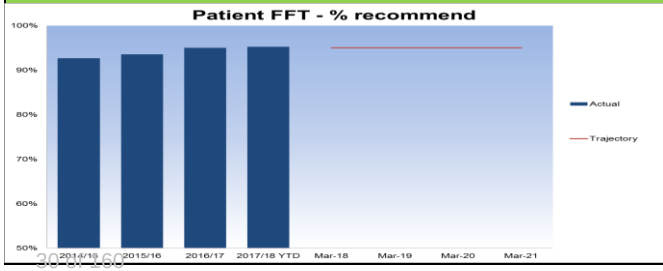
Friends & Family Test (FFT) - Staff - % recommend as a place to receive care



The Staff Friends and Family Test (FFT) was introduced in 2014/15 and gives staff the opportunity to give feedback on the organisation they work in. The chart shows the trend in the percentage of staff that would recommend HDFT as a place to receive care. A high percentage is good.

HDFT's score of 85% for Q1 2017/18 placed us in the middle 50% of Trusts. HDFT's aim is to achieve and maintain 90% of staff recommending the Trust as a place to receive care from March 2019 onwards.

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.

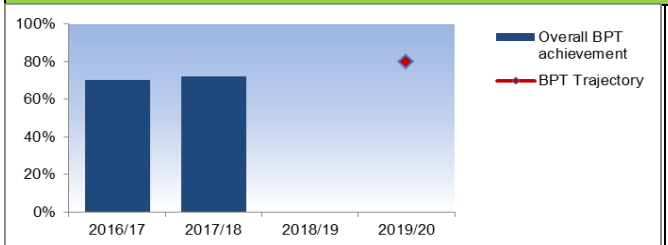
During 2017/18 to date, 95.3% of patients surveyed by HDFT would recommend our services. HDFT's aim is to achieve and maintain 95% of patients recommending the Trust as a place to receive care.

Board of Directors Strategic KPIs report - September 2017

Delivering high quality care

Patient outcomes

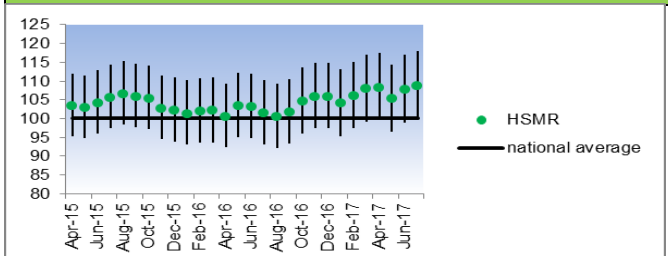
Proportion of Best Practice Tariff achieved



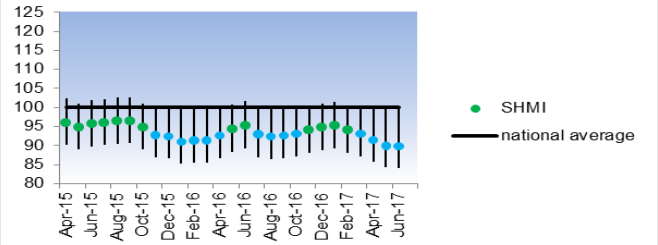
The chart compares year to date (to Aug-17) achievement for each key area of Best Practice Tariffs against previous year's achievement. There are two areas where increases in achievement have been made (same day emergency care and fragility hip) whilst the other areas have shown a decrease. Overall achievement is 72% in 2017/18 to date, compared to 70% in 2016/17.

A trajectory of achieving 80% of total possible BPT income by March 2020 is proposed.

HSMR and SHMI indicator



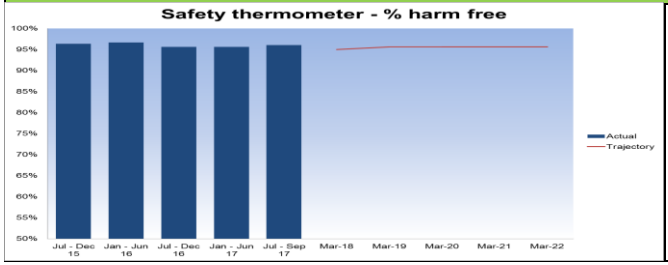
The Hospital Standardised Mortality Ratio (HSMR) looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care. A low figure is good. HDFT's HSMR was 108.6 for the rolling 12 months ending July 2017, an increase on recent months but remaining within expected levels.



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 was 89.9 for the rolling 12 months ending July 2017, below expected levels.

The Trust aims to maintain within expected levels for both metrics over the next 5 years.

Safety Thermometer



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.

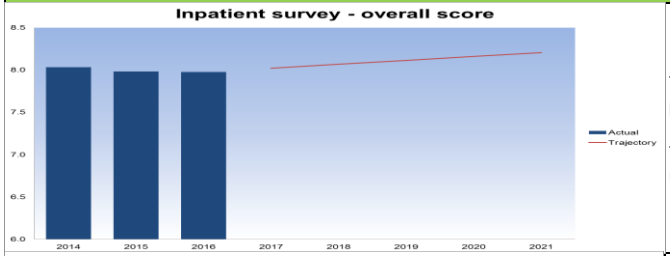
The harm free percentage reported for HDFT for the period Jul-17 to Sep-17 was 96.0%. HDFT's aim is to continue to maintain at least 95.6% harm free consistently by March 2019, based on the average harm free % of outstanding CQC acute providers.

Board of Directors Strategic KPIs report - September 2017

Delivering high quality care

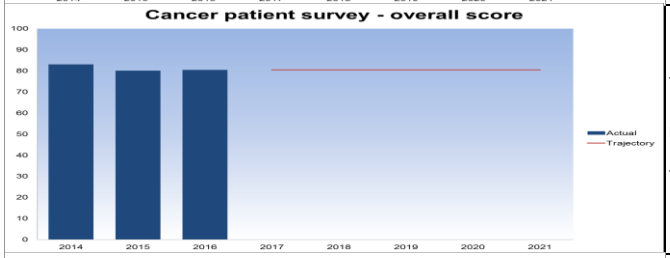
Harrogate and District NHS Foundation Trust

Patient surveys



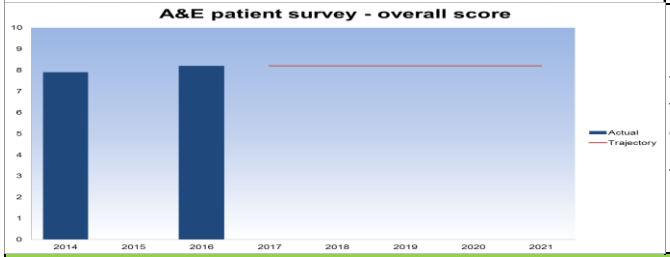
The national **adult inpatient survey** for 2016 was published in May 2017. HDFT's overall score of 8.0 placed us 18th out of 149 participating Trusts.

The proposed trajectory is to achieve an overall score of 8.2 by 2021, in line with the highest overall score reported by an Acute (Non-Specialist) Trust in the 2016 survey.



The national **cancer patient survey** 2016 was published in July 2017. HDFT came joint 4th out of the 148 Trusts who took part in the survey achieving an average score of 80.4. This placed us joint 1st for non-specialist Acute Trusts.

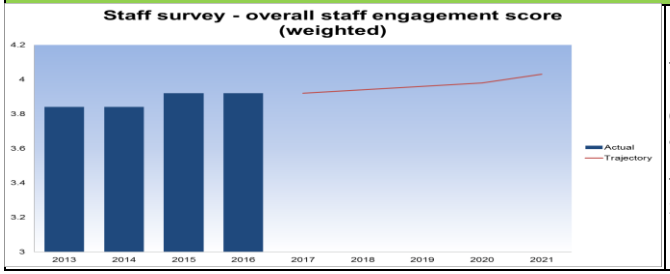
The proposed trajectory is to maintain our score of 80.4.



The national **A&E patient survey** 2016 was published in October 2017. The survey is conduceted every two years. In the latest survey, HDFT came joint 1st out of the 137 Trusts who took part in the survey achieving an average score of 8.2.

The proposed trajectory is to maintain our score of 8.2.

Staff survey - overall engagement score



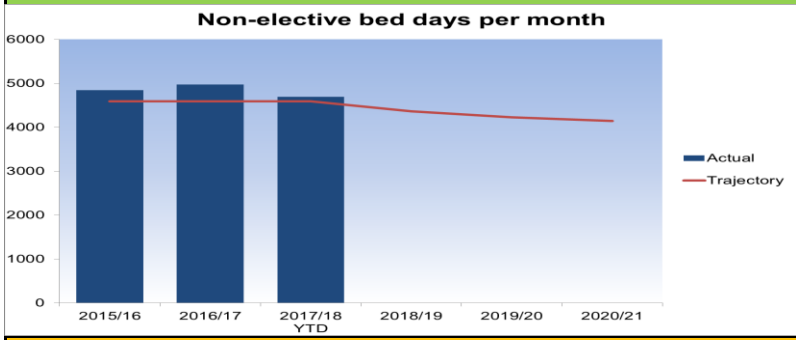
The national staff survey is carried out annually. Results are presented in 32 key areas known as 'Key Findings' as well as a measure of overall staff engagement. in 2016, HDFT scores above average in 22 out of 32 areas. HDFT's overall staff engagement score (weighted) was 3.92, which is ranked above average.

The trajectory is to maintain an overall engagement score of 3.92 for 2017 and achieve a score of 4.03 by 2021, in line with the highest score for combined acute and community trusts in 2016.

Board of Directors Strategic KPIs report - September 2017

Working with Partners

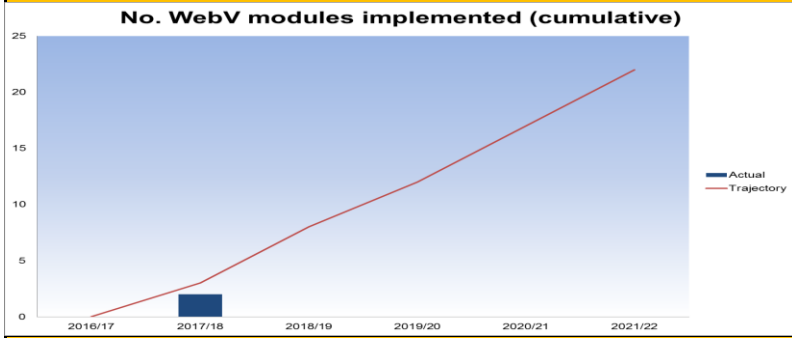
Non-elective bed days



The chart shows the number of non-elective (emergency) bed days at HDFT for patients aged 18+, per month per 100,000 population. The chart only includes the local HARD CCG area. A lower figure is preferable. Average non-elective bed days seen in 2017/18 to date are below trajectory. However the metric is seasonal with more non-elective bed days seen in the winter months.

The provisional trajectory proposed is in line with the draft Sustainable Harrogate financial modelling and is an estimate based on a system apporach. Therefore attainment of this trajectory is dependent on whole system commitment and is therefore to be confirmed.

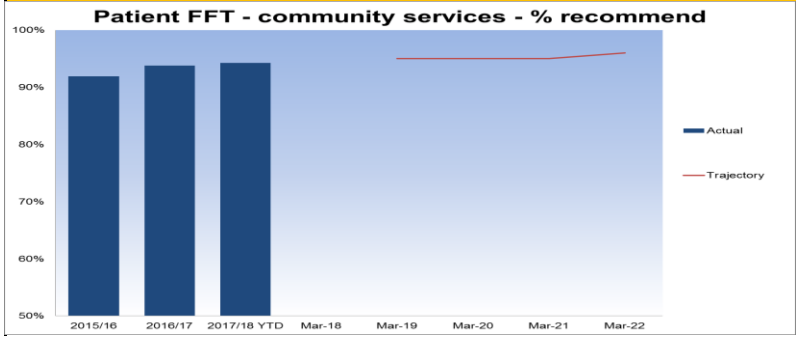
Delivery of IT strategy in line with agreed milestones



In August 2016, the Trust signed a memorandum of agreement for a two year proof of concept with North Lincolnshire and Goole Foundation Trust (NLG) to deploy the WebV EPR system. This supports the delivery of the Trust's strategy of an integrated electronic patient record system which will enable the organisation to be paperlite, provide clinicians with clinical decision tools and enable the sharing of information not just to HDFT staff but to the wider community.

To date, two WebV modules are live with the scanning and documents modules due to go live in the current quarter which will bring the delivery on track. Whilst progress was initially slow due to the upgrade of WebV to a more modern platform, the projects are now moving at pace with benefits already being delivered.

Patient satisfaction of new models of care - Adult Community Services Friends and Family Test



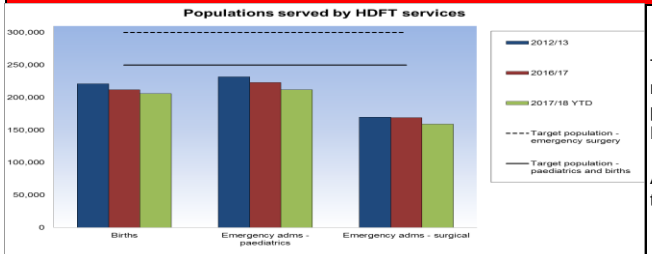
The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment. The data presented is for community services, including district nursing, community podiatry and GP OOH. A high percentage is good.

In 2017/18 to date, HDFT reported that 94.3% of patients surveyed would recommend our community services. This places us below the latest national average of 96%. The trajectory is to achieve 96% by March 2022.

Board of Directors Strategic KPIs report - September 2017

Clinical and financial sustainability

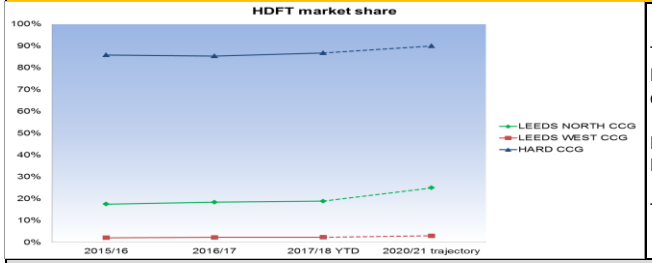
Sufficient catcment population for key specialities of maternity, paediatrics and emergency surgery



The chart shows estimated catchment populations served by HDFT services in recent years for maternity, paediatrics and emergency surgery, along with target population sizes. A target catchment population of 300,000 for emergency surgery and 250,000 for paediatrics and maternity services by March 2021 is proposed.

As can be seen from the chart, the catchment populations for all 3 services have reduced in 2017/18 to date.

Increased share of HaRD CCG, Leeds North CCG and Leeds West CCG referrals

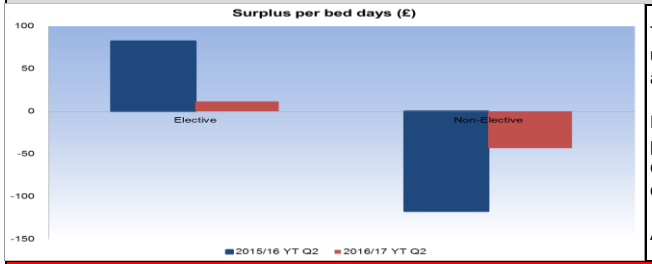


The chart shows the proportion of first outpatient attendances from each locality that are seen at HDFT. The data is sourced from the HED (Healthcare Evaluation Data) benchmarking system and only includes specialties for which HDFT run services.

HDFT's market share in 2017/18 to date is 87% in HARD CCG, 19% in Leeds North CCG and 2% in Leeds West CCG, no significant change on the previous year.

The chart also shows the aspirational market shares for 2020/21.

Surplus per occupied bed days

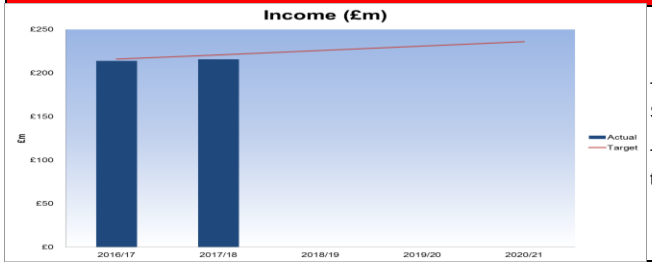


The chart outlines the current surplus per occupied bed day for elective and non-elective activity, utilising information from the service line reporting system. The position for 2017/18 to date is not yet available.

Movements between years are influenced by a number of items which include movements in tariff prices, performance against elective activity plan and prior year position, move to daycase from elective work (daycase income and activity excluded) and higher levels of non elective bed occupancy.

An improvement trajectory of a 3% year on year improvement is proposed.

Income



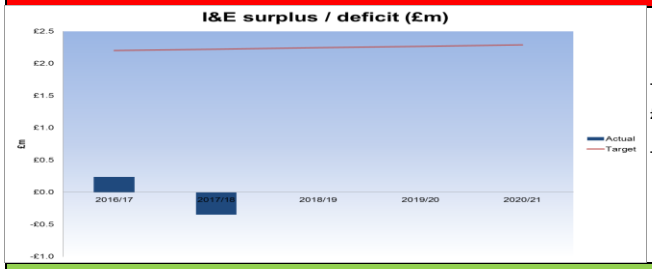
The chart opposite shows the income achievement in 2016/17 and the forecast for 2017/18, excluding S&T funding.

The trajectory is to increase income by £5m year on year for the next 5 years to reflect the ambition in the Trust's business development strategy.

Board of Directors Strategic KPIs report - September 2017

Clinical and financial sustainability

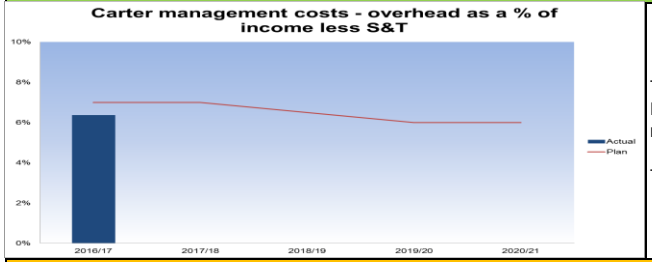
I&E surplus / deficit



The chart shows the I&E position in 2016/17 and the risk adjusted forecast outturn for 2017/18 (-£0.35m), excluding S&T funding.

The trajectory is to deliver a surplus of 1% per annum.

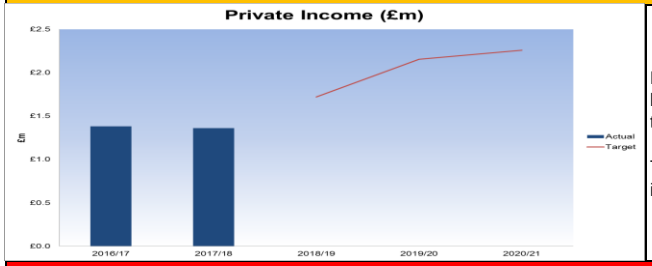
Carter management costs



There is no update of this data available since the last report. This indicator highlights the Hospital Management Overheads using 2016/17 data. This chart shows that the Trust has operated its management costs below next year's target of 7%.

The trajectory is to achieve 6% by March 2018.

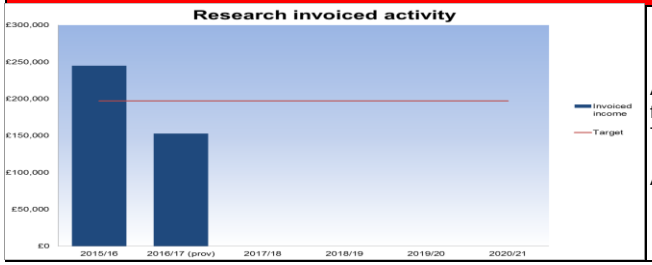
Private income



Private patient income has been behind plan for the past two financial years. The resultant pressure is being addressed through the 2017/18 planning process. The strategy for Private Patient Services will then build on this reset position and will be presented to Trust Board in August.

THe trajectory shown is as set out in the Private Patient Strategy. The aim is to increase private income by £2m over the next 5 years.

Research income



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. In 2015/16, the Trust invoiced for a total of £223k, and in 2016/17 the Trust invoiced for £152,928.

A trajectory to maintain the current level of income is proposed.

Board of Directors Strategic KPIs report - September 2017

Regulatory Compliance

Harrogate and District NHS Foundation Trust

NHS Improvement Single Oversight Framework - Use of Resources Metric

Element	Plan	Actual
Capital Service Cover	2	4
Liquidity	2	1
I&E Margin	1	4
I&E Variance From Plan	1	4
Agency	1	1
Financial Sustainability Risk Rating	2	3

From 1st October 2016, NHS Improvement introduced the Single Oversight Framework. As part of this this, Use of Resource Metric was introduced to replace the previous Financial Sustainability Risk Rating. This is the product of five elements which are rated between 1 (best) to 4.

The Trust will report a rating of 3 for September. This is behind the plan of 2 and is a result of the variance from plan for income and expenditure.

NHS Improvement Single Oversight Framework - Operational Performance Metrics

Standard	Q1	Q2	Q3	Q4	YTD
RTT incomplete pathways	93.8%	92.3%			93.0%
A&E 4-hour standard	96.7%	96.0%			96.4%
Cancer - 62 days	86.0%	88.8%			87.5%
Diagnostic waits	99.8%	99.6%			99.7%

From October 2016, NHS Improvement will 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 “operational performance metrics” section.

In Quarter 2 2017/18, HDFT's performance is above the required level for all 4 key operational performance metrics.

CQC Inspection Rating

Ratings	
Overall rating for this trust	Good
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Good
Are services at this trust caring?	Outstanding
Are services at this trust responsive?	Good
Are services at this trust well-led?	Good

CQC monitor, inspect and regulate health and social care services to make sure they meet fundamental standards of quality and safety and publish their findings. HDFT was last inspected by CQC in February 2016. Overall, HDFT was given a "good" rating in the inspection report published by CQC in July 2016. A further breakdown of the rating is provided in the table to the left.

Following publication of the report, the Trust agreed an action plan with CQC and HARD CCG to address the small number of issues identified during the inspection. Actions are now being progressed in preparation for a likely re-inspection in the coming year. The Trust aims to maintain a rating of good or outstanding overall in the next inspection.

Strategic KPIs report - list of indicators - September 2017

Harrogate and District NHS Foundation Trust

Section	Indicator	Rationale	Goal / ambition	Scope
Delivering high quality care - patient safety	Emergency admissions receiving senior reviews within 14 hours of admission to hospital	This indicator is one of the national 7-day working clinical standards. Delays to both consultant reviews and a lack of on-going senior involvement in patient care have been linked to poor outcomes in patients. Timely reviews are linked to better outcomes.	100% achievement by March 2019, in line with the nationally proposed improvement trajectory.	Acute Services
	Reporting culture - Ratio of high/low risks	A large number of reported incidents but with a low proportion classified as causing significant harm is indicative of a good incident reporting culture. HDFT currently performs worse than the national average on this metric.	The national average based on the 2016/17 benchmark report is a ratio of 37. HDFT aspires to achieve this level by March 2019.	Trust wide
Delivering high quality care - patient experience	Friends & Family Test (FFT) - Staff - % recommend as a place to receive care. A high rate of approval demonstrates a high level of confidence in care quality amongst staff	The Staff Friends and Family Test (FFT) gives staff the opportunity to give feedback on the organisation they work in. A high rate of approval reflects a high level of confidence in the quality of care being provided.	% recommend = 90% by March 2019 and then maintain this performance. Current national figures: average = 79%, upper decile = 92%, upper quartile = 87%, HDFT = 87%.	Trust wide
	Friends & Family Test (FFT) - Patients. A high level of approval is evidence of a positive experience of care from patient/service user perspective	The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. A high level of approval reflects a high level of satisfaction with care received.	% recommend = 95% by March 2018 and then maintain this performance. Current national average is: 94%, HDFT is 94.6%.	Trust wide
Delivering high quality care - patient outcomes	Proportion of Best Practice Tariff achieved	Best practice tariffs (BPTs) are designed to incentivise pathways which reduce unexplained variation in quality and promote best practice. Achievement of BPTs is a measurable proxy indicator aimed at assessing the proportion of care that the Trust is delivering in line with best practice.	Achievement of 80% of total possible BPT income by March 2020.	Acute Services
	HSMR and SHMI indicators.	The Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Mortality Index (SHMI) look at in-hospital mortality standardised against various criteria including age, sex and comorbidities. Mortality is a nationally recognised outcome indicator and sometimes seen as an overall indicators of care quality for acute care	Maintain within expected range.	Acute Services
	Safety Thermometer	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. Whilst there is no nationally defined target for this measure, a score of 95% or above is considered best practice.	Maintain 95% harm free care and achieve 95.6% harm free by March 2019 - based on average harm free % of outstanding CQC acute providers. Review performance as a 6-month rolling average position.	Acute and adult community services
	Inpatient survey	National survey of inpatients conducted annually.	Achieve an overall score of 8.2 by 2021 (in line with the highest overall score reported by an Acute (Non-Specialist) Trust in the 2016 survey).	Acute Services
	Cancer patient survey	National survey of cancer patients conducted annually.	Maintain 2016 score.	Acute Services

Strategic KPIs report - list of indicators - September 2017

Harrogate and District NHS Foundation Trust

Section	Indicator	Rationale	Goal / ambition	Scope
	A&E patient survey	National survey of patients attending A&E which is conducted every 2-3 years.	Maintain 2016 score.	Acute Services
	Staff survey	The national NHS staff survey is conducted annually. Results are presented in 32 key areas known as 'Key Findings' as well as a measure of overall Staff Engagement. High levels of staff engagement are positively associated with positive clinical outcomes.	Maintain overall engagement score (weighted) for 2017 and achieve overall engagement score (weighted) of 4.03 by 2021, in line with the highest score in 2016 for Combined Acute and Community Trusts.	Trust wide
Working with partners	Non-elective bed days	The indicator looks at the number of non-elective (emergency) bed days at HDFT for patients aged 18+, per month per 100,000 population. There is a shared local ambition to reduce reliance on bed based care where clinically appropriate. Preventing avoidable admissions and reducing acute LOS can only be achieved through partnership working and delivery of integrated care.	5% reduction in 2018/19, 3% reduction in 2019/20 and 2% reduction in 2020/21.	Trust wide
	Delivery of IT strategy in line with agreed milestones	The IT strategy aims to provide a robust scalable IT infrastructure that delivers information where staff need it; robust governance arrangements; high quality information management; training and development of IT skills in staff; efficient project management and procurement; and collaborative working with other NHS organisations. An element of the strategy is access to a shared record for all clinicians involved in a patient's care which is a critical success factor for delivering integrated care.	Paperlite by 2020. Delivery of implementation of WebV modules as set out in IT strategy.	Trust wide
	Patient satisfaction of new models of care - Adult Community Services Friends and Family Test	The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. This metric is used to monitor the impact of system-wide transformation programmes on the experience of patients using our adult community services.	Current national average is: 96%, HDFT is 93.6%. % recommend 95% by March 2019 and 96% by March 2022.	Community Services
Clinical and financial	Sufficient catchment population for key specialties of maternity, paediatrics and emergency surgery	To achieve clinical and financial sustainability, the Trust needs a catchment population which will generate sufficient activity/income to cover the baseline cost/fixed cost of providing the service. Growth beyond the fixed cost base delivers a growing margin and hence growing the catchment population becomes progressively more valuable.	A target catchment population of 300,000 for emergency surgery and 250,000 for paediatrics and maternity services by March 2021.	Acute Services
	Increased share of HaRD CCG, Leeds North CCG and Leeds West CCG referrals	This indicator assesses the Trust's progress against its strategic objective of continuing to expand secondary care services into Leeds.	HARD CCG - 90% applicable market share, Leeds North CCG - 25% market share, Leeds West CCG - 3% market share - by 2020/21.	Acute Services
	Surplus per occupied bed days	This reflects operational efficiency and productivity for in patient areas	3% improvement year on year.	Acute Services
	Income	A driver of financial sustainability	Increase of £5m per year next 5 years.	Trust wide
	I&E surplus / deficit	An indicator of current and future sustainability.	1% surplus per annum	Trust wide
	Carter management costs	This indicator assesses the hospital management overheads in comparison to other organisations.	Achieve 6% by March 2018 and then maintain.	Trust wide

Strategic KPIs report - list of indicators - September 2017

Harrogate and District NHS Foundation Trust

Section	Indicator	Rationale	Goal / ambition	Scope
	Private income	Exploring opportunities to increase the income received from delivery of private patient care was identified as one element of maintaining clinical and financial sustainability. PPI generates a higher contribution than NHS tariff based income. Growth in private income as a % of overall revenue will strengthen bottom line indicators	Increase private income by £2m over the next 5 years.	Acute Services
	Research income	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. high levels of engagement in R&D are associated with positive clinical outcomes.	Maintain current levels.	Trust wide
Regulatory compliance	NHS Improvement Financial Risk Rating	As part of NHS Improvement's Single Oversight Framework, the Use of Resource Metric is used to assess an organisation's financial sustainability. This is the product of five elements which are rated between 1 (best) to 4.	To achieve a financial risk rating of 1.	Trust wide
	NHS Improvement Single Oversight Framework	NHS Improvement 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. This metric reviews how the Trust is performing against the national performance standards in the “operational performance metrics” section.	To achieve a green rating overall each quarter.	Trust wide
	CQC Inspection Rating	CQC monitor, inspect and regulate health and social care services to make sure they meet fundamental standards of quality and safety and publish their findings. HDFT was last inspected by CQC in February 2016 and was given a "good" rating overall.	To maintain a rating of good or outstanding overall in the next inspection.	Trust wide

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NHS
Harrogate and District
NHS Foundation Trust

Date of Meeting:	25 October 2017	**Agenda item:**	6.0
Report to:	Board of Directors		
Title:	Report from the Chief Executive		
Sponsoring Director:	Dr Ros Tolcher, Chief Executive		
Author(s):	Dr Ros Tolcher, Chief Executive		

Report Purpose:

Decision	✓	Discussion/ Consultation		Assurance		Information	✓

Executive Summary:

- Financial performance continues to be a high risk to the Trust, with a deficit of £5.57m reported for the year to date. The in month improvement in financial performance is slightly above the risk adjusted forecast and reflects the positive impact of financial recovery plans on both income and expenditure.
- The Trust was above the required level for all 4 key operational performance metrics in NHS Improvement's Single Oversight Framework for Quarter 2.
- A draft WY&H HCP financial plan has been received.
- The new Sterile Services Department commenced operations on 27 September in line with the revised plan. Indicators of theatre productivity improved in month.
- Average length of stay fell slightly for both planned and unplanned care in month.
- Occupancy levels on wards remain high and despite a number of new starters this month gaps in the registered nurse establishment continue to present a risk.

Related Trust Objectives

To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓

Key implications

Risk Assessment:	Strategic and operational risks are noted in section 7. Risks associated with this report are reflected in the Board Assurance Framework: BAF 14: risk to deliver of integrated models of care; BAF 15: misalignment of partner strategic plans; and BAF 9; failure to deliver the operational plan.
Legal / regulatory:	There are no legal/regulatory implications highlighted within the report.
Resource:	There are no resource implications highlighted within the report.
Impact Assessment	Not applicable
Conflicts of Interest:	None identified.
Reference documents:	• State of Health and Adult Social Care in England – Care Quality Commission: http://www.cqc.org.uk/news/stories/most-people-are-getting-good-safe-care-future-quality-precarious

Action Required by the Board of Directors:

- The Board is requested to **note** the strategic and operational updates
- The Board is asked to **note** progress on risks recorded in the BAF and Corporate Risk Register and **confirm** that progress reflects the current risk appetite.

1.0 MATTERS RELATING TO QUALITY, PATIENT EXPERIENCE AND PERFORMANCE

1.1 Operational Performance (details contained within the Integrated Board Report)

High levels of demand continue with non-elective admissions 6.5% above plan in month and approximately 3.6% above plan year to date. Relatively high occupancy rates continue as a result of this demand and measures to reduce bank and agency expenditure. A number of new staff joined the registered nurse workforce this month and this is reflected in an improvement to the overall safer staffing metric to 99.3%. Indicators of care quality including complaints, incidents and pressure ulcers remain broadly stable. There has however been a small increase in the number of falls causing harm year to date and this is currently being investigated. Two cases of hospital apportioned C. difficile were recorded in September, the first such cases this year.

Key standards relating to cancer pathways and RTT were achieved in month but HDFT's performance against the A&E 4-hour standard fell just below the 95% target at 94.2% in September. Attendances in the department were 2% above plan for the month.

Performance on key metrics relating to children's community services remains positive.

The Trust was above the required level for all 4 key operational performance metrics in NHS Improvement's Single Oversight Framework for Quarter 2. As previously reported, delivery of the 18 weeks standard is becoming increasingly challenging with the Trust reporting a performance of 92.0% in both August and September, in line with the minimum performance standard.

2.0 FINANCIAL POSITION

2.1 Financial performance

Financial performance continues to be a high risk to the Trust, with a deficit of £5.57m reported for the year to September. The Trust will report a Use of Resources rating of 3 for September. This is behind the plan of 2 and is a result of the variance from plan for income and expenditure.

The Trust continues to report a forecast outturn to NHS Improvement that achieves the Board approved plan and control total. Achieving the control total relies upon all agreed actions achieving full impact. The forecast outturn after risk adjustment would deliver a deficit position of £350,000. We anticipate additional actions over the reminder of the year narrowing this gap.

2.2 Financial Recovery Plan

The financial recovery plans scrutinised by the Board at its September and prior meetings are gaining traction but financial performance continues to be a high risk to the Trust, with a deficit of £5.57m reported for the year to date.

The recovery plans for August and September outlined in month run rate improvements of £466k and £616k respectively (a total improvement of £1,082 against the previous run rate). After risk adjustment the planned improvement was assessed as £766k. The actual run rate improvement was £833k reflecting a small positive variance.

The actions contributing to this position include a return to planned levels of income and improvements to spending on ward based staff. A number of efficiency and productivity metrics have shown positive improvement in month, offering some assurance on progress for example:

- Theatre productivity metrics have improved
- Length of stay reductions in elective and non-elective care (but note DTOC's of 5%)
- Agency spend in relation to total pay has reduced

While the progress to date is encouraging financial performance remains a risk for the Trust and it is crucial that the actions agreed to date are pursued with rigour. A key priority now is to further mitigate risk by strengthening plans thereby increasing the risk adjusted total. All interim measures remain in place and the Senior Management Team will continue to manage the recovery plan, budgetary control and delivery of CIPs tightly.

I would like to record my thanks for the considerable effort of colleagues across the Trust, whose actions are contributing to the progress being made.

2.3 Meeting with NHS Improvement

On 10 October 2017 NHS Improvement visited Harrogate to discuss the Trust's current financial position and the action being taken to deliver financial recovery. The meeting included executive and non-executive representatives from the Trust; in addition Chairman designate Angela Schofield was in attendance. The meeting was supportive and positive; NHS Improvement confirmed the meeting proved helpful in understanding the Trust's financial recovery plan and the drivers for the current financial gap. NHS Improvement will return to the Trust for a further meeting in November 2017.

3 STRATEGIC UPDATE

3.1 West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) and West Yorkshire Association of Acute Trusts (WYAAT) update

Work is progressing to develop a Memorandum of Understanding (MOU) between partners across the West Yorkshire and Harrogate Health and Care Partnership. The MOU paves the way to take partners beyond existing working arrangements and towards an accountable care system model of working.

In WY&H to date, conversations about 'accountable care' have rightly taken place in each local 'place'. Learning from other areas, the goal is to describe one 'accountable care system' at WY&H level, supported by six or more 'accountable care partnerships' which would be based on the local health and wellbeing board footprints. Harrogate and rural district would be one of these six local 'places'.

The MOU will incorporate:

- A redefined relationship with national bodies including greater funding and control in return for the STP taking a stronger role in system leadership, oversight and delivery;
- A clearer description of the relationship partners have with each other which incorporates a mutual accountability framework that ensures collective ownership of delivery, rather than a top-down performance management approach;

- An effective system of risk and reward for a single control total and the associated arrangements below WY&H level.
- A clearer approach to delivery and information management and reporting system which provides timely information against our shared objectives.

The WY&H HCP System Leaders Executive Group has received an initial report from the group commissioned to support the development of a West Yorks and Harrogate financial plan. In reality the system needs a plan grounded in clinical sustainability and while the top down financial modelling has presented a framework for discussion much work remains to be done within each local 'place' to develop tangible proposals. There is growing support for the development of some WY&H principles to guide local plans. These principles would from part of the MoU referred to above and would address issues such as shared control totals, sector based investment plans and the approach to gain and risk share. It is also recognised that until the WY&H HCP has a clear strategy for service delivery access to transformational funds and capital will be constrained.

Following a presentation to the WY&H HCP System Leadership Executive Group, the WY&H Local Maternity System will be formalised as a programme of the WY&H HCP. Local Maternity System's (LMS) are joint provider/commissioner groups instigated following the National Maternity Review '*Better Births'*. They are required to develop plans by October 2017 which demonstrate how *Better Births* will be delivered by 2020/21. Harrogate is currently non-compliant with some of the recommendations and the Trust is fully engaged in this work.

3.2 WYAAT Getting it Right First Time (GIRFT) Workshop

GIRFT is a national programme designed to improve clinical quality and efficiency within the NHS by reducing unwarranted variations. WYAAT hosted the first ever HCP/STP GIRFT workshop, led by the GIRFT National Lead Professor Tim Briggs on 9 October 2017. The morning focused on a system level orthopaedic GIRFT report at which Harrogate and District NHS Foundation Trust was well represented. Further sessions on vascular, oral and maxillofacial surgery (OMF) and ENT services were held in the afternoon.

The GIRFT approach offers an evidence base for the WYAAT Elective Care clinical collaboration workstream wherein unwarranted variations in outcome and efficiency will be addressed through standardisation and a network approach to service delivery.

Availability of ring-fenced beds for elective orthopaedic work is a key recommendation which the Trust will need to address. The Trust has also received an HDFT GIRFT report for T&O and will meet with the national GIRFT team to review its content next month.

4 WORKING IN PARTNERSHIP

4.1 Pathology Networks

Following communications received from NHS Improvement in September 2017, Trusts from across WYATT sent a joint response setting out our common position on the proposal to establish a WY&H Pathology Network. The letter was approved under authority delegated by the Trust's Board in September 2017.

The letter confirmed WYAAT trusts agreed with the composition of the proposed WY&H (North 2) pathology network; however the future network operating model of pathology

services within WY&H would require further development. Meetings between NHS Improvement and local Trusts are now being scheduled.

4.2 Harrogate Health Transformation Board (HHTB)

The Harrogate Health Transformation Board (HHTB) met on 28 September 2017. The HHTB received an update about the sustainable Harrogate programme of work; partners within Harrogate health and social care system have been working together to develop options to enable the local health system to get back to a sustainable position. In support of this work Mr Rob Webster, the HCP lead for West Yorkshire and Harrogate, is to be invited to meet with the Board in November.

Transitional funding from NHS England for the new care model has been confirmed for quarters one and two of 2017-18. The Board were briefed about the proposed final phase for the new care model programme, running through to the end of March 2018. It was agreed to test the following, continuing to work with Leeds Road Practice, Moss and Partners and Leeds Road Practice:

- Admission avoidance at the point of crisis working with GPs and the ED
- Development of Discharge to Assess pathways to complement HDFT's Supportive Discharge Service
- Testing closer working with NYCC assessment, care planning and reablement
- Testing closer working between practice nursing and community nursing (within the Integrated Response service).

An update was received about the outline approach and principles for commissioning integrated care. It is anticipated that a newly commissioned model will be operational by 1 April 2019. The overarching principles include a practice-centred model, the workforce operating as an integrated unit, an outcome-focused approach and embedded continuous improvement methodology. Commissioners are seeking a novel response from providers.

5 SENIOR MANAGEMENT TEAM (SMT) MEETING

The SMT met on 18 October 2017. The following key areas are for noting:

- Progress on the financial recovery plan was scrutinised. Noted that delays in progressing service changes at Wharfedale present a significant risk. Actions to expedite a resolution will be taken. Decisions relating to arrangements for professional leave are not straightforward and a degree of discretion is being exercised.
- The new Surgical Assessment Unit will commence on 6th November. This will enable a more seamless pathway for patients and assist in flow out of the Emergency Department.
- Staffing levels and in particular the number of registered nurses relative to patients on medical wards are being closely managed. Immediate mitigating actions were taken following escalation of concerns by ward based colleagues. Further work is underway with particular reference to winter planning and the likelihood of escalation beds being required.
- Four new cases of C. Diff have been reported in October of which one will be hospital apportioned.
- The new CQC Insight report was received and discussed. A pro-active approach to using this intelligence was agreed, noting that data is all already known to the Trust and it should therefore contain no surprises.
- A further acute oncology locum has been engaged.
- Action is being taken to address some gaps in safeguarding training.

- The Quarter 2 staff Friend and Family Test (FFT) findings were discussed. The response rate in Q2 was high at 24% but both indicators showed a small negative change. This requires further exploration.
- A workshop has been held to explore models for delivering corporate support functions to a widely distributed service model in Childrens and County Wide Community services.
- The Special Care baby Unit has achieved 'Baby Friendly' accreditation; the HDFT SCBU is only the second unit nationally to achieve this status.
- Progress on WYH HCP development was discussed, including issues relating to acute hospital configuration.

6 COMMUNICATIONS RECEIVED AND ACTED UPON OR TO NOTE

6.1 State of Health and Adult Social Care in England – Care Quality Commission

The Care Quality Commission (CQC) has published its annual assessment of quality, performance, trends and themes. Overall the CQC concluded that most patients are still receiving high quality care. However there have been signs that quality is deteriorating and some services and staff are showing signs of strain. The CQC noted staff resilience is a growing concern given the pressures from rising demand and workforce shortages. Staffing vacancies remain high across all sectors; vacancies across all NHS settings increased by 16% in the two years to March 2017, within this nursing and midwifery vacancies rose by 22%.

It is interesting to note that since 2010-11 available acute beds have decreased by 8% while decisions to admit rose by 16%. Meanwhile social care capacity has reduced by 2% which equates to a reduction of 4000 beds since March 2015.

In the report the CQC comment that the biggest challenges facing hospitals relate to maintaining consistent patient flow through pathways. Reductions in follow-on care has led to increasing delayed transfers of care, within this delays for people waiting for care home packages has seen a significant increase.

6.2 Winter Readiness in the NHS and Care Sectors – NHS Improvement

Trusts have received a letter from Pauline Philip, National Urgent and Emergency Care Director at NHS England. The letter included the following initiatives designed to protect the front line:

1. Expanding the flu vaccination programme to additional patient groups, NHS staff, and care home staff – 21 million will be eligible for and offered vaccination across England. This includes a requirement for Trusts to ensure that every member of staff is personally offered a flu vaccination and either signs a consent form to do so or states if they decline to do so that this is not because of a lack of opportunity. Payment of this year's flu CQUIN Will require this record collection. The practical and cost implications of this requirement are being evaluated.

2. Creating extra hospital bed capacity by reducing delayed transfers of care through use of IBCF funds. There are a small minority of councils, including North Yorkshire County Council, that have not yet signed off DTOC reduction targets as part of local BCF investment although plans are in place directed to the unmet social care needs. It is proposed that in areas where plans are not agreed, and progress is deemed to be unsatisfactory, NHS Improvement and NHE England would exceptionally consider

authorising hospitals to use NHS-derived BCF funds to source additional home care and care home places over the winter period.

3. Increasing our emergency care workforce – plans were announced by NHS England, NHS Improvement and Health Education England to announce an expansion in the ED consultant trainee workforce and investing in the growth of the Advanced Clinical Practitioner (ACP) workforce.

4. Clinical oversight and risk management – in addition to local clinically-led escalation plans a new National Emergency Pressures Panel will be established. This will be chaired by Sir Bruce Keogh and will identify levels of system risk and recommended contingency responses, graded to reflect levels of pressure regionally and/or nationally.

7 BOARD ASSURANCE AND CORPORATE RISK

7.1 Board Assurance Framework (BAF)

No new risks have been added to the BAF this month. Six risks are currently assessed as having achieved their target risk score. The strategic risks are as summarized as follows:

Ref	Description	Risk score	Progress score	Target risk score reached
BAF 1	Risk of a lack of medical, nursing and clinical staff	*Red 12 ↔*	*Unchanged at 1*	
BAF 2	Risk of a high level of frailty in the local population	*Amber 8 ↔*	*Unchanged at 1*	✓
BAF 3	Risk of a failure to learn from feedback and Incidents	*Amber 9 ↔*	*Unchanged at 2*	
BAF 4	Risk of a lack of integrated IT structure	*Amber 8 ↓*	*Unchanged at 1*	✓
BAF 5	Risk of maintaining service sustainability	*Amber 9 ↑*	*Unchanged at 1*	
BAF 9	Risk of a failure to deliver the Operational Plan	*Red 16 ↑*	*Unchanged at 2*	
BAF 10	Risk of breaching the terms of the Trust's Licence to operate	*Yellow 5 ↔*	*Unchanged at 1*	✓
BAF 12	Risk of external funding constraints	*Red 12 ↔*	*Unchanged at 1*	✓
BAF 13	Risk of a reduced focus on quality	*Yellow 4 ↔*	*Unchanged at 1*	✓
BAF 14	Risk of delivery of integrated models of care	*Red 12 ↔*	*Unchanged at 1*	
BAF 15	Risk of misalignment of strategic plans	*Red 12 ↔*	*Reduced to 2*	
BAF 16	Risk that the Trust's critical infrastructure is not fit for purpose	*Amber 8 ↓*	*Unchanged at 1*	✓
BAF 17	Risk to senior leadership capacity	*Amber 9 ↔*	*Unchanged at 1*	

7.2 Corporate Risk Register (CRR)

The CRR was reviewed at the monthly meeting of the Corporate Risk Review Group on 13 October 2017. The Corporate Risk Register contains 10 risks.

Corporate Risk Register Summary

Ref	Description	Current risk score	Risk movement	Current progress score	Notes
CR2	Risk to the quality of service delivery in Medicine due to gaps in rotas following the Deanery allocation process	12	↔	*2*	
CR5	Risk to service delivery due gaps in registered nurses establishment	16	↔	*2*	*NB. Risk to patient safety, experience and staff welfare due to staffing establishment Granby Ward noted October 2017 (LTUC 45)*
CR12	Risk to financial sustainability from failure to deliver the Clinical Transformation Programme at pace and scale	12	↔	*1*	*Progress improved*
CR13	Risk to urgent care system due to a lack of capacity in the out of hospital services	12	↔	*2*	
CR14	Risk of financial deficit and impact on service delivery due to failure to deliver the Trust annual plan by having excess expenditure or a shortfall in income.	16	↔	*2*	*Progress improved*
CR17a	Risk of patient harm as a result of being lost to follow-up as a result of current processes	12	↔	*2*	*Progress improved*
CR17b	Risk of patient harm as a result of being lost to follow up as a result of historic processes	12	↔	*4*	
CR18	Risk to provision of service and not achieving national standards in cardiology due to potential for lab equipment breaking down	12	↔	*2*	*Target risk score and date to be updated following service review*
CR24	Risk to patient safety, quality, experience, reputation, staff wellbeing and and associated effect on timely discharge from the reduction to baseline (2011) funding capacity	15	↑	*2*	*Risk increased October 2017*

Risks added to the corporate risk register

Specific risk to patient safety, experience and staff welfare due to staffing establishment Granby Ward (LTUC 45) added to CR6 Risk to service delivery due to gaps in registered nurses establishment.

Risks removed from corporate risk register

None

Risks with amended target dates or target scores

None

***Progress key**

1 = fully on plan across all actions

2 = actions defined - most progressing, where there are delays, interventions are being taken

3 = actions defined - work started but behind plan

4 = actions defined but largely behind plan

5 = actions not yet fully defined

8.0 DOCUMENTS SIGNED AND SEALED

The following documents have been signed during the month:

- Licence for podiatry clinics to occupy rooms at Silver Birches in Filey was renewed for a further two year term.

Dr Ros Tolcher, Chief Executive

Harrogate and District NHS Foundation Trust

Date of Meeting:	25th October 2017	**Agenda item:**	6.0
Report to:	Board of Directors		
Title:	Integrated Board Report		
Sponsoring Director:	Dr Ros Tolcher, Chief Executive		
Author(s):	Ms Rachel McDonald, Head of Performance & Analysis		

Report Purpose:

Decision		Discussion/ Consultation	✓	Assurance	✓	Information	✓

Executive Summary:

The Trust is required to report its operational performance to NHS Improvement and to routinely submit performance data to NHS England and Harrogate and Rural District CCG. The Board of Directors are asked to note that:

- The Trust reported a rating of 3 (where 1 is best) for NHS Improvement's Use of Resource Metric in September, against an expected rating of 2. The Trust's financial position remains a significant risk, with the year to date position a deficit of £5,575k.
- In Quarter 2, HDFT was above the required level for all 4 key operational performance metrics in NHS Improvement's Single Oversight Framework. However delivery of the 18 weeks standard is becoming increasingly challenging.
- There were 2 hospital acquired C. diff cases reported in September. These are the first hospital acquired cases reported in 2017/18.
- Theatre utilisation increased in September.
- HDFT's performance against the A&E 4-hour standard was 94.2% in September. However Trustwide performance for Quarter 2 overall was above the required 95% standard.

Related Trust Objectives

To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓

Key implications

Risk Assessment:

Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF 4: risk of a lack of interoperable systems across New Care Models partners; BAF 9: risk of a failure to deliver the

	operational plan; BAF 10: risk of a breach of the terms of the NHS Provider licence; BAF 16: risk to delivery of integrated care models.
Legal / regulatory:	None identified.
Resource:	Not applicable.
Impact Assessment:	Not applicable.
Conflicts of Interest:	None identified.
Reference documents:	None.

Action Required by the Board of Directors:
The Board of Directors are asked to receive and note the content of the report.

Integrated board report - September 2017

Key points this month

1. The Trust reported a rating of 3 (where 1 is best) for NHS Improvement's Use of Resource Metric in September, against an expected rating of 2. The Trust's financial position remains a significant risk, with the year to date position a deficit of £5,575k. The in month position has improved, but it is vital that the Trust starts to achieve a surplus monthly position.

2. In Quarter 2, HDFT was above the required level for all 4 key operational performance metrics in NHS Improvement's Single Oversight Framework. However delivery of the 18 weeks standard is becoming increasingly challenging with the Trust reporting a performance of 92.0% in both August and September, in line with the minimum performance standard.

3. There were 2 hospital acquired C. diff cases reported in September. These are the first hospital acquired cases reported in 2017/18.

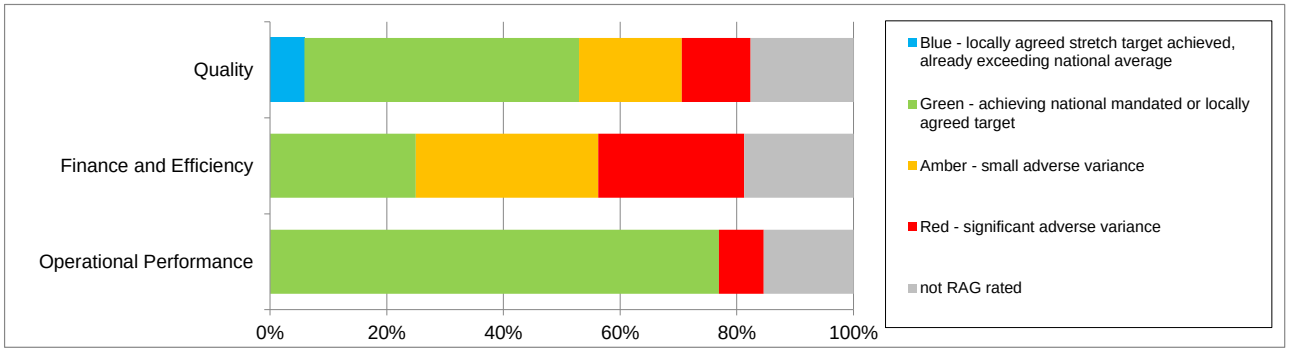
4. The latest published data on incident reporting shows that HDFT's low:high harm reporting ratio was 22 - this is an improvement on the last publication but HDFT remains in the bottom 25% of Trusts nationally.

5. The final returns during the appraisal period have been completed with 84.6% compliance achieved in comparison to 79% as at the end of March 2017.

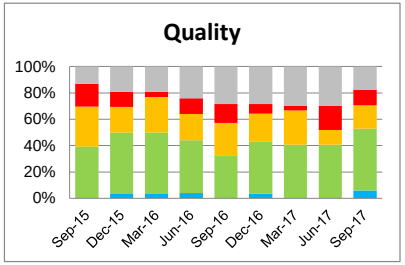
6. Theatre utilisation increased in September. Sterile Services returned on site during the month which has had a positive impact, as well as a number of other initiatives being carrried out by Planned & Surgical Care Directorate

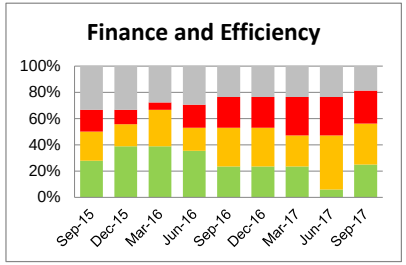
7. HDFT's performance against the A&E 4-hour standard was 94.2% in September. However Trustwide performance for Quarter 2 overall was above the required 95% standard.

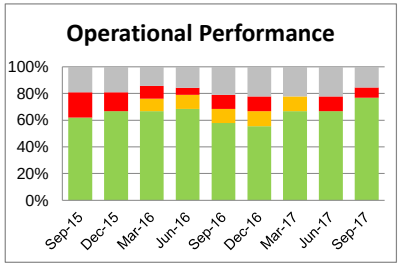
Summary of indicators - current month



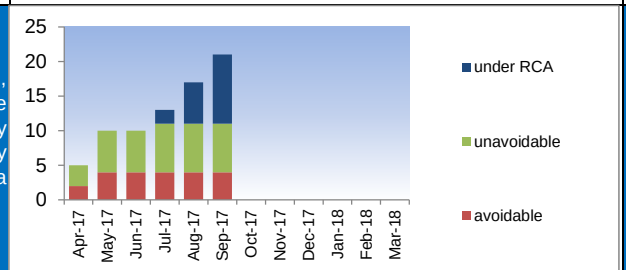
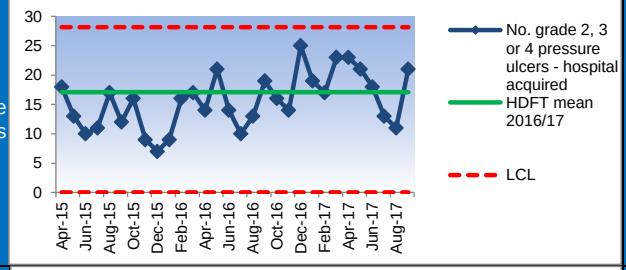
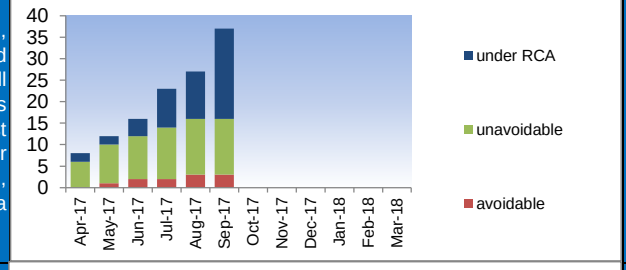
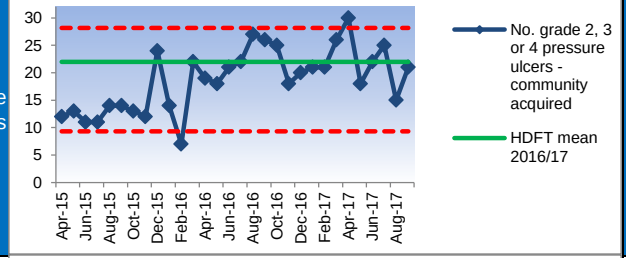
Summary of indicators - recent trends



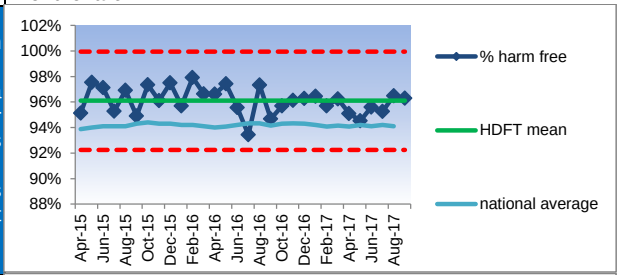
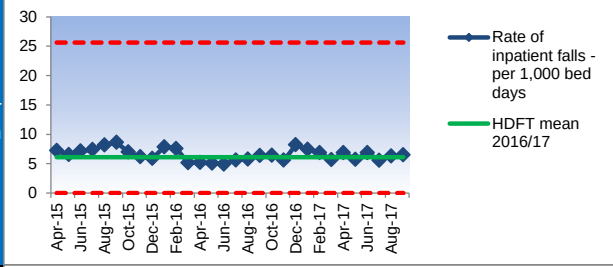
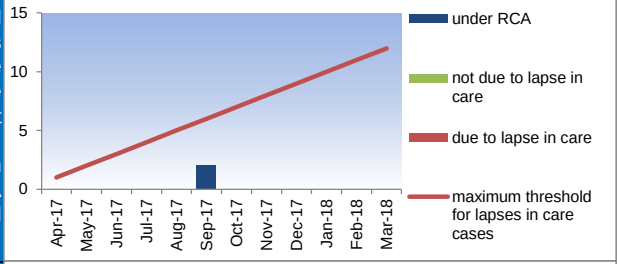
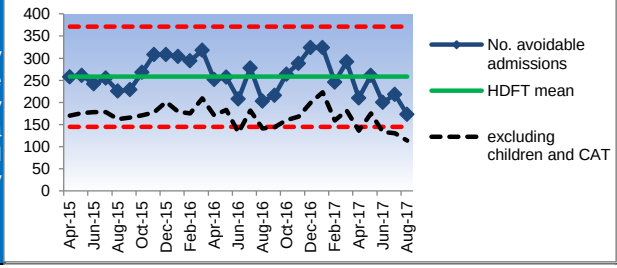




Quality - September 2017

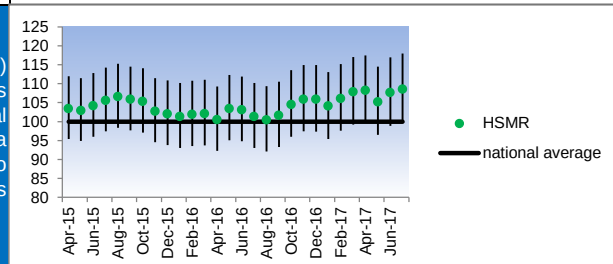
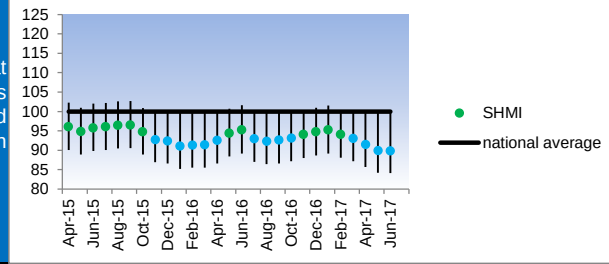
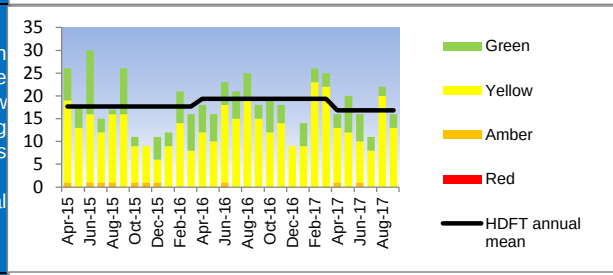
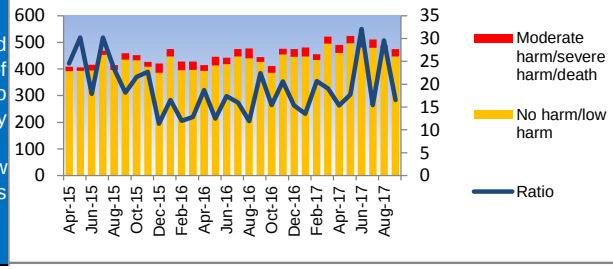
Indicator name / data quality assessment	Description	Trend chart	Interpretation
✓ **Pressure ulcers - hospital acquired**	The chart shows the cumulative number of category 3, category 4 or unstageable hospital acquired pressure ulcers in 2017/18. The Trust has set a local trajectory for 2017/18 to reduce the number of avoidable category 3, category 4 or unstageable pressure ulcers. The data includes hospital teams only.		There were 4 hospital acquired unstageable or category 3 pressure ulcers reported in September, with the year to date total now at 21. Of these, 10 are still under root cause analysis (RCA), 4 have been assessed as avoidable and 7 as unavoidable. No category 4 hospital acquired pressure ulcers have been reported in 2017/18 to date. In 2016/17, 33 hospital acquired category 3 or unstageable pressure ulcers were reported. Of these, 19 were deemed to be avoidable.
✓	The chart includes category 2, 3 and 4 and unstageable hospital acquired pressure ulcers. The data includes hospital teams only.		The number of hospital acquired category 2-4 (or unstageable) pressure ulcers reported in September was 21, an increase on recent months.
✓ **Pressure ulcers - community acquired**	The chart shows the cumulative number of category 3, category 4 or unstageable community acquired pressure ulcers in 2017/18. This metric includes all pressure ulcers identified by community teams including pressure ulcers already present at the first point of contact. The Trust has set a local trajectory for 2017/18 to reduce the number of avoidable category 3, category 4 or unstageable pressure ulcers. The data includes community teams only.		There were 10 community acquired category 3 (or unstageable) pressure ulcers reported in September, bringing the year to date total to 37. Of these, 21 are still under root cause analysis (RCA), 3 have been assessed as avoidable and 13 as unavoidable. No category 4 community acquired pressure ulcers have been reported in 2017/18 to date. In 2016/17, 79 community acquired category 3 or 4 or unstageable pressure ulcers were reported (including 3 category 4 cases) of which, 42 were deemed to be avoidable.
▲	The chart includes category 2, 3 and 4 and unstageable community acquired pressure ulcers. The data includes community teams only.		The number of community acquired category 2-4 (or unstageable) pressure ulcers reported in September was 21 cases, compared to 15 last month.

Quality - September 2017

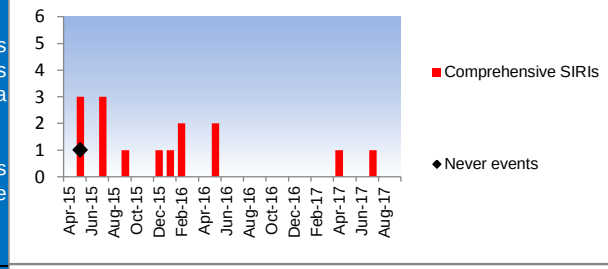
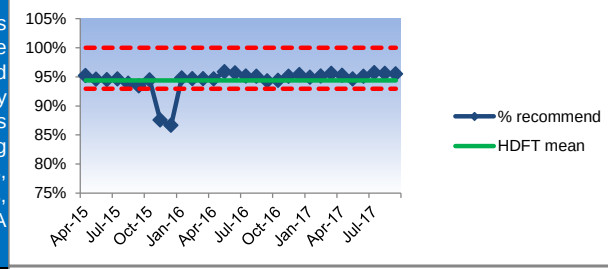
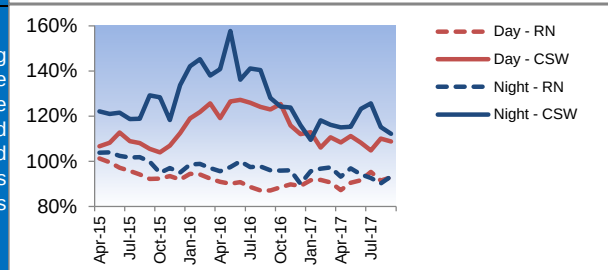
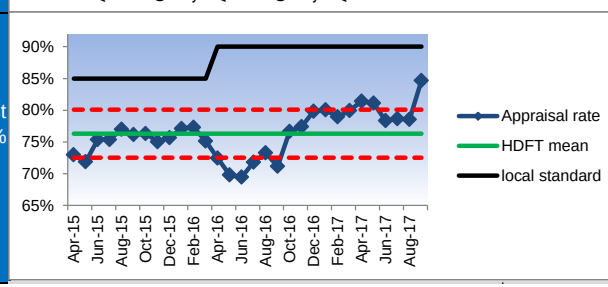
Indicator name / data quality assessment	Description	Trend chart	Interpretation
Safety Thermometer - harm free care ✓	Measures the percentage of patients receiving harm free care (defined as the absence of pressure ulcers, harm from a fall, urine infection in patients with a catheter and new VTE) in 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.		The harm free percentage for September was 96.3%, remaining above the latest national average.
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.		The rate of inpatient falls was 6.49 per 1,000 bed days in September, a small increase on last month and just above the average HDFT rate for 2016/17. There were 3 falls causing moderate harm in September (3 last month), 2 of which resulted in a fracture. In 2016/17, 697 inpatient falls were reported (including those not causing harm), a 14% reduction on the number of inpatient falls reported in the previous year.
Infection control ✓	The chart shows the cumulative number of hospital apportioned C. difficile cases during 2017/18. HDFT's C. difficile trajectory for 2017/18 is 12 cases, no change on last year's trajectory. Cases where a lapse in care has been deemed to have occurred would count towards this. Hospital apportioned MRSA cases will be reported on an exception basis. HDFT has a trajectory of 0 MRSA cases for 2017/18. The last reported case of hospital acquired MRSA at HDFT was in Oct-12.		There were 2 cases of hospital apportioned C. difficile reported in September. Both cases are still under root cause analysis and are due to be reviewed with HARD CCG in November. No hospital apportioned MRSA cases have been reported in 2017/18 to date.
Avoidable admissions ✓	The chart shows the number of avoidable emergency admissions to HDFT as per the national definition. The admissions included are those where the primary diagnosis of the patient does not normally require a hospital admission. Conditions include pneumonia and urinary tract infections in adults and respiratory conditions in children.		There were 173 avoidable admissions in August, a reduction on last month. This metric is seasonal with less avoidable admissions in the summer compared to the winter months. However this is significantly below the level reported in August last year (203). Adult admissions (excluding CAT attendances) also decreased signficantly this month and are now at the lowest level since this metric was introduced in 2014.

Quality - September 2017

Harrogate and District NHS Foundation Trust

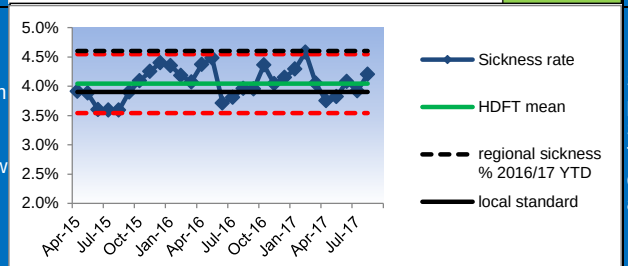
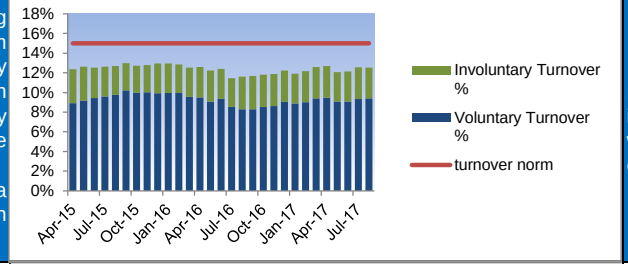
Indicator name / data quality assessment	Description	Trend chart	Interpretation
Mortality - HSMR ✓	The Hospital Standardised Mortality Ratio (HSMR) looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care. A low figure is good.		HDFT's HSMR increased to 108.6 for the rolling 12 months ending July 2017 but remains within expected levels. At specialty level, one specialty (Geriatric Medicine) continues to have a standardised mortality rate above expected levels. A clinical case note review of a sample of 30 cases from Geriatric Medicine is in progress.
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 remains unchanged at 89.9 for the rolling 12 months ending June 2017, remaining below expected levels. At specialty level, two specialties (Geriatric Medicine and Gastroenterology) continue to have a standardised mortality rate above expected levels.
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.		16 complaints were received in September, compared to 22 last month, with no complaints classified as amber or red. The main subjects referenced in the complaints received were communication / attitude and delay / failure / dispute over diagnosis. For the complaints received in 2017/18 to date, 23% are still under investigation. Of those completed, 63% were upheld and 37% were not upheld.
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 latest published national data (for the period Oct-16 to Mar-17) shows that Acute Trusts reported an average ratio of 39 no harm/low harm incidents for each incident classified as moderate harm, severe harm or death (a high ratio is better). HDFT's ratio was 22, an improvement on the last publication but remaining in the bottom 25% of Trusts nationally. The focus going forward is to improve our incident reporting rate particularly encouraging staff to report no harm/ near miss incidents. Options to improve the Datix system to simplify the incident reporting process are being explored.

Quality - September 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
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. Only comprehensive SIRIs are included in this indicator, as concise SIRIs are reported within the presure ulcer / falls indicators above.		There were no comprehensive SIRIs or Never Events reported in September. There have been 2 comprehensive SIRIs and no Never Events in 2017/18 to date.
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.		95.5% of patients surveyed in September would recommend our services, no change on last month and remaining above the latest published national average (94%). Around 4,100 patients responded to the survey this month.
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.		Overall staffing compared to planned was at 99.3% in September, an increase on last month. Care Support Worker staffing remains high compared to plan - this is reflective of the increased need for 1-1 care. Whilst safer staffing levels for registered nurses remains below 100%, the staffing level achieved still enables the delivery of safe care. Achieving safe staffing levels remains challenging and requires the increasing use of temporary staff through the nurse bank and agencies.
Staff appraisal rates ✓	The chart shows the staff appraisal rate over the most recent rolling 12 months. The Trusts aims to have 90% of staff appraised. A high percentage is good.		The final returns during the appraisal period have been completed and as a Trust we have achieved 84.6% in comparison to 79% as at the end of March 2017. A review of the effectiveness of the appraisal period is currently being undertaken and recommendations will be taken to the Workforce and OD Steering Group in November.

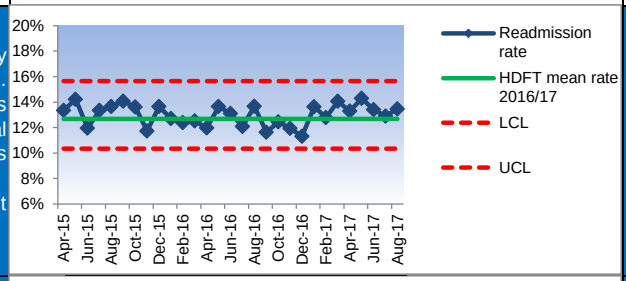
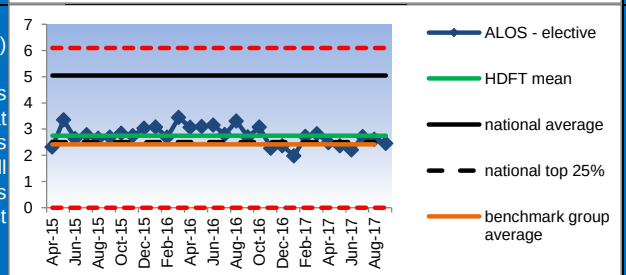
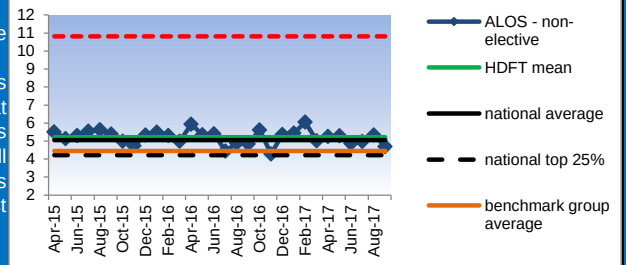
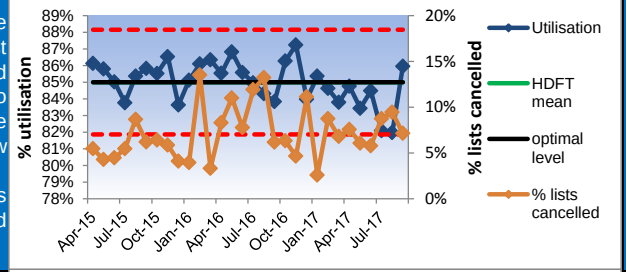
Quality - September 2017

Harrogate and District NHS Foundation Trust

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Mandatory training rates ✓	The table shows the most recent training rates for all mandatory elements for substantive staff.	See table below	The data shown is for the end of September and includes the staff who were TUPE transferred into the organisation on the 1st April 2016. The overall training rate for mandatory elements for substantive staff is 87%. The new follow up procedure is now in place for Directorates to use and we hope to see a positive impact on compliance going forward.
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.		Sickness absence is currently above the Trust target at 4.2% predominantly driven by an increase in absence within the Planned and Surgical Care Directorate and Children's and County Wide Directorate. The hotspot areas continue to focus on developing managers to ensure consistency and the effective management of staff back to work. Theatres and Day Surgery have been added to the hotspot reviews.
Staff turnover rate ✓	The chart shows the staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts. The turnover figures include both voluntary and involuntary turnover. Voluntary turnover is when an employee chooses to leave the Trust and involuntary turnover is when the employee unwillingly leaves the Trust. Data from the Times Top 100 Employers indicated a turnover rate norm of 15%, i.e. the level at which organisations should be concerned.		Labour Turnover remains static at 12.54%. A review of the save/exit interview pilot is underway with an analysis of the feedback received. This will be taken to the Nurse Recruitment and Retention group for consideration and incorporated into plans as appropriate.

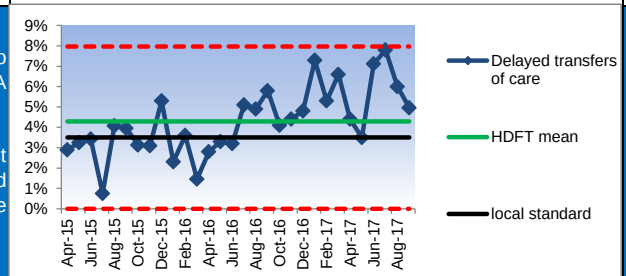
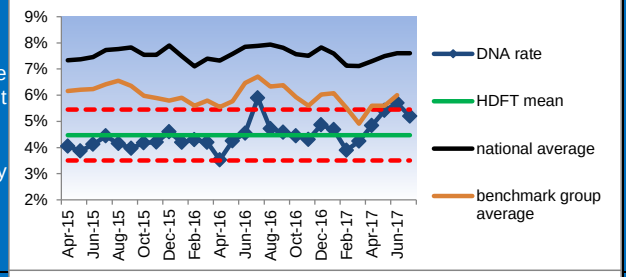
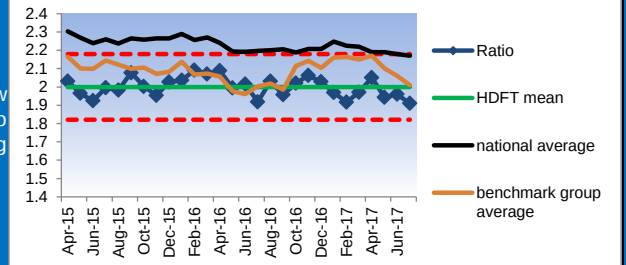
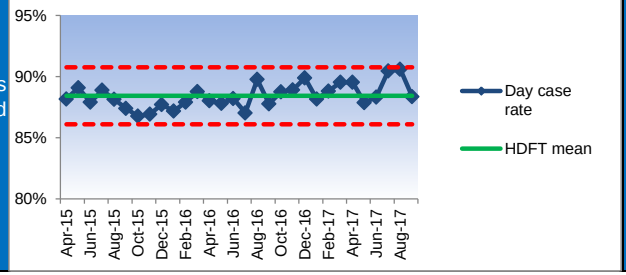
Competence Name	% Completed
Equality, Diversity and Human Rights - Level 1	89
Fire Safety Awareness	75
Infection Prevention & Control (Including Hand Hygiene) 1	100
Infection Prevention & Control (Including Hand Hygiene) 2	79
Data Security Awareness	81
Prevent Basic Awareness (December 2015)	100
Safeguarding Children & Young People Level 1 - Introduction	93

Finance and Efficiency - September 2017

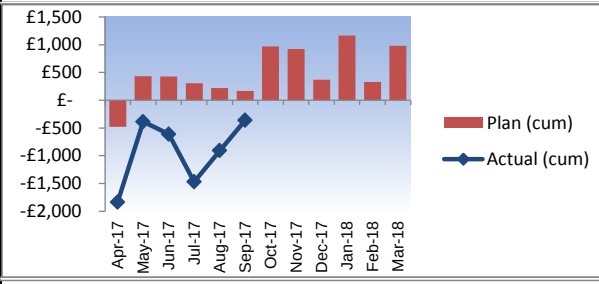
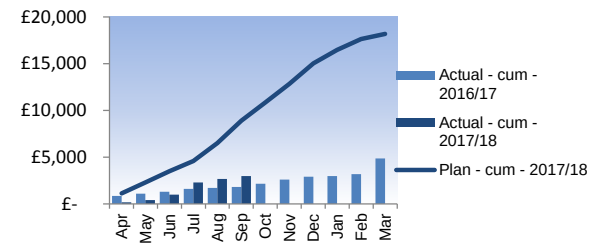
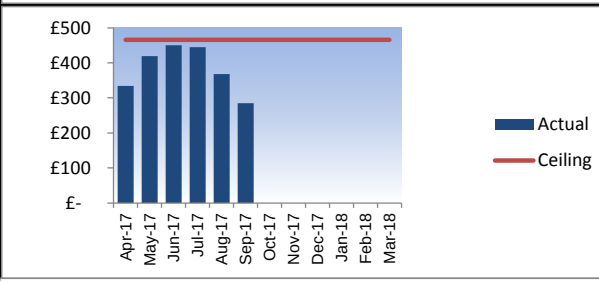
Indicator name / data quality assessment	Description	Trend chart	Interpretation
Readmissions	% of patients readmitted to hospital as an emergency within 30 days of discharge (PbR exclusions applied). To ensure that we are not discharging patients inappropriately early and to assess our overall surgical 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.		The number of readmissions increased in August when expressed as a percentage of all emergency admissions and remains above the HDFT average rate for 2016/17. The review undertaken with HARD CCG has still be be finalised and the changes to the readmissions reimbursement agreed. This is very important to ensure that the Trust is appropriately paid for patients who are readmitted appropriately.
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 September was 2.5 days, a decrease on the previous month and in line with the benchmark group average.
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 September was 4.7 days, a decrease on last month, remaining abovethe benchmark group average but below the national average. The implementation of the SAFER care bundle, which supports discharge processes is now being supported by a live information dashboard, which enables ward level length of stay, morning discharges and use of planned discharge dates to be monitored at the daily bed meeting. Directorates are then progressing with targeted reductions in length of stay by ward area.
Theatre utilisation	The percentage of time utilised during elective theatre sessions (i.e. those planned in advance for waiting list patients). The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc. An extra line has been added to the chart to allow monitoring of this. A higher utilisation rate is good as it demonstrates effective use of resources. A utilisation rate of around 85% is often viewed as optimal.		Theatre utilisation increased to 86.0% in September and the number of cancelled sessions decreased to 7.1%. Sterile Services returned on site during September which has had a positive impact on theatre utilisation, as well as a number of initiatives being carrried out by Planned & Surgical Care Directorate as detailed in the Chief Operating Officer Report. A new theatre utilisation dashboard is being developed and the metric used in this report will be aligned with this going forward.

Finance and Efficiency - September 2017

Harrogate and District NHS Foundation Trust

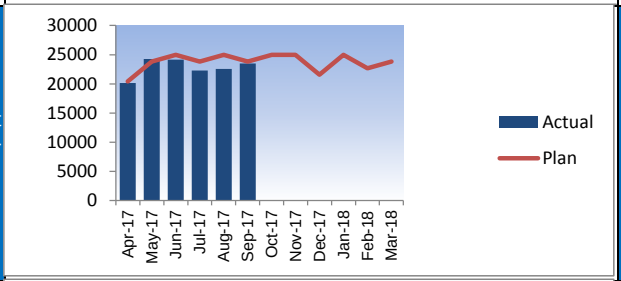
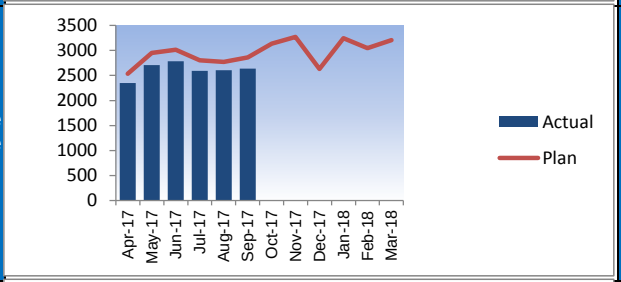
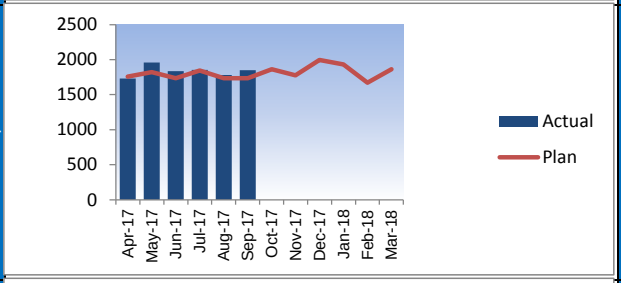
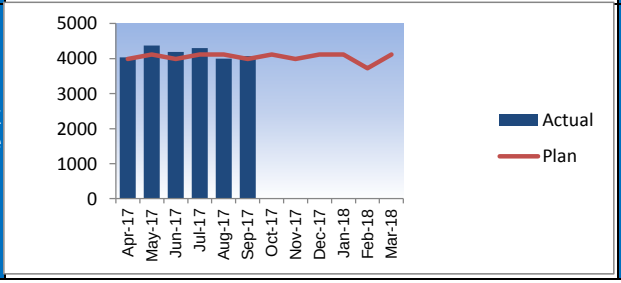
Indicator name / data quality assessment	Description	Trend chart	Interpretation
Delayed transfers of care ✓	The proportion of patients in acute hospital beds who are medically fit for discharge but are still in hospital. A low rate is preferable. A snapshot position is taken at midnight on the last Thursday of each month. The maximum threshold shown on the chart (3.5%) has been agreed with the CCG.		Delayed transfers of care decreased to 5.0% when the snapshot was taken in September, but remains above the maximum threshold of 3.5% set out in the contract. This remains a significant concern going into winter.
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.		As anticipated, HDFT's DNA rate decreased to 5.2% in July following a number of months of increase. A similar upward trend was seen in the same period last year with the DNA rate peaking at 5.9% in July last year. HDFT's DNA remains below that of both the benchmarked group of trusts and the national average.
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.		Reducing the number of follow ups is a major part of HARD CCG's financial recovery plan. HDFT's new to follow up ratio was 1.91 in July, remaining below both the histroical average for HDFT and also below both the national and benchmark group average. As part of the financial recovery plan, outpatient clinic templates are being adjusted to increase the number of new slots where changes can be made to reduce the number of patients being booked for follow up. It remains essential that the Clinical Directorate teams monitor the waiting times for patients booked for follow up to ensure that they receive timely care where they do need to return.
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 day case rate decreased to 88.4% in September.

Finance and Efficiency - September 2017

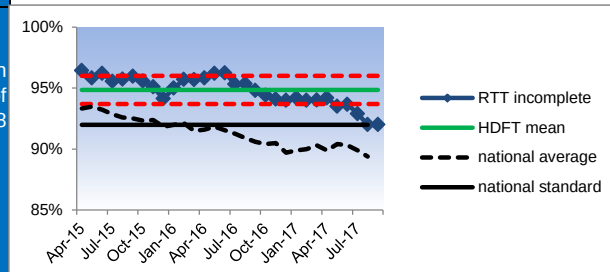
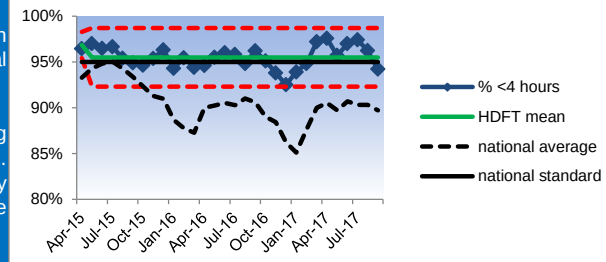
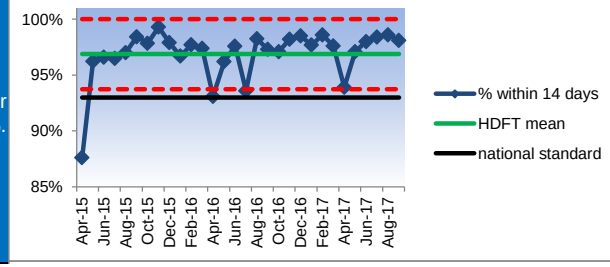
Indicator name / data quality assessment	Description	Trend chart	Interpretation
Surplus / deficit and variance to plan	Monthly Surplus/Deficit (£'000s). In some months, a deficit is planned for. This indicator reports positive or adverse variance against the planned position for the month.		The Trust financial position remains a significant risk, with the year to date position a deficit of £5,575k. The in month position has improved, with a number of the recovery actions starting to show a benefit. This optimism needs to be tempered with the Trust still reporting a loss in month, and it is vital that the Trust starts to achieve a surplus monthly position.
NHS Improvement Single Oversight Framework - Use of Resource Metric	From 1st October 2016, NHS Improvement introduced the Single Oversight Framework. As part of this this, Use of Resource Metric was introduced to replace the previous Financial Sustainability Risk Rating. This is the product of five elements which are rated between 1 (best) to 4.	**Element** / **Plan** / **Actual** Capital Service Cover: 2 / 4 Liquidity: 2 / 1 I&E Margin: 1 / 4 I&E Variance From Plan: 1 / 4 Agency: 1 / 1 **Financial Sustainability Risk Rating: 2 / 3**	The Trust will report a rating of 3 for September. This is behind the plan of 2 and is a result of the variance from plan for income and expenditure.
Capital spend	Cumulative Capital Expenditure by month (£'000s)		Capital expenditure is behind plan. However it is anticipated that expenditure will increase to planned levels as the year progresses.
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 Trust aims to have less than 3% of the total pay bill on agency staff.		Year to date agency expenditure is 2.95% of total employee expenses. Although this continues to be below the agency ceiling, there is still work underway to drive down agency usage and cost. This is being led through the Workforce Efficiency Group. Improvements were seen in September to this position.

Finance and Efficiency - September 2017

Harrogate and District NHS Foundation Trust

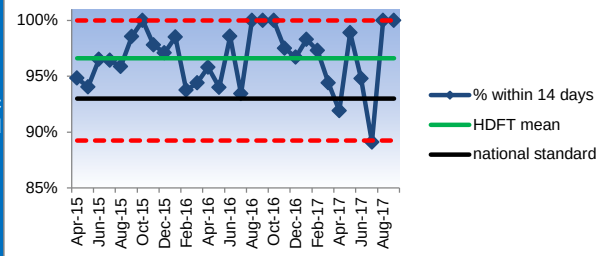
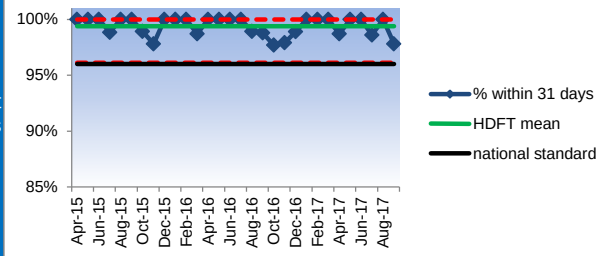
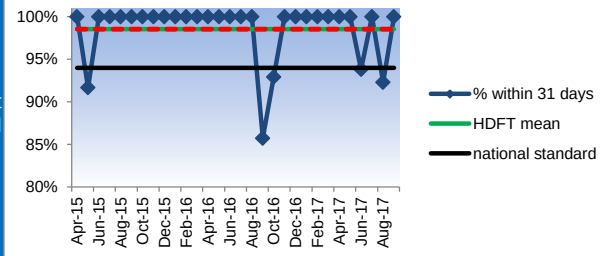
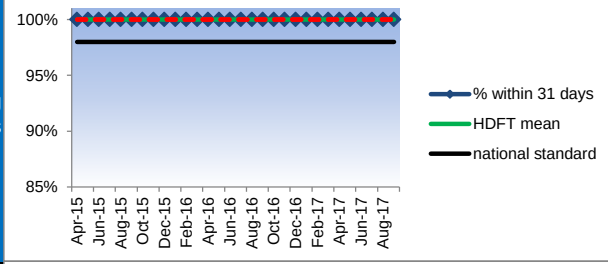
Indicator name / data quality assessment	Description	Trend chart	Interpretation
Outpatient activity against plan ✓	The chart shows the position against plan for outpatient activity. The data includes all outpatient attendances - new and follow-up, consultant and non-consultant led.		Outpatient activity was 1.3% below plan in the month of September and 3.5% below plan year to date. This is an improvement on last month's position. A number of actions are being undertaken by Planned & Surgical Care Directorate to improve this position further, as detailed within the Chief Operarting Officer's Report.
Elective activity against plan ✓	The chart shows the position against plan for elective activity. The data includes inpatient and day case elective admissions.		Elective activity was 7.7% below plan in the month of September and 7.5% below plan year to date. A number of actions are being undertaken by Planned & Surgical Care Directorate to improve this position. Financial recovery plans are also discussed in detail at Operational Delivery Group. Further information is provided within the Chief Operarting Officer's Report.
Non-elective activity against plan ✓	The chart shows the position against plan for non-elective activity (emergency admissions).		Non-elective activity was 6.5% above plan in the month of September and 3.6% above plan year to date.
A&E activity against plan ✓	The chart shows the position against plan for A&E attendances at Harrogate Emergency Department. The data excludes planned follow-up attendances at A&E.		A&E attendances were 2.0% above plan in the month of September and 2.6% above plan year to date.

Operational Performance - September 2017

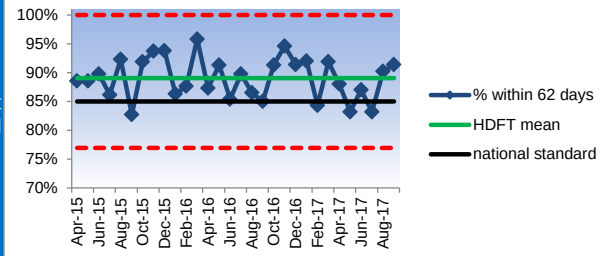
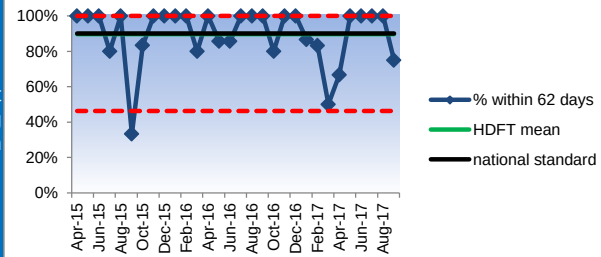
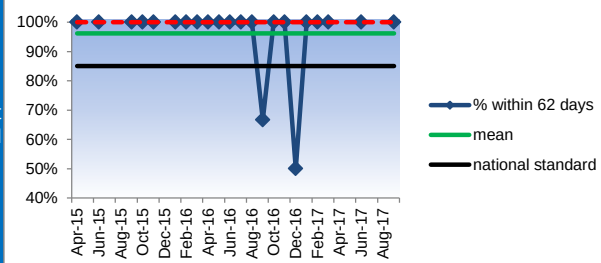
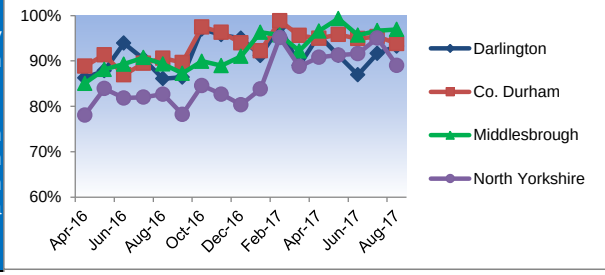
Indicator name / data quality assessment	Description	Trend chart	Interpretation
NHS Improvement Single Oversight Framework ✓	From October 2016, NHS Improvement use a variety of information to assess a Trust's governance risk rating, including CQC information, access and outcomes metrics, third party reports and quality governance metrics. The table to the right shows how the Trust is performing against the national performance standards in the "operational performance metrics" section.	<table><tr><th>Standard</th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th><th>YTD</th></tr><tr><td>RTT incomplete pathways</td><td>93.8%</td><td>92.3%</td><td></td><td></td><td>93.0%</td></tr><tr><td>A&E 4-hour standard</td><td>96.7%</td><td>96.0%</td><td></td><td></td><td>96.4%</td></tr><tr><td>Cancer - 62 days</td><td>86.0%</td><td>88.8%</td><td></td><td></td><td>87.5%</td></tr><tr><td>Diagnostic waits</td><td>99.8%</td><td>99.6%</td><td></td><td></td><td>99.7%</td></tr></table>	In Quarter 2, HDFT's performance is above the required level for all 4 key operational performance metrics.
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. A high percentage is good.		92.0% of patients were waiting 18 weeks or less at the end of September, no change on last month. Performance has deteriorated significantly recently with the Trust overall performance now at the minimum level of 92% for the second successive month. At specialty level, Trauma & Orthopaedics and General Surgery were below the 92% standard. Operational Delivery Group reviews long waiting patients on a weekly basis to ensure that patients receive a date for treatment as soon as possible and the Trust maintains the national standard for RTT. Specialties with long waits are being targeted as part of the financial recovery plan and it is therefore planned to improve this position, along with income.
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. Historical data for HDFT included both Ripon and Selby MIUs. In agreement with local CCGs, York NHSFT are reporting the activity for Selby MIU from 1st May 2015.		HDFT's Trust level performance for September was 94.2%, a reduction on last month and below the required 95% standard. This includes data for the Emergency Department at Harrogate and Ripon MIU. Performance for Harrogate ED was below the 95% standard at 93.0%. However, Trustwide performance for Quarter 2 overall was above the required 95% standard at 96.0% and HDFT's performance remains well above the national average.
Cancer - 14 days maximum wait from urgent GP referral for suspected cancer referrals ✓	Percentage of urgent GP referrals for suspected cancer seen within 14 days. The operational standard is 93%. A high percentage is good.		Delivery at expected levels.

Operational Performance - September 2017

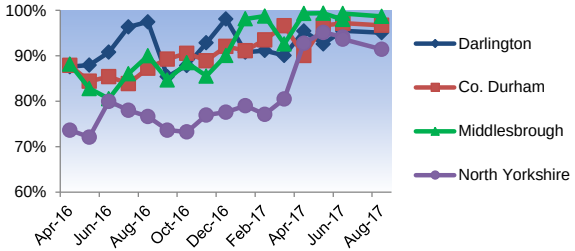
Harrogate and District NHS Foundation Trust

Indicator name / data quality assessment	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.		Provisional performance is at 100% for August and September, an improvement on the July position. Performance for Quarter 2 to date is above the required 93% standard.
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.		Delivery at expected levels.
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.		Provisional performance is at 100% for September, an improvement on the August position. Performance for Quarter 2 to date is above the required 93% standard.
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.		Delivery at expected levels.

Operational Performance - September 2017

Indicator name / data quality assessment	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.		Provisional performance for September is above the required 85% standard at 91.4% with 6 accountable breaches. Of the 11 tumour sites, 4 had performance below 85% in September - colorectal (3 breaches), gynaecological (0.5), head and neck (1) and lung (1.5). Three patients waited over 104 days in September. The main reasons for the delays were patient choice and outpatient capacity.
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.		Provisional performance for Quarter 2 is just below the required 90% standard at 89%. However there are currently less than 5 accountable pathways meaning that the Trust is below 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.		Delivery at expected levels.
Children's Services - 10-14 day new birth visit ▲	The percentage of babies who had a new birth visit by the Health Visiting team within 14 days of birth. A high percentage is good. Data shown is for the 0-5 Health Visiting Service in North Yorkshire and the Healthy Child Programme in Darlington, Co. Durham and Middlesbrough. A high percentage is good. The contract does not specify a required level.		In August, the validated performance position is that 92% of babies were recorded on Systmone as having had a new birth visit within 14 days of birth. The data is reported a month in arrears so that the validated position can be shared.

Operational Performance - September 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Children's Services - 2.5 year review	The percentage of children who had a 2.5 year review. A high percentage is good. Data shown is for the 0-5 Health Visiting Service in North Yorkshire and the Healthy Child Programme in Darlington, Co. Durham and Middlesbrough. A high percentage is good. The contract does not specify a required level.		In August, the validated performance position is that 95% of children were recorded on Systmone as having had a 2.5 year review. The data is reported a month in arrears so that the validated position can be shared.

Data Quality - Exception Report

Harrogate and District NHS Foundation Trust

Report section	Indicator	Data quality rating	Further information
Quality	Pressure ulcers - community acquired - grades 2, 3 or 4	**Amber** 	The observed increase in reported cases over the last two years may be partly due to improvements in incident reporting during the period.
Finance and efficiency	Theatre utilisation	**Amber** 	The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc. An extra line has been added to the chart to allow monitoring of cancelled sessions.
Operational Performance	Children's Services - 10-14 day new birth visit	**Amber** 	Caution should be exercised as further work is required to understand the completeness and quality of this data.
Operational Performance	Children's Services - 2.5 year review	**Amber** 	Caution should be exercised as further work is required to understand the completeness and quality of this data.

Harrogate and District NHS Foundation Trust

Indicator traffic light criteria

Section	Indicator	Further detail	Traffic light criteria	Rationale/source of traffic light criteria
Quality	**Pressure ulcers - hospital acquired**	No. category 3 and category 4 avoidable hospital acquired pressure ulcers	tbc	tbc
Quality	**Pressure ulcers - community acquired**	No. category 3 and category 4 community acquired pressure ulcers	tbc	tbc
Quality	**Safety thermometer - harm free care**	% harm free	Blue if latest month >=97%, Green if >=95% but <97%, red if latest month <95%	National best practice guidance suggests that 95% is the standard that Trusts should achieve. In addition, HDFT have set a local stretch target of 97%.
Quality	**Falls**	IP falls per 1,000 bed days	Blue if YTD position is a reduction of >=50% of HDFT average for 2016/17, Green if YTD position is a reduction of between 20% and 50% of HDFT average for 2016/17, Amber if YTD position is a reduction of up to 20% of HDFT average for 2016/17, Red if YTD position is on or above HDFT average for 2016/17.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
Quality	**Infection control**	No. hospital acquired C.diff cases	Green if below trajectory YTD, Amber if above trajectory YTD, Red if above trajectory at end year or more than 10% above trajectory in year.	NHS England, NHS Improvement and contractual requirement
Quality	**Avoidable admissions**	The number of avoidable emergency admissions to HDFT as per the national definition.	tbc	tbc
Quality	**Mortality - HSMR**	Hospital Standardised Mortality Ratio (HSMR)	Blue = better than expected (95% confidence interval), Green = as expected, Amber = worse than expected (95% confidence interval), Red = worse than expected (99% confidence interval).	Comparison with national average performance.
Quality	**Mortality - SHMI**	Summary Hospital Mortality Index (SHMI)		
Quality	**Complaints**	No. complaints, split by criteria	Blue if no. complaints in latest month is below LCL, Green if below HDFT average for 2016/17, Amber if on or above HDFT average for 2016/17, Red if above UCL. In addition, Red if a new red rated complaint received in latest month.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
Quality	**Incidents - all**	Incidents split by grade (hosp and community)	Blue if latest month ratio places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%	Comparison of HDFT performance against most recently published national average ratio of low to high incidents.
Quality	**Incidents - complrehensive SIRIs and never events**	The number of comprehensive SIRIs and the number of never events reported in the year to date. The indicator includes hospital and community data.	Green if none reported in current month; Red if 1 or more never event or comprehensive reported in the current month.	
Quality	**Friends & Family Test (FFT) - Patients**	% recommend, % not recommend - combined score for all services currently doing patient FFT	Green if latest month >= latest published national average, Red if < latest published national average.	Comparison with national average performance.
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%.	The Trusts aims for 100% staffing overall.
Quality	**Staff appraisal rate**	Latest position on no. staff who had an appraisal within the last 12 months	Annual rolling total - 90% green. Amber between 70% and 90%, red<70%.	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%-95% overall, amber if between 50% and 75%, red if below 50%.	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	**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
Finance and efficiency	**Readmissions**	No. emergency readmissions (following elective or non-elective admission) within 30 days.	Blue if latest month rate < LCL, Green if latest month rate < HDFT average for 2016/17, Amber if latest month rate > HDFT average for 2016/17 but below UCL, red if latest month rate > UCL.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
Finance and efficiency	**Length of stay - elective**	Average LOS for elective patients	Blue if latest month score places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%.	Comparison with performance of other acute trusts.
Finance and efficiency	**Length of stay - non-elective**	Average LOS for non-elective patients		
Finance and efficiency	**Theatre utilisation**	% of theatre time utilised for elective operating sessions	Green = >=85%, Amber = between 75% and 85%, Red = <75%	A utilisation rate of around 85% is often viewed as optimal.

Section	Indicator	Further detail	Traffic light criteria	Rationale/source of traffic light criteria
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
Finance and efficiency	Outpatient DNA rate	% first OP appointments DNA'd	Blue if latest month score places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%.	Comparison with performance of other acute trusts.
Finance and efficiency	Outpatient new to follow up ratio	No. follow up appointments per new appointment.		
Finance and efficiency	Day case rate	% elective admissions that are day case		
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	Locally agreed targets.
Finance and efficiency	NHS Improvement Financial Performance Assessment	An overall rating is calculated ranging from 4 (no concerns) to 1 (significant concerns). This indicator monitors our position against plan.	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 NHS Improvement
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	Locally agreed targets.
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.	Locally agreed targets.
Finance and efficiency	Outpatient activity against plan (new and follow up)	Includes all outpatient attendances - new and follow-up, consultant and non-consultant led.	Green if on or above plan in month, amber if below plan by < 3%, red if below plan by > 3%.	Locally agreed targets.
Finance and efficiency	Elective activity against plan	Includes inpatient and day case activity		Locally agreed targets.
Finance and efficiency	Non-elective activity against plan			Locally agreed targets.
Finance and efficiency	Emergency Department attendances against plan	Excludes planned followup attendances.		Locally agreed targets.
Operational Performance	NHS Improvement governance rating	Trust performance on Monitor's risk assessment framework.	As per defined governance rating	as defined by NHS Improvement
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.	Blue if latest month >=97%, Green if >=95% but <97%, red if latest month <95%	NHS England, NHS Improvement and contractual requirement of 95% and a locally agreed stretch target of 97%.
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, NHS Improvement 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, NHS Improvement 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, NHS Improvement 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, NHS Improvement 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, NHS Improvement 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, NHS Improvement 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, NHS Improvement 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, NHS Improvement and contractual requirement
Operational Performance	Children's Services - 10-14 day new birth visit	% new born visit within 14 days of birth	Green if latest month >=90%, Amber if between 75% and 90%, Red if <75%.	Contractual requirement
Operational Performance	Children's Services - 2.5 year review	% children who had a 2 and a half year review	Green if latest month >=90%, Amber if between 75% and 90%, Red if <75%.	Contractual requirement

Data quality assessment

Green		No known issues of data quality - High confidence in data
Amber		On-going minor data quality issue identified - improvements being made/ no major quality issues
Red		New data quality issue/on-going major data quality issue with no improvement as yet/ data confidence low/ figures not reportable

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Harrogate and District
NHS Foundation Trust

Date of Meeting:	25th October 2017	**Agenda item:**	7.0
Report to:	Board of Directors		
Title:	Finance Report		
Sponsoring Director:	Jonathan Coulter Deputy Chief Executive / Finance Director		
Author(s):	Finance Department		
Report Purpose:	**Decision** [ ] **Discussion/ Consultation** [✓] **Assurance** [✓] **Information** [✓]		
Executive Summary:	• The Trust reported a deficit position of £5,575k to date, resulting in a use of resource metric of 3. • Actions in relation to the recovery plan previously discussed at Board are being progressed, with the report detailing the impact to date. • Despite being £530k ahead of plan, the cash balance of £2.7m and forecast outturn represent a challenging position, details of which are included at the end of this report.		

Related Trust Objectives					
To deliver high quality care	✓	**To work with partners to deliver integrated care:**	✓	**To ensure clinical and financial sustainability:**	✓

Key implications	
Risk Assessment:	The paper outlines the financial risks facing the Trust and the mitigations being put in place to resolve these in terms of revenue and cash.
Legal / regulatory:	None directly identified.
Resource:	The document outlines the financial challenges and approach to resolving these issues.
Impact Assessment:	A number of quality impact assessments are undertaken on elements of the recovery plan and CIP programme.
Conflicts of Interest:	None
Reference documents:	

Action Required by the Board of Directors:
The Board of Directors is asked to note the contents of this report.

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September 2017 Financial Position

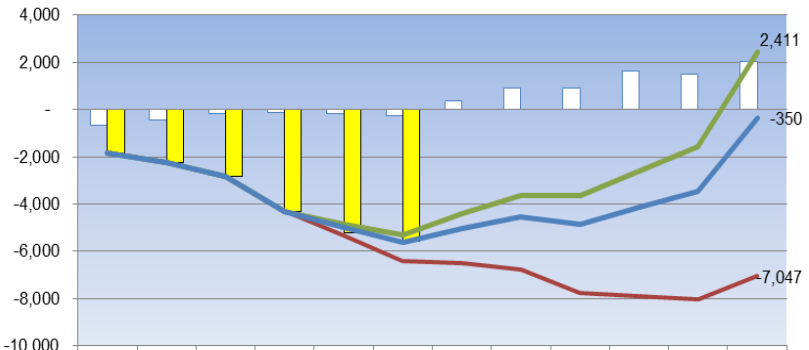
Financial Performance

- Financial performance continues to be a high risk to the Trust, with a deficit of £5.575m reported for the year to September. No Sustainability and Transformation Funding (STF) has been assumed in this position as a result of the adverse position. The Use of Resources rating remains as a 3. The position summarised in the table below -

	Budget (£m)	Actual (£m)	Variance (£m)
Income	107.1	104.0	-3.6
Expenditure	108.1	109.6	-1.8
Surplus / Deficit before STF	**-0.2**	**-5.6**	**-5.4**
Surplus / deficit after STF	**+1.1**	**-5.6**	**-6.7**

- Recovery plans are being implemented across the Trust, and the report details overall progress against these plans, as well as the impact each plan is having.
- The fully achieved recovery plan (not risk-adjusted) would have delivered a position of a deficit of £5.33m, the risk adjusted forecast was a deficit of £5.64m, with a 'do nothing' forecast of £6.41m. The actual position is therefore slightly better than the risk-adjusted plan.
- NHS Improvement reviewed the plan and process the Trust has in place to achieve the recovery plans. The key message was that we need to continue to work on ensuring that the plans we have in place are delivered, which will improve the financial position significantly.
- The Trust continues to report a forecast outturn to NHS Improvement that achieves the original plan and control total set for the Trust. This remains challenging as demonstrated by the graph, however, it is important that we build on the initial momentum from the changes that been introduced as well as the work being done by staff across the organisation.

Financial position and recovery trajectory (£'000s)



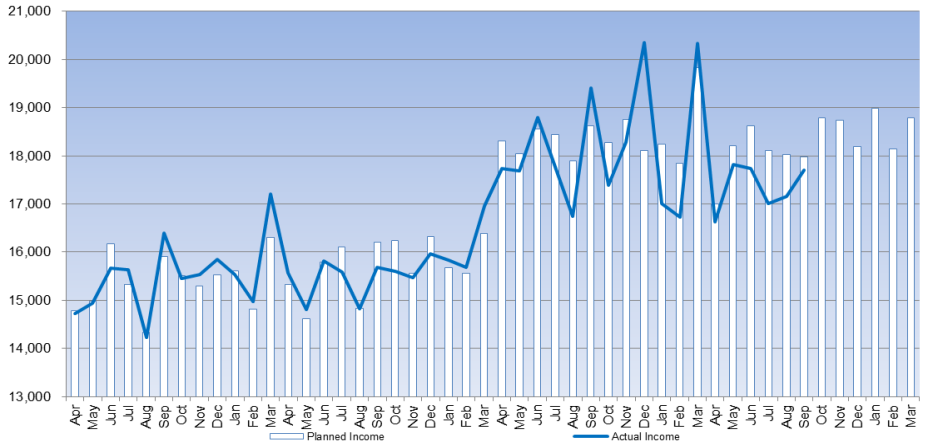
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan Pre S&T	-666	-424	-188	-137	-168	-249	344	890	885	1,611	1,499	2,040
Actual Performance	-1,835	-2,224	-2,836	-4,304	-5,213	-5,575						
Forecast Outturn - do nothing	-1,835	-2,224	-2,836	-4,304	-5,340	-6,408	-6,516	-6,760	-7,760	-7,901	-8,010	-7,047
Forecast Outturn - All Actions	-1,835	-2,224	-2,836	-4,304	-4,874	-5,326	-4,416	-3,653	-3,635	-2,609	-1,559	2,411
Forecast Outturn - risk adjusted actions	-1,835	-2,224	-2,836	-4,304	-5,010	-5,642	-5,029	-4,560	-4,839	-4,154	-3,442	-350

Plan Pre S&T
Actual Performance
Forecast Outturn - do nothing
Forecast Outturn - All Actions
Forecast Outturn - risk adjusted actions

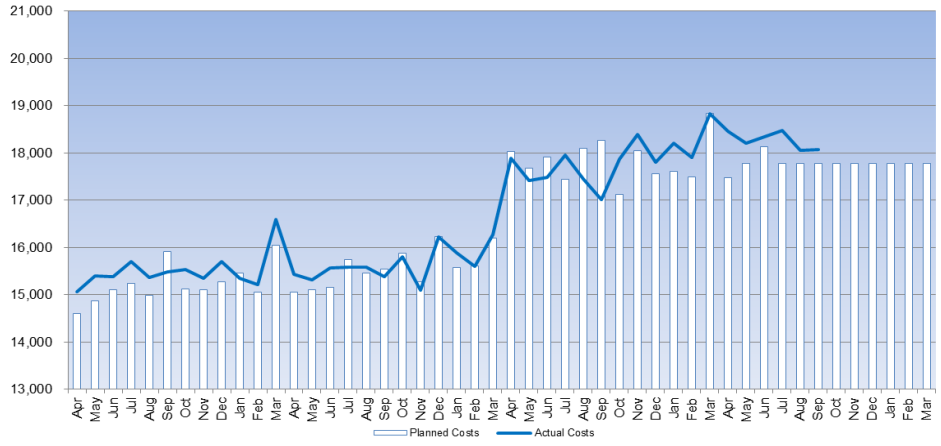
	Budget		Actual	Cumulative	September
	Annual Budget £000	Proportion To Date £000	To Date £000	Variance £000	Actuals £'000
INCOME					
NHS Clinical Income (Commissioners)					
NHS Clinical Income - Acute	147,934	72,734	70,607	(2,128)	11,973
NHS Clinical Income - Community	52,480	26,252	25,824	(429)	4,393
System Resilience & Better Care Funding	913	457	457	0	76
Non NHS Clinical Income					
Private Patient & Amenity Bed Income	1,473	736	687	(49)	104
Other Non-Protected Clinical Income (RTA)	523	261	243	(18)	43
Other Income					
Non Clinical Income	11,894	6,303	5,935	(368)	870
Hosted Services	309	309	309	0	296
TOTAL INCOME	**215,526**	**107,053**	**104,061**	**(2,992)**	**17,756**
EXPENSES					
Pay					
Pay Expenditure	(152,361)	(77,799)	(77,926)	(127)	(12,919)
Non Pay					
Drugs	(8,605)	(7,252)	(7,169)	83	(1,280)
Clinical Services & Supplies	(15,393)	(8,123)	(8,114)	9	(1,345)
Other Costs	(18,056)	(10,812)	(11,887)	(1,074)	(1,961)
Reserves : Pay	(2,950)	(0)	0	0	0
Pay savings targets	0	0	0	0	0
Other Reserves	(3,796)	1,042	0	(1,042)	0
High Cost Drugs	(3,948)	0	0	0	0
Non Pay savings targets	9	0	0	0	0
Other Finance Costs	(18)	(9)	(6)	3	0
Hosted Services	(402)	(366)	(367)	(1)	(57)
TOTAL COSTS	(205,517)	(103,320)	(105,469)	(2,150)	**(17,563)**
EBITDA	**10,008**	**3,734**	**(1,408)**	**(5,142)**	**192**
Profit / (Loss) on disposal of assets	0	0	0	0	0
Depreciation	(5,081)	(2,540)	(2,706)	(165)	(463)
Interest Payable	(90)	(45)	(114)	(69)	(21)
Interest Receivable	41	20	8	(12)	2
Dividend Payable	(2,746)	(1,373)	(1,355)	18	(73)
Net Surplus/(Deficit) before donations and impairments	**2,132**	**(204)**	**(5,576)**	**(5,371)**	**(363)**
Donated Asset Income	0	0	0	0	0
Impairments re Donated assets	0	0	0	0	0
Impairments re PCT assets	0	0	0	0	0
Net Surplus/(Deficit)	**2,132**	**(204)**	**(5,576)**	**(5,371)**	**(363)**
Sustainability and Transformation Fund	3,777	1,322	0	(1,322)	0
Operational Budgetary Position	**5,909**	**1,118**	**(5,576)**	**(6,693)**	**(363)**

Financial Position Monthly Run Charts

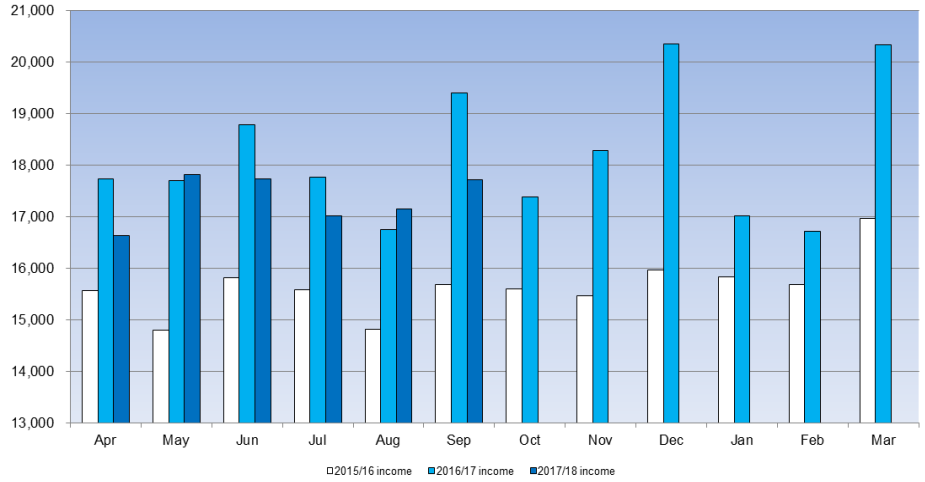
Planned and Actual Income Apr 2014 - Mar 2018



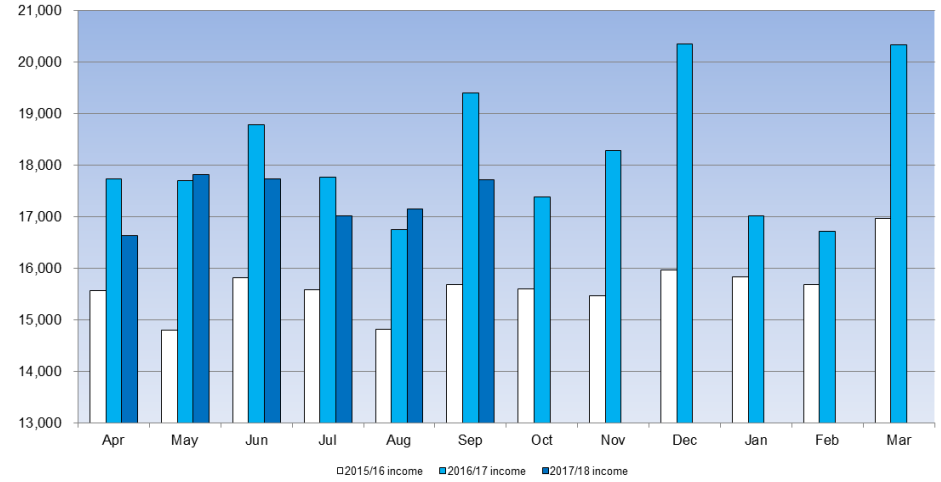
Planned and Actual Costs Apr 2014 - Mar 2018



Actual Income 2015/16, 2016/17 & 2017/18



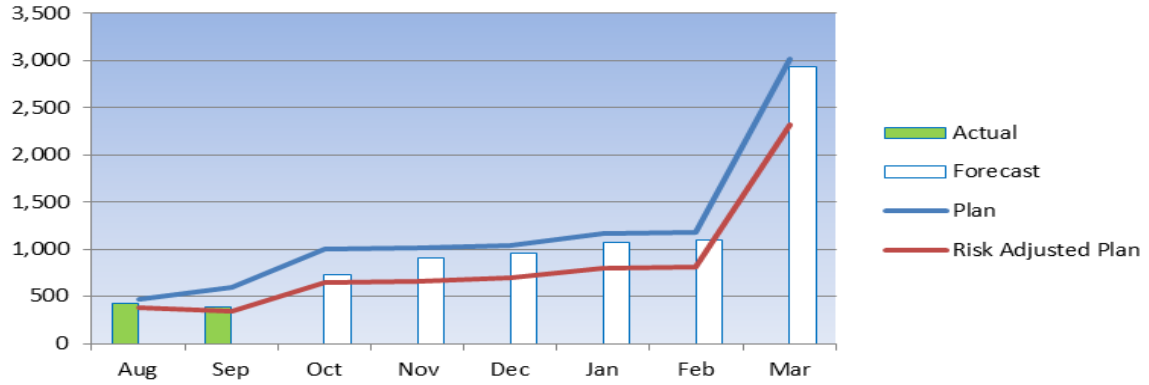
Actual Income 2015/16, 2016/17 & 2017/18

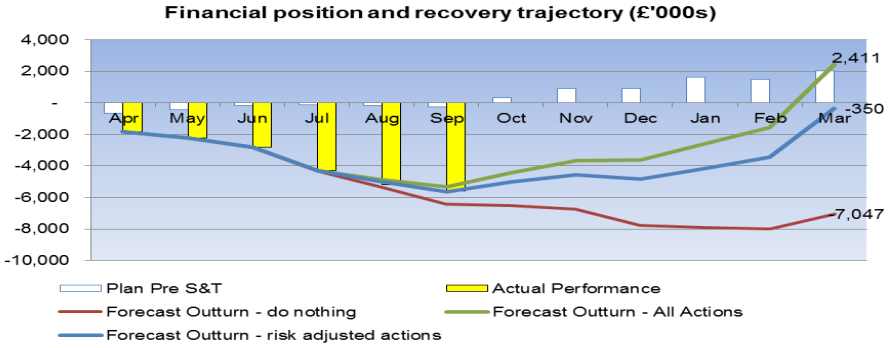


Financial Recovery Plans - Summary

The impact of recovery plans are summarised in the table and graph below. These are clearly a key subset of the current financial performance and should be viewed in summary alongside the overall financial position against our plan in Slide 1. This is repeated below for ease of comparison.

Plan/Actual	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Plan	466	603	1,007	1,015	1,043	1,175	1,178	3,020	9,506
Risk Adjusted Plan	383	352	650	660	702	796	809	2,321	6,673
Actual	434	392	0	0	0	0	0	0	826
Risk Adjusted Var	51	40	0	0	0	0	0	0	90
Forecast			732	908	961	1,074	1,100	2,934	7,708





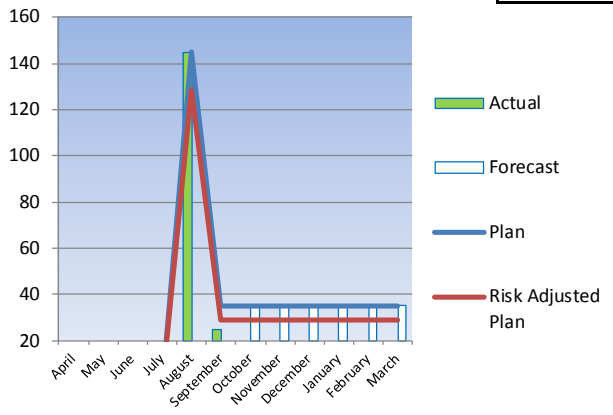
Further detail on individual schemes is contained within the following slides. Summaries can be found on pages 16 to 19.

Financial Recovery Plans - detail

Plan	Casemix

Executive Lead	Robert Harrison
Management Lead	Rachel McDonald
Finance Lead	Sharon Ainley

	In Month (£'000s)	YTD (£'000s)	Full Year (£'000s)
Plan	35	180	390
Risk Adjusted Plan	29	158	330
Actual/Forecast	25	170	380
Variance to Plan	**-10**	**-10**	**-10**
Variance to Risk Adjusted Plan	**-4**	**13**	**50**



Risk Assessment	Medium

Actions Completed
Technical issue with coding depth resolved
Coding for jnr docs included on induction
Awareness poster in place

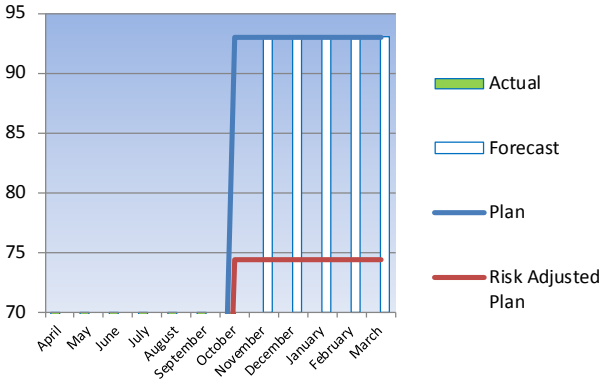
Risks/Issues
Recruitment and training of coders

Next Steps
Continued awareness
Information reported on coding depth at ODG
Plan in place regarding vacancies

Plan	Locum T&O Consultant

Executive Lead	Robert Harrison
Management Lead	Jonny Hammond
Finance Lead	Rachel Lerner

	In Month (£'000s)	YTD (£'000s)	Full Year (£'000s)
Plan	0	0	558
Risk Adjusted Plan	0	0	446
Actual/Forecast	0	0	465
Variance to Plan	**0**	**0**	**-93**
Variance to Risk Adjusted Plan	**0**	**0**	**19**



Risk Assessment	Medium

Actions Completed
Recruitment of consultant complete - awaiting start date - expected early November.

Risks/Issues
Start date will have an impact on the recovery plan.

Next Steps
Confirm start date and adjust recovery plan if appropriate.

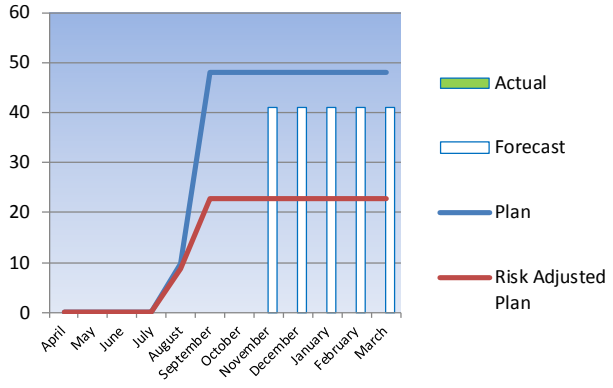
Financial Recovery Plans - detail

Plan	General Surgery

Risk Assessment	High

Executive Lead	Robert Harrison
Management Lead	Jonny Hammond
Finance Lead	Rachel Lerner

	In Month (£'000s)	YTD (£'000s)	Full Year (£'000s)
Plan	48	58	345
Risk Adjusted Plan	23	31	168
Actual/Forecast	0	0	205
Variance to Plan	**-48**	**-58**	**-140**
Variance to Risk Adjusted Plan	**-23**	**-31**	**37**



Actions Completed
IT infrastructure now in place to increase list capacity.

Risks/Issues

Agreement still needed on changes to service.
Ongoing discussions regarding access.

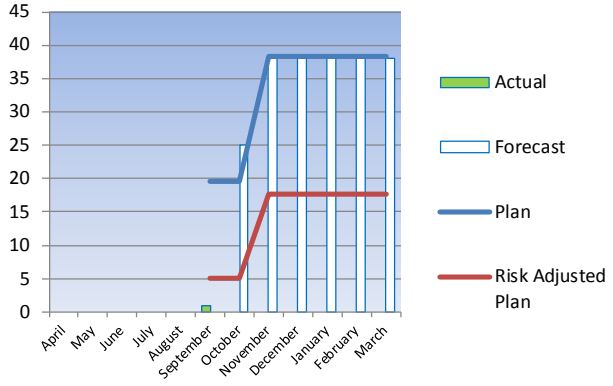
Next Steps
Discussions with General Surgeons continue
Activity per list in WGH to increase from October, but still in process of organising extra lists

Plan	Ophthalmology

Risk Assessment	High

Executive Lead	Robert Harrison
Management Lead	Jonny Hammond
Finance Lead	Rachel Lerner

	In Month (£'000s)	YTD (£'000s)	Full Year (£'000s)
Plan	20	20	231
Risk Adjusted Plan	5	5	98
Actual/Forecast	1	1	216
Variance to Plan	**-19**	**-19**	**-15**
Variance to Risk Adjusted Plan	**-4**	**-4**	**118**



Actions Completed
Loss making lists stopped. Agreement for reduced payment for additional lists achieved as well as use of topical agent for weekend cataracts only

Risks/Issues

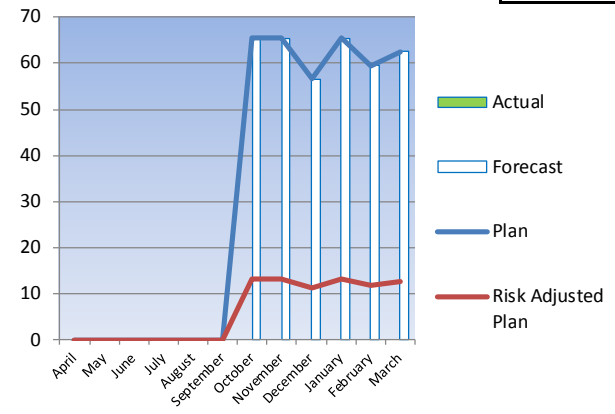
Next Steps
Agreement regarding topical lists in week

Financial Recovery Plans - detail

Plan	Professional Leave

Executive Lead	David Scullion
Management Lead	Joanne Harrison
Finance Lead	Annette Cadwallader

	In Month (£'000s)	YTD (£'000s)	Full Year (£'000s)
Plan	0	0	375
Risk Adjusted Plan	0	0	75
Actual/Forecast	0	0	375
Variance to Plan	0	0	0
Variance to Risk Adjusted Plan	0	0	300



Risk Assessment	High

Actions Completed
Policy and procedure developed and being implemented

Risks/Issues

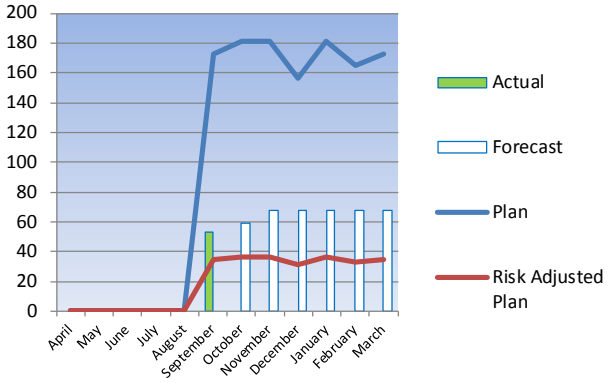
Process change results in increased activity
Goodwill in relation to work already undertaken

Next Steps
Activity to be tracked moving forward

Plan	Activity Recovery General

Executive Lead	Robert Harrison
Management Lead	Directorate led
Finance Lead	Directorate led

	In Month (£'000s)	YTD (£'000s)	Full Year (£'000s)
Plan	173	173	1,211
Risk Adjusted Plan	35	35	242
Actual/Forecast	53	53	453
Variance to Plan	-120	-120	-758
Variance to Risk Adjusted Plan	19	19	211



Risk Assessment	High

Actions Completed
Switch in Theatre lists agreed for 2 months
A number of outpatient clinic switches have taken place

Risks/Issues

Not all clinic switches agreed.

Next Steps
Monitor activity
Continue to implement changes to clinic templates
Scope potential for further benefits

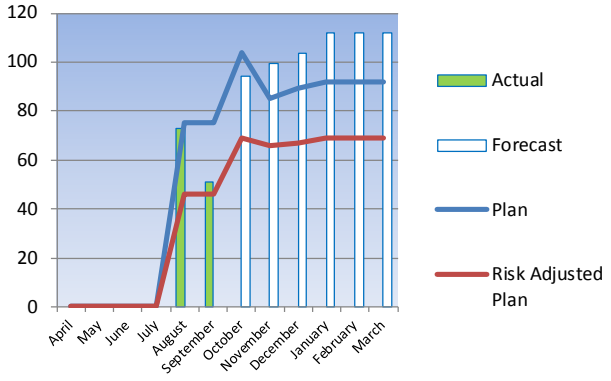
Financial Recovery Plans - detail

Plan	Ward Pay

Risk Assessment	High

Executive Lead	Jill Foster
Management Lead	Tracy Campbell
Finance Lead	Kim Donkersley

	In Month (£'000s)	YTD (£'000s)	Full Year (£'000s)
Plan	75	150	704
Risk Adjusted Plan	46	92	502
Actual/Forecast	51	124	757
Variance to Plan	-24	-26	52
Variance to Risk Adjusted Plan	5	32	255



Actions Completed
- Approved business case rosters being implemented
- Over cap agency minimised
- Ward non pay savings increased

Risks/Issues
- Need to sustain improvements to roster management
- Non elective activity pressures
- Recruitment of registered nurses
- Availability of bank and below cap staff

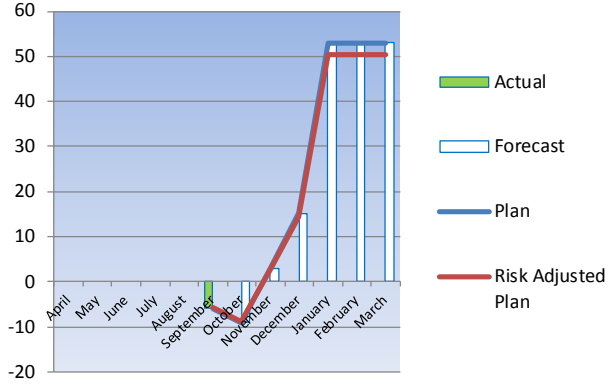
Next Steps
- Continue careful management of bed base
- Continue non pay savings schemes (£27.5k to date)

Plan	Theatres Pay

Risk Assessment	Low

Executive Lead	Robert Harrison
Management Lead	Jonny Hammond
Finance Lead	Rachel Lerner

	In Month (£'000s)	YTD (£'000s)	Full Year (£'000s)
Plan	-6	-6	162
Risk Adjusted Plan	-6	-6	154
Actual/Forecast	-6	-6	162
Variance to Plan	0	0	0
Variance to Risk Adjusted Plan	0	0	8



Actions Completed
- Strategy Approved
- New starters in November
- Adverts out for band 3/4 roles

Risks/Issues
- Risk in relation to successful recruitment to all posts
- Other turnover

Next Steps
- Recruit further posts
- Advertise benefits of programme

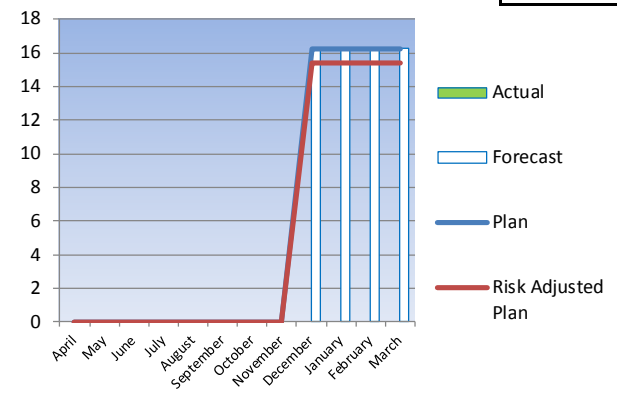
Financial Recovery Plans - detail

Plan	Agency

Risk Assessment	Low

Executive Lead	Phillip Marshall
Management Lead	Joanne Harrison
Finance Lead	Jordan McKie

	In Month (£'000s)	YTD (£'000s)	Full Year (£'000s)
Plan	0	0	65
Risk Adjusted Plan	0	0	62
Actual/Forecast	0	0	65
Variance to Plan	0	0	0
Variance to Risk Adjusted Plan	0	0	3



Actions Completed
Internal bank business case approved
Preferred provider chosen for direct engagement
Implementation for master vendor commenced

Risks/Issues

Take up of direct engagement - low risk

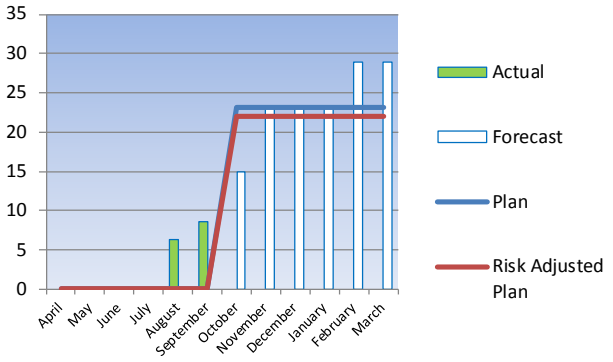
Next Steps
Finalise implementation plan
Implement

Plan	Community

Risk Assessment	Low

Executive Lead	Robert Harrison
Management Lead	Mike Forster
Finance Lead	Kim Donkersley

	In Month (£'000s)	YTD (£'000s)	Full Year (£'000s)
Plan	0	0	139
Risk Adjusted Plan	0	0	132
Actual/Forecast	9	15	157
Variance to Plan	9	15	18
Variance to Risk Adjusted Plan	9	15	25



Actions Completed
Unfunded beds at Trinity closed

Risks/Issues

Capacity of bed base and other pressures

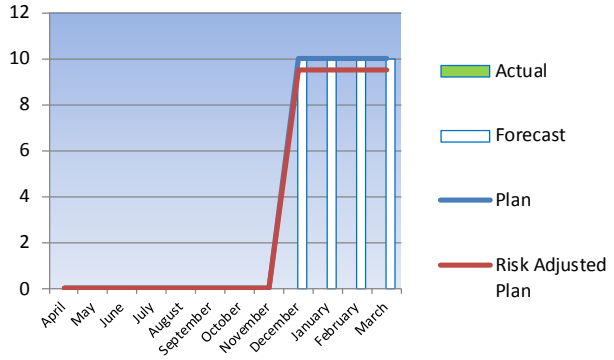
Next Steps

Financial Recovery Plans - detail

Plan	Further Procurement Opportunities

Executive Lead	Jonathan Coulter
Management Lead	David Sales
Finance Lead	Jordan McKie

	In Month (£'000s)	YTD (£'000s)	Full Year (£'000s)
Plan	0	0	40
Risk Adjusted Plan	0	0	38
Actual/Forecast	0	0	40
Variance to Plan	0	0	0
Variance to Risk Adjusted Plan	0	0	2



Risk Assessment	Low

Actions Completed
Work being undertaken as part of WYAAT programme

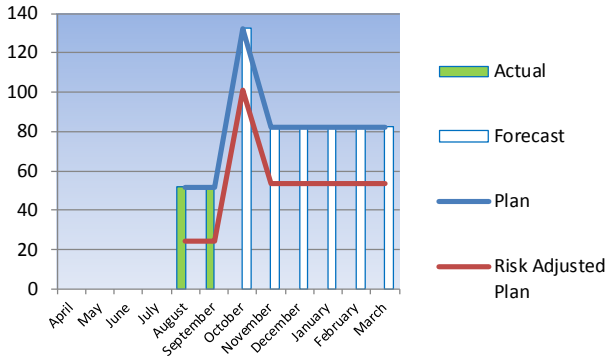
Risks/Issues

Next Steps
Implementation December

Plan	Additional CIP

Executive Lead	Jonathan Coulter
Management Lead	Directorate Led
Finance Lead	Directorate Led

	In Month (£'000s)	YTD (£'000s)	Full Year (£'000s)
Plan	52	103	646
Risk Adjusted Plan	24	48	416
Actual/Forecast	52	104	647
Variance to Plan	0	1	1
Variance to Risk Adjusted Plan	28	56	232



Risk Assessment	High

Actions Completed
Various

Risks/Issues
Various

Next Steps
Various

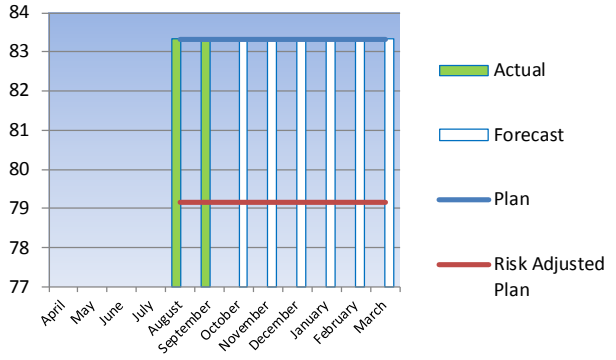
Financial Recovery Plans - detail

Plan	Board Contingency

Risk Assessment	Low

Executive Lead	Jonathan Coulter
Management Lead	Jordan McKie
Finance Lead	Jordan McKie

	In Month (£'000s)	YTD (£'000s)	Full Year (£'000s)
Plan	83	167	667
Risk Adjusted Plan	79	158	633
Actual/Forecast	83	167	667
Variance to Plan	0	0	0
Variance to Risk Adjusted Plan	4	8	33



Actions Completed

Board Contingency released

Risks/Issues

No funding available for developments

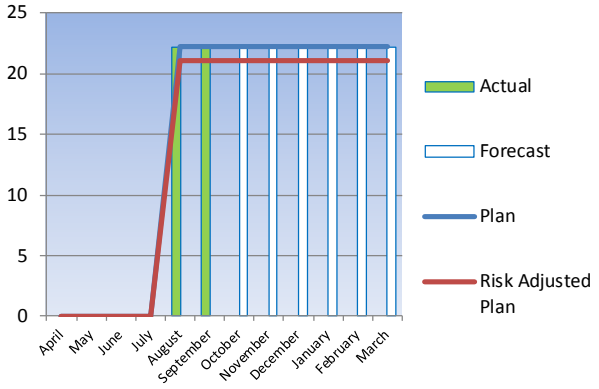
Next Steps

Plan	Capitalisation

Risk Assessment	Low

Executive Lead	Jonathan Coulter
Management Lead	Thomas Morrison
Finance Lead	Jordan McKie

	In Month (£'000s)	YTD (£'000s)	Full Year (£'000s)
Plan	22	44	178
Risk Adjusted Plan	21	42	169
Actual/Forecast	22	44	178
Variance to Plan	0	0	0
Variance to Risk Adjusted Plan	1	2	9



Actions Completed

Risks/Issues

Next Steps

Continue to assess capital programme thoroughly

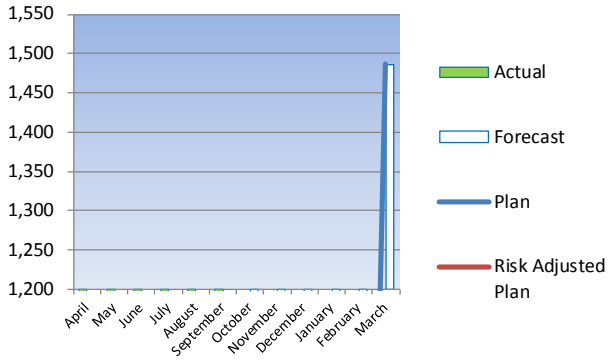
Financial Recovery Plans - detail

Plan	ASDM

Risk Assessment	Medium

Executive Lead	Jonathan Coulter
Management Lead	Phil Sturdy
Finance Lead	Thomas Morrison / Jordan McKie

	In Month (£'000s)	YTD (£'000s)	Full Year (£'000s)
Plan	0	0	1,486
Risk Adjusted Plan	0	0	1,189
Actual/Forecast	0	0	1,486
Variance to Plan	0	0	0
Variance to Risk Adjusted Plan	0	0	297



Actions Completed
Outline business case approved

Risks/Issues
Timescales involved are tight

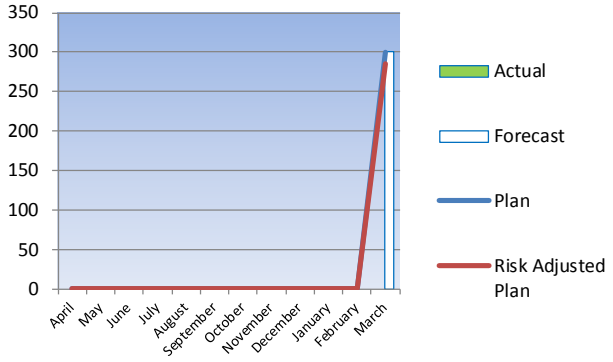
Next Steps
Full business case to be completed

Plan	Provisions

Risk Assessment	Low

Executive Lead	Jonathan Coulter
Management Lead	Jordan McKie
Finance Lead	Jordan McKie

	In Month (£'000s)	YTD (£'000s)	Full Year (£'000s)
Plan	0	0	300
Risk Adjusted Plan	0	0	285
Actual/Forecast	0	0	300
Variance to Plan	0	0	0
Variance to Risk Adjusted Plan	0	0	15



Actions Completed

Risks/Issues

Next Steps
Provisions are being assessed to ensure they remain at appropriate levels in relation to wider policies.

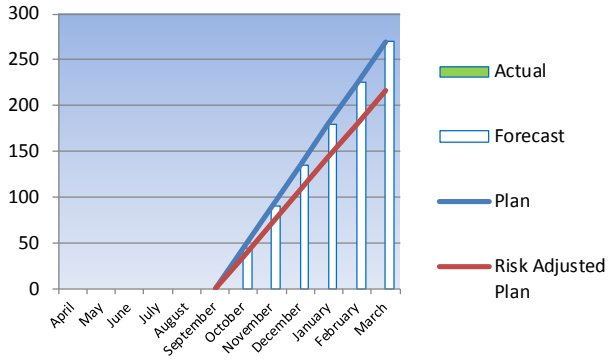
Financial Recovery Plans - detail

Plan	Holding Vacancies

Risk Assessment	Medium

Executive Lead	Phillip Marshall
Management Lead	Joanne Harrison
Finance Lead	Jordan McKie

	In Month (£'000s)	YTD (£'000s)	Full Year (£'000s)
Plan	0	0	945
Risk Adjusted Plan	0	0	756
Actual/Forecast	0	0	945
Variance to Plan	0	0	0
Variance to Risk Adjusted Plan	0	0	189



Actions Completed
Central vacancy control established
Exceptions establshed
QIA and finance process established

Risks/Issues

Unintended consequences of not filling posts being monitored.

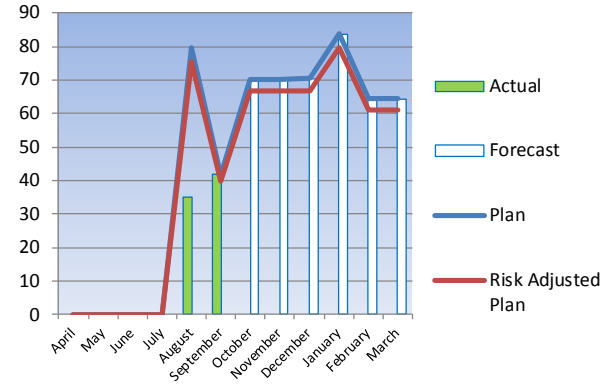
Next Steps

Plan	Corporate Actions

Risk Assessment	Low

Executive Lead	Robert Harrison
Management Lead	Various
Finance Lead	Katie Laurence

	In Month (£'000s)	YTD (£'000s)	Full Year (£'000s)
Plan	42	121	545
Risk Adjusted Plan	40	115	518
Actual/Forecast	42	77	500
Variance to Plan	0	-44	-44
Variance to Risk Adjusted Plan	2	-38	-17



Actions Completed
Internal bank business case approved
Preferred provider chosen for direct engagement
Implementation for master vendor commenced

Risks/Issues

Take up of direct engagement - low risk

Next Steps
Finalise implementation plan
Implement

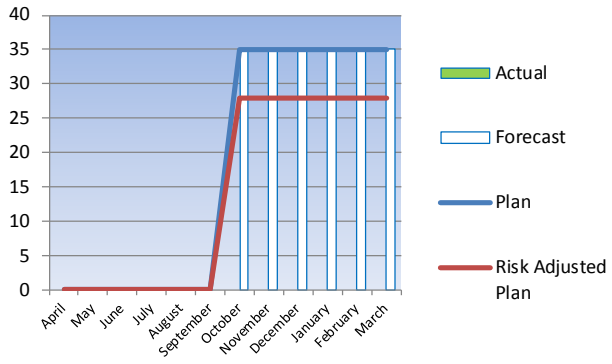
Financial Recovery Plans - detail

Plan	Non Pay Controls

Risk Assessment	Medium

Executive Lead	Jonathan Coulter
Management Lead	Directorate Led
Finance Lead	Jordan McKie

	In Month (£'000s)	YTD (£'000s)	Full Year (£'000s)
Plan	0	0	210
Risk Adjusted Plan	0	0	168
Actual/Forecast	0	0	210
Variance to Plan	0	0	0
Variance to Risk Adjusted Plan	0	0	42



Actions Completed
Awareness of key variances identified and plans developed.
Process strengthened.

Risks/Issues

Small areas where alternative ways of purchasing can mean spend continues, these are being monitored.

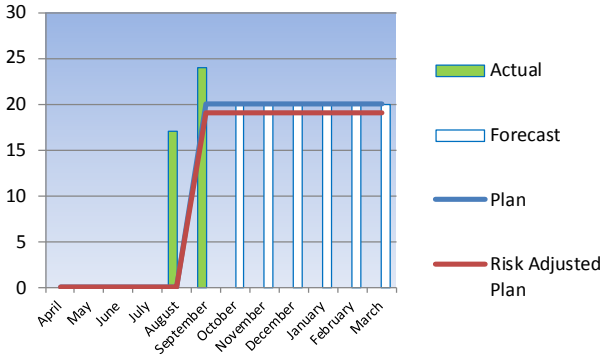
Next Steps
Continue actions

Plan	Additional hrs/Overtime Reduction

Risk Assessment	Low

Executive Lead	Jonathan Coulter
Management Lead	Directorate Led
Finance Lead	Directorate Led

	In Month (£'000s)	YTD (£'000s)	Full Year (£'000s)
Plan	20	20	140
Risk Adjusted Plan	19	19	133
Actual/Forecast	24	41	161
Variance to Plan	4	21	21
Variance to Risk Adjusted Plan	5	22	28



Actions Completed
Awareness of areas impacted
Directorate reviews of usage

Risks/Issues

Needs to be balanced with the use of agency/bank, and availability of staff to support activity recovery.

Next Steps
Continue to monitor

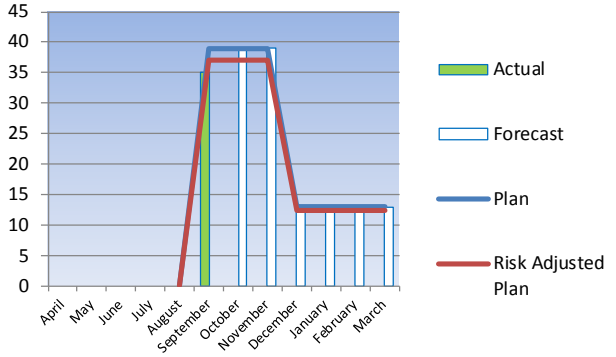
Financial Recovery Plans - detail

Plan	Training Reduction

Risk Assessment	Low

Executive Lead	Phillip Marshall
Management Lead	Joanne Harrison
Finance Lead	Katie Laurence

	In Month (£'000s)	YTD (£'000s)	Full Year (£'000s)
Plan	39	39	169
Risk Adjusted Plan	37	37	161
Actual/Forecast	35	35	165
Variance to Plan	-4	-4	-4
Variance to Risk Adjusted Plan	-2	-2	4



Actions Completed

Principles in relation to this scheme agreed and shared.

Risks/Issues

Need to ensure individuals maintain skills
Goodwill

Next Steps

Continue to monitor

Financial Recovery Plans - Income

Category	Plan/Actual	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	RAG
Income											
Casemix	Plan	145	35	35	35	35	35	35	35	**390**	MEDIUM
	Risk Adjusted Plan	129	29	29	29	29	29	29	29	**330**	
	Actual	145	25	0	0	0	0	0	0	**170**	
	Forecast	0	0	35	35	35	35	35	35	**210**	
locum T&O consultant	Plan	0	0	93	93	93	93	93	93	**558**	MEDIUM
	Risk Adjusted Plan	0	0	74	74	74	74	74	74	**446**	
	Actual	0	0	0	0	0	0	0	0	**0**	
	Forecast	0	0	0	93	93	93	93	93	**465**	
GS / Gastro incl Wharfedale	Plan	10	48	48	48	48	48	48	48	**345**	HIGH
	Risk Adjusted Plan	9	23	23	23	23	23	23	23	**168**	
	Actual	0	0	0	0	0	0	0	0	**0**	
	Forecast	0	0	0	41	41	41	41	41	**205**	
Ophthalmology	Plan	0	20	20	38	38	38	38	38	**231**	HIGH
	Risk Adjusted Plan	0	5	5	18	18	18	18	18	**98**	
	Actual	0	1	0	0	0	0	0	0	**1**	
	Forecast	0	0	25	38	38	38	38	38	**215**	
Professional leave	Plan	0	0	65	65	57	65	60	63	**375**	HIGH
	Risk Adjusted Plan	0	0	13	13	11	13	12	13	**75**	
	Actual	0	0	0	0	0	0	0	0	**0**	
	Forecast	0	0	65	65	57	65	60	63	**375**	
Activity recovery general	Plan	0	173	181	181	157	181	165	173	**1,211**	HIGH
	Risk Adjusted Plan	0	35	36	36	31	36	33	35	**242**	
	Actual	0	53	0	0	0	0	0	0	**53**	
	Forecast	0	0	59	68	68	68	68	68	**399**	
sub-total	Plan	**155**	**276**	**442**	**461**	**427**	**461**	**439**	**450**	3,110	
	Risk Adjusted Plan	**137**	**91**	**180**	**193**	**186**	**193**	**188**	**191**	1,359	
	Actual	**145**	**79**	**0**	**0**	**0**	**0**	**0**	**0**	**224**	
	Forecast	**0**	**0**	**185**	**340**	**332**	**340**	**335**	**338**	1,869	

Financial Recovery Plans - Expenditure

Category	Plan/Actual	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	RAG
Spend											
Ward Pay	Plan	75	75	104	85	89	92	92	92	**704**	HIGH
	Risk Adjusted Plan	46	46	69	66	67	69	69	69	**502**	
	Actual	73	51	0	0	0	0	0	0	**124**	
	Forecast	0	0	94	100	104	112	112	112	**633**	
Theatre Pay	Plan	0	-6	-9	3	15	53	53	53	**162**	LOW
	Risk Adjusted Plan	0	-6	-9	3	14	50	50	50	**154**	
	Actual	0	-6	0	0	0	0	0	0	**-6**	
	Forecast	0	0	-9	3	15	53	53	53	**168**	
Agency	Plan	0	0	0	0	16	16	16	16	**65**	LOW
	Risk Adjusted Plan	0	0	0	0	15	15	15	15	**62**	
	Actual	0	0	0	0	0	0	0	0	**0**	
	Forecast	0	0	0	0	16	16	16	16	**65**	
Community	Plan	0	0	23	23	23	23	23	23	**139**	LOW
	Risk Adjusted Plan	0	0	22	22	22	22	22	22	**132**	
	Actual	6	9	0	0	0	0	0	0	**15**	
	Forecast	0	0	15	23	23	23	29	29	**142**	
Additional Procurement Opportunities	Plan	0	0	0	0	10	10	10	10	**40**	LOW
	Risk Adjusted Plan	0	0	0	0	10	10	10	10	**38**	
	Actual	0	0	0	0	0	0	0	0	**0**	
	Forecast	0	0	0	0	10	10	10	10	**40**	
Additional CIP Requirement	Plan	52	52	132	82	82	82	82	82	**646**	HIGH
	Risk Adjusted Plan	24	24	101	53	53	53	53	53	**416**	
	Actual	52	52	0	0	0	0	0	0	**104**	
	Forecast	0	0	132	82	82	82	82	82	**543**	
sub total	Plan	**127**	**121**	**250**	**194**	**236**	**276**	**276**	**276**	**1,756**	
	Risk Adjusted Plan	**70**	**65**	**183**	**144**	**182**	**220**	**220**	**220**	**1,303**	
	Actual	**131**	**106**	**0**	**0**	**0**	**0**	**0**	**0**	**237**	
	Forecast	**0**	**0**	**232**	**208**	**250**	**296**	**302**	**302**	**1,591**	

Financial Recovery Plans - Other

Category	Plan/Actual	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	RAG
Other											
Board contingency	Plan	83	83	83	83	83	83	83	83	**667**	LOW
	Risk Adjusted Plan	79	79	79	79	79	79	79	79	**633**	
	Actual	83	83	0	0	0	0	0	0	**167**	
	Forecast	0	0	83	83	83	83	83	83	**500**	
capitalisation	Plan	22	22	22	22	22	22	22	22	**178**	LOW
	Risk Adjusted Plan	21	21	21	21	21	21	21	21	**169**	
	Actual	22	22	0	0	0	0	0	0	**44**	
	Forecast	0	0	22	22	22	22	22	22	**133**	
ASDM	Plan	0	0	0	0	0	0	0	1,486	**1,486**	MEDIUM
	Risk Adjusted Plan	0	0	0	0	0	0	0	1,189	**1,189**	
	Actual	0	0	0	0	0	0	0	0	**0**	
	Forecast	0	0	0	0	0	0	0	1,486	**1,486**	
Provisions	Plan	0	0	0	0	0	0	0	300	**300**	LOW
	Risk Adjusted Plan	0	0	0	0	0	0	0	285	**285**	
	Actual	0	0	0	0	0	0	0	0	**0**	
	Forecast	0	0	0	0	0	0	0	300	**300**	
sub total	Plan	**106**	**106**	**106**	**106**	**106**	**106**	**106**	**1,892**	**2,630**	
	Risk Adjusted Plan	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**1,574**	**2,276**	
	Actual	**106**	**106**	**0**	**0**	**0**	**0**	**0**	**0**	**211**	
	Forecast	**0**	**0**	**106**	**106**	**106**	**106**	**106**	**1,892**	**2,419**	

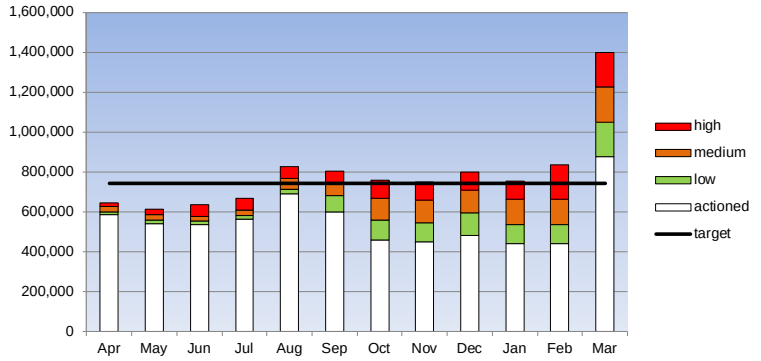
Financial Recovery Plans – Further Controls

Category	Plan/Actual	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	RAG
Further Controls											
Holding Vacancies	Plan	0	0	45	90	135	180	225	270	**945**	MEDIUM
	Risk Adjusted Plan	0	0	36	72	108	144	180	216	**756**	
	Actual	0	0	0	0	0	0	0	0	**0**	
	Forecast	0	0	45	90	135	180	225	270	**945**	
Corporate Services Actions	Plan	80	42	70	70	70	84	64	64	**545**	LOW
	Risk Adjusted Plan	76	40	67	67	67	80	61	61	**518**	
	Actual	35	42	0	0	0	0	0	0	**77**	
	Forecast	0	0	70	70	70	84	64	64	**423**	
Non Pay Control	Plan	0	0	35	35	35	35	35	35	**210**	MEDIUM
	Risk Adjusted Plan	0	0	28	28	28	28	28	28	**168**	
	Actual	0	0	0	0	0	0	0	0	**0**	
	Forecast	0	0	35	35	35	35	35	35	**210**	
Reduce overtime/additional hours	Plan	0	20	20	20	20	20	20	20	**140**	LOW
	Risk Adjusted Plan	0	19	19	19	19	19	19	19	**133**	
	Actual	17	24	0	0	0	0	0	0	**41**	
	Forecast	0	0	20	20	20	20	20	20	**120**	
Training	Plan	0	39	39	39	13	13	13	13	**169**	LOW
	Risk Adjusted Plan	0	37	37	37	12	12	12	12	**161**	
	Actual	0	35	0	0	0	0	0	0	**35**	
	Forecast	0	0	39	39	13	13	13	13	**130**	
sub total	Plan	**80**	**101**	**209**	**254**	**273**	**332**	**357**	**402**	**2,009**	
	Risk Adjusted Plan	**76**	**96**	**187**	**223**	**234**	**283**	**300**	**336**	**1,735**	
	Actual	**52**	**101**	**0**	**0**	**0**	**0**	**0**	**0**	**153**	
	Forecast	**0**	**0**	**209**	**254**	**273**	**332**	**357**	**402**	**1,828**	

Efficiency Programme

The CIP target was increased to £9.4m in June with new targets issued to each of the directorates. Current performance shows that plans are in place for 100% of this target, however the risk adjusted total outlines potential delivery of 90%

Trustwide Cost Improvement Programme 2017/18

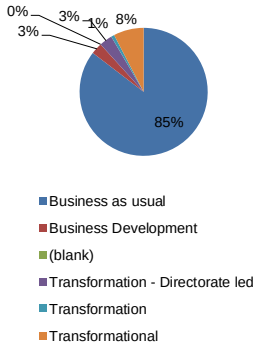


Summary	Target	Actioned	Low	Medium	High	Total	Total %age	Risk Adjust	Risk Adj %age
Trustwide	9,409,800	6,615,213	936,693	991,467	869,473	9,412,846	100%	8,472,140	90%
		% age of target	10%	11%	9%				

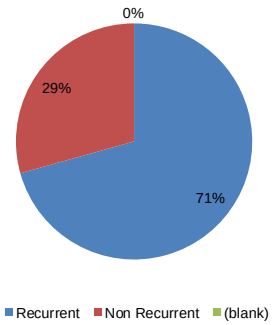
Top 10 unactioned schemes Top 10 as % of schemes - 15%

No.	Scheme	Directorate	Value	Risk
1	Recruitment Process	LTUC	240,000	Medium
2	Bed Savings	Planned Care	203,530	High
3	Endoscopy	Planned Care	159,143	High
4	Outpatient Productivity	LTUC	150,000	Medium
5	Vacancy Control	LTUC	143,500	Low
6	Inpatient Flow	LTUC	127,000	Low
7	Theatre Utilisation	Planned Care	125,000	High
8	Hand Trauma	Planned Care	100,833	High
9	Pathology service review	LTUC	100,000	Medium
10	Scheduling	Planned Care	83,333	High

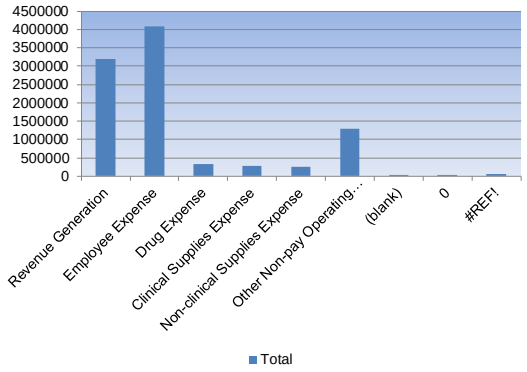
CIP schemes by internal category



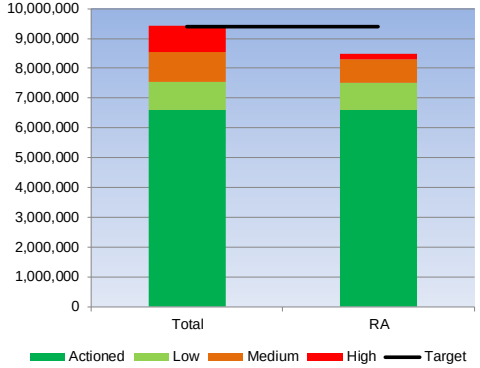
Recurrent V Non Recurrent Plans



Efficiency Category



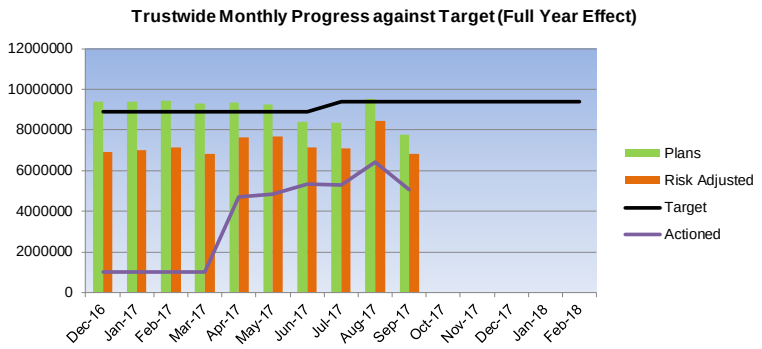
Risk Profile

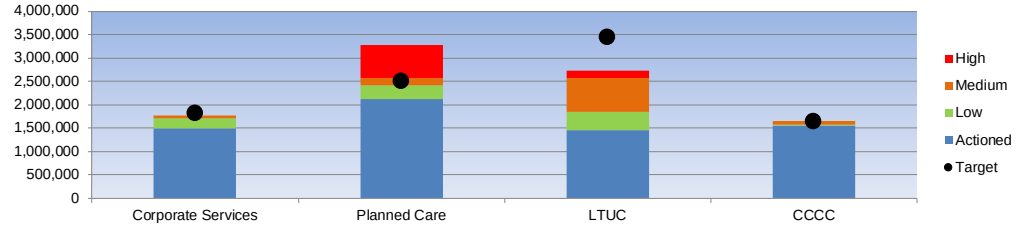


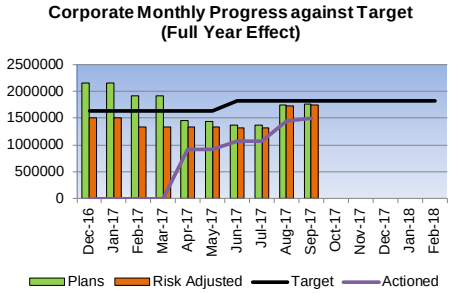
Efficiency Programme Cont.

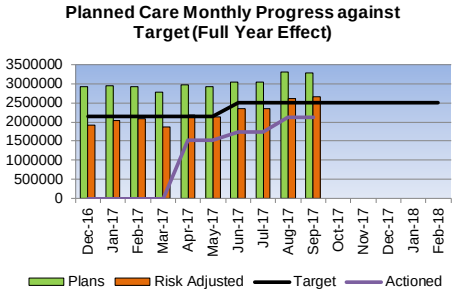
Trustwide Cost Improvement Programme 2017/18

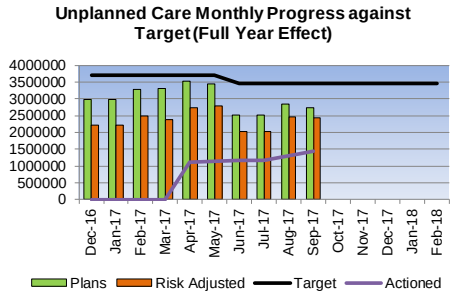
Summary	Target	Actioned	Low	Medium	High	Total	Total %age	Risk Adjust	Risk Adj %age
Corporate Services	1,818,900	1,493,250	221,900	49,300	0	1,764,450	97%	1,743,495	96%
Planned Care	2,497,000	2,120,763	295,893	148,667	703,673	3,268,996	131%	2,661,530	107%
LTUC	3,446,000	1,447,800	393,900	724,000	165,800	2,731,500	79%	2,434,365	71%
CCCC	1,647,900	1,553,400	25,000	69,500	0	1,647,900	100%	1,632,750	99%

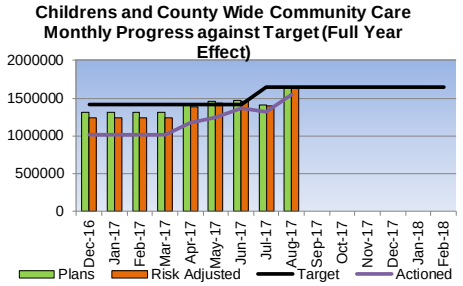


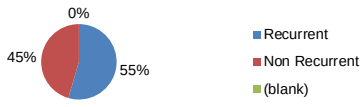


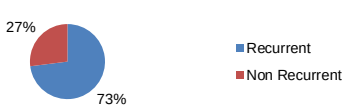


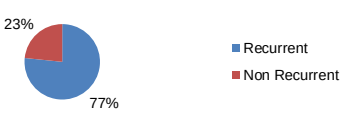


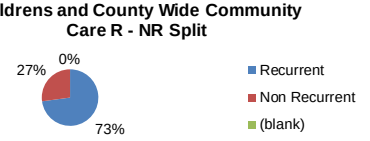












Cashflow

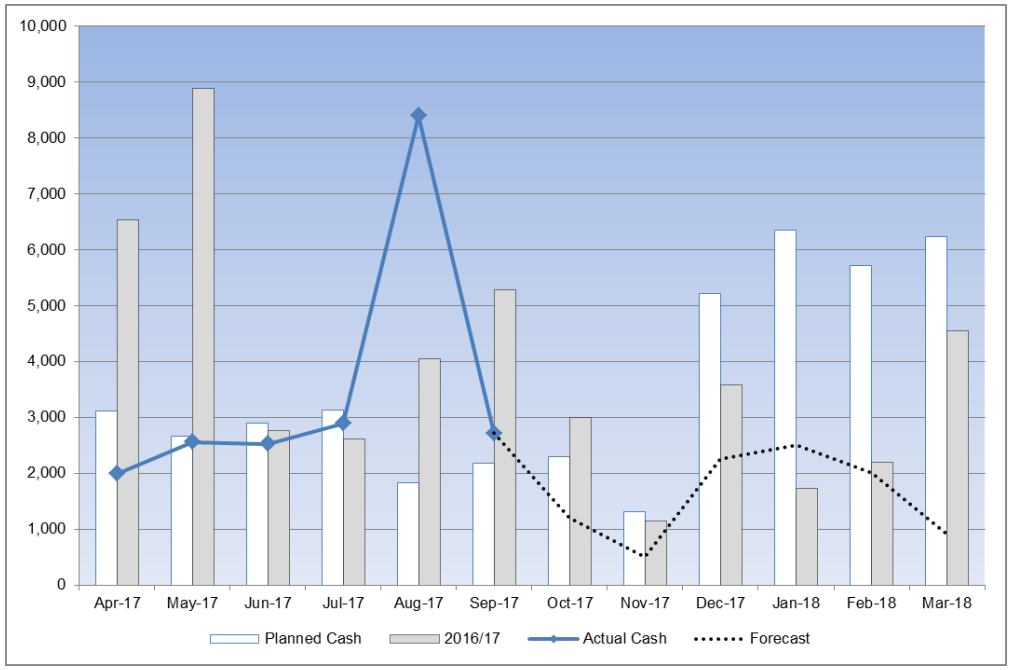
As a result of the financial position and a number of historic issues the cash position for the Trust remains challenging.

The graph on the right outlines the current position and forecast in relation to cash. As described in August, the current favourable performance against plan is a result timing of cash flows related to the capital programme. As the forecast position shows this will reduce significantly.

The forecast is based on the “do nothing” forecast revenue position. Any improvements may need to support the management of debtors or the capital programme.

The forecast is also based on all commissioners being able to make payments related to current contractual agreements.

As well as the pressure from the current position, a number of debts remain outstanding with other organisations. The top 5 organisations are outlined the table below. Following further discussions with HaRD CCG, £1.4m cash payment is due very shortly. We are continuing to prioritise cash collection and further letters have been sent to organisations with long outstanding debts.



	0 to 30 Days £000	31 to 60 Days £000	61 to 90 Days £000	Over 91 Days £000	Total £000
NHS/WGA Debts	1,380	438	974	8,230	11,022
Insurance Companies	25	35	14	17	91
Other	125	81	73	1,872	2,151
Totals	1,530	554	1,061	10,119	13,264

Sep-17	£
NHS HARROGATE AND RURAL DISTRICT CCG	6,375,712.07
NHS SCARBOROUGH AND RYEDALE CCG	757,286.55
NHS VALE OF YORK CCG	744,928.82
NORTH YORKSHIRE COUNTY COUNCIL	727,830.36
NHS HAMBLETON RICHMONDSHIRE AND WHITBY CCG	725,133.23
	9,330,891.03

Harrogate and District
NHS Foundation Trust

Date of Meeting:	25th October 2017	**Agenda item:**	**8.0**
Report to:	Board of Directors		
Title:	Chief Operating Officer's Report		
Sponsoring Director:	Mr Robert Harrison, Chief Operating Officer		
Author(s):	Ms Rachel McDonald, Head of Performance and Analysis Mr Jonathan Green, Information Analyst Specialist		
Report Purpose:	**Decision** [ ] **Discussion/ Consultation** [✓] **Assurance** [✓] **Information** [✓]		
Executive Summary:	• Elective and outpatient activity remains below plan but with an improved position reported for inpatient elective activity and new outpatient attendances in September. • The latest Emergency Department Patient Survey results show that HDFT was ranked joint first out of 136 participating Trusts. • The latest SSNAP results for the Apr – Jul 17 period have been published. HDFT has been rated D overall, no change on the previous publication.		

Related Trust Objectives					
To deliver high quality care	✓	**To work with partners to deliver integrated care:**	✓	**To ensure clinical and financial sustainability:**	✓

Key implications	
Risk Assessment:	Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF 4: risk of a lack of interoperable systems across New Care Models partners; BAF 9: risk of a failure to deliver the operational plan; BAF 10: risk of a breach of the terms of the NHS Provider licence; BAF 16: risk to delivery of integrated care models.
Legal / regulatory:	None identified.
Resource:	None identified.
Impact Assessment:	Not applicable.
Conflicts of Interest:	None identified.
Reference documents:	None.

Action Required by the Board of Directors:
It is recommended that the Board of Directors receive and note the content of the report, and approve the Information Governance Toolkit baseline submission.

1.0 SERVICE ACTIVITY

The table below summarises the year to date position on activity for the main points of delivery.

	Jul-17			Aug-17			Sep-17			Sep-17 YTD		
Activity type	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance
New outpatients	7926	8167	-2.9%	8088	8556	-5.5%	8581	8167	5.1%	48347	48612	-0.5%
Follow-up outpatients	15133	16379	-7.6%	15319	17159	-10.7%	15779	16379	-3.7%	93315	97495	-4.3%
Elective inpatients	247	307	-19.5%	245	305	-19.7%	307	310	-0.9%	1698	1883	-9.8%
Elective day cases	2343	2498	-6.2%	2361	2466	-4.3%	2332	2552	-8.6%	13977	15060	-7.2%
Non-electives	1853	1844	0.5%	1781	1735	2.6%	1848	1735	6.5%	11009	10628	3.6%
A&E attendances	4296	4120	4.3%	3999	4120	-2.9%	4068	3987	2.0%	24958	24320	2.6%

Overall the Trust remains significantly behind plan for elective admissions – both inpatients and day cases. However in September there was a significant month on month improvement in elective inpatient activity with this being close to plan, despite sterile services being off site. Day case activity remain behind plan which is mainly linked to activity at Wharfedale Hospital and the endoscopy activity included in the plan for the new Endoscopy Unit, originally planned for the backend of 2017 but now due in April 2018. Sterile services are now back on site and daily scheduling meetings are aimed at ensuring that theatre lists are fully utilised.

For outpatients, the significant improvement in activity is as the result of additional clinics and amendments to templates. Follow ups remain below plan - in part due to outpatient clinic templates being adjusted to increase the number of new slots where changes can be made to reduce the number of patients being booked for follow up. It remains essential that the Clinical Directorate teams monitor the waiting times for patients booked for follow up to ensure that they receive timely care where they do need to return.

Actions being undertaken to improve the activity position include:

- Continued alteration of clinic templates to increase the number of new patients seen per clinic;
- Replacing 10 other specialty theatre lists with T&O during September and October and with 6 further sessions planned in November;
- The majority of theatre lists given up due to annual leave over the half term period in October have been backfilled;
- The recruitment of a locum T&O consultant due to start in mid/late November;
- Ongoing actions regarding ensuring clinics are filled at short notice when patient cancellations free up slots;
- The continued increase in Saturday day surgery lists to additional specialties and utilising the skills of SAS doctors more and where possible, running lists without anaesthetists (local anaesthetic lists only) for appropriate cases, to therefore reduce costs and increase margin;
- Progression of the theatre staffing strategy with further interviews taking place during October;
- Work continues with regards to theatre productivity with a focus currently on list start times in main theatre. In DSU a focused 2 week piece of work being undertaken to ask three questions at the end of each list. ‘What went well?’ ‘What could have gone better?’ and ‘What could we have done to make the list run more effectively and efficiently?’ this is being led by the DSU Safety, Quality and Delivery Manager and the clinical lead for DSU and is designed so that staff lead the change programme in DSU to improve productivity.

2.0 CANCER SERVICES

Acute oncology consultant cover

Consultant cover for Acute Oncology continues to be a significant issue for the Trust. Conversations are ongoing with York and Leeds around Oncology support but capacity within these Trusts means they can only give limited support on top of the sessions they already provide. The Trust is exploring the option of a long term agency Consultant Oncologist (to start at end October) and re-advertising for a substantive post in collaboration with Leeds Teaching Hospitals NHS Trust.

Performance

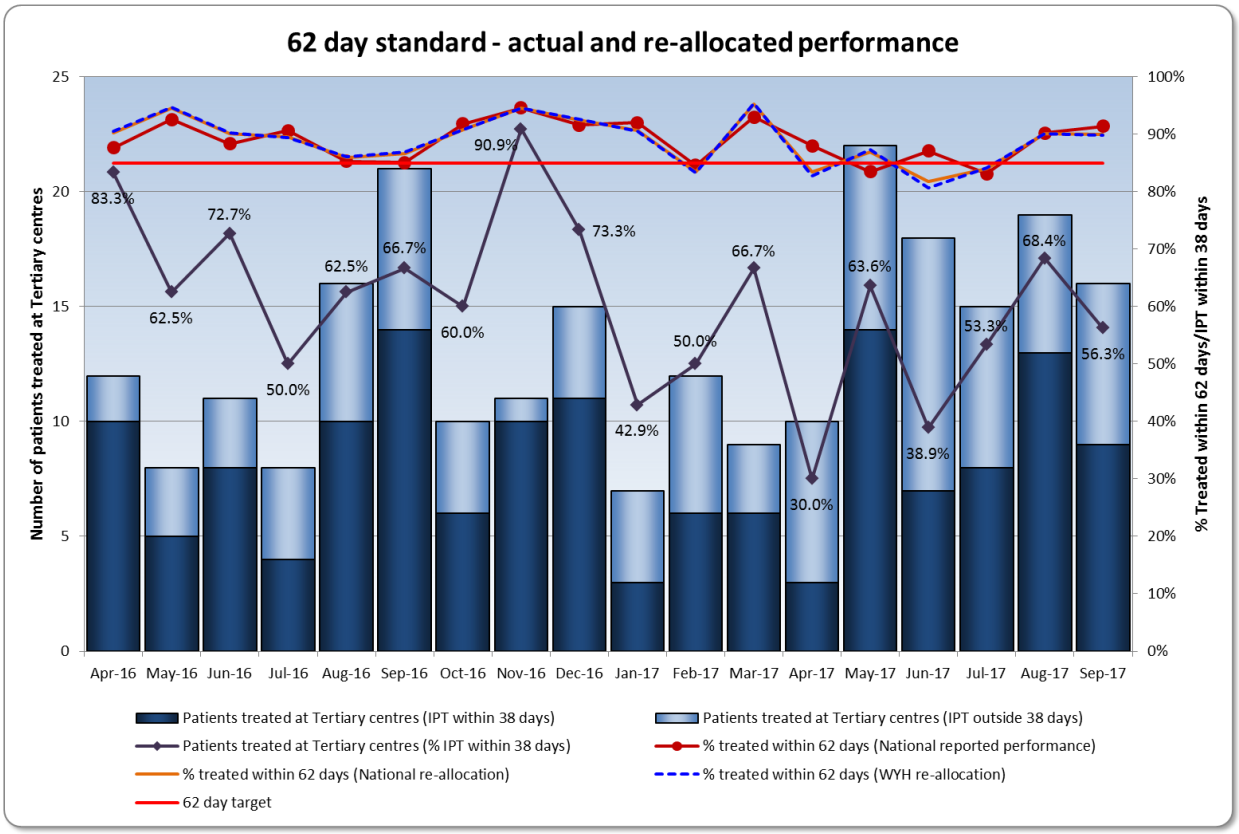
All applicable Cancer Waiting Times standards were achieved for Q2.

Trust performance for the 62 day standard was above the 85% for August, September and Q2 (90.2%, 91.4%, and 88.8% respectively).

Inter-Provider Transfer (IPT) performance

As stated above, performance for Q2 with the current allocation rules is at 88.8%. A total of 50 patients were treated at tertiary centres in the quarter following a 2WW referral to Harrogate. Of these, 30 were transferred by day 38 (60%).

Shadow reporting of the 62 day standard shows that when re-allocation rules are applied, performance would be 0.4% lower for Q2 but would still be above the expected standard at 88.4%. The chart and table below illustrate HDFT's performance when re-allocation rules are applied.



During the shadow reporting period Trusts in West Yorkshire and Harrogate have agreed to trial the internal breach arbitration process and HDFT will be testing out a couple of scenario's where it is believed the breach should sit with another provider.

ACTUAL performance	Apr-17	May-17	Jun-17	Q1	Jul-17	Aug-17	Sep-17	Q2
Total	**50.0**	**57.5**	**58.0**	**165.5**	**47.5**	**61.5**	**70.0**	**179.0**
Within 62 days	44.0	48.0	50.5	**142.5**	39.5	55.5	64.0	**159.0**
Outside 62 days	6.0	9.5	7.5	**23.0**	8.0	6.0	6.0	**20.0**
Performance	88.0%	83.5%	87.1%	**86.1%**	83.2%	90.2%	91.4%	**88.8%**

Re-allocation (NATIONAL)	Apr-17	May-17	Jun-17	Q1	Jul-17	Aug-17	Sep-17	Q2
Total	**48.5**	**57.5**	**57.5**	**163.5**	**47.0**	**60.5**	**69.5**	**177.0**
Within 62 days	40.5	50.0	47.0	**137.5**	39.5	54.5	62.5	**156.5**
Outside 62 days	8.0	7.5	10.5	**26.0**	7.5	6.0	7.0	**20.5**
Performance	83.5%	87.0%	81.7%	**84.1%**	84.0%	90.1%	89.9%	**88.4%**

Difference (National/Actual)	Apr-17	May-17	Jun-17	Q1	Jul-17	Aug-17	Sep-17	Q2
Total	**-1.5**	**0.0**	**-0.5**	**-2.0**	**-0.5**	**-1.0**	**-0.5**	**-2.0**
Within 62 days	-3.5	2.0	-3.5	**-5.0**	0.0	-1.0	-1.5	-2.5
Outside 62 days	2.0	-2.0	3.0	**3.0**	-0.5	0.0	1.0	0.5
% difference	-4.5%	3.5%	-5.3%	**-2.0%**	0.9%	-0.2%	-1.5%	**-0.4%**

Re-allocation (WYH policy)	Apr-17	May-17	Jun-17	Q1	Jul-17	Aug-17	Sep-17	Q2
Total	**46.5**	**59.5**	**54.5**	**160.5**	**47.5**	**60.5**	**68.5**	**176.5**
Within 62 days	38.5	52.0	44.0	**134.5**	40.0	54.5	61.5	**156.0**
Outside 62 days	8.0	7.5	10.5	**26.0**	7.5	6.0	7.0	**20.5**
Performance	82.8%	87.4%	80.7%	**83.8%**	84.2%	90.1%	89.8%	**88.4%**

Difference (WYH policy/Actual)	Apr-17	May-17	Jun-17	Q1	Jul-17	Aug-17	Sep-17	Q2
Total	**-3.5**	**2.0**	**-3.5**	**-5.0**	**0.0**	**-1.0**	**-1.5**	**-2.5**
Within 62 days	-5.5	4.0	-6.5	**-8.0**	0.5	-1.0	-2.5	**-3.0**
Outside 62 days	2.0	-2.0	3.0	**3.0**	-0.5	0.0	1.0	**0.5**
% difference	-5.2%	3.9%	-6.3%	**-2.3%**	1.1%	-0.2%	-1.6%	**-0.4%**

IPTs SENT (actual patients treated at Tertiary centres)	Apr-17	May-17	Jun-17	Q1	Jul-17	Aug-17	Sep-17	Q2
Total	**10**	**22**	**18**	**50**	**15**	**19**	**16**	**50**
Within 38 days	3	14	7	**24**	8	13	9	**30**
Outside 38 days	7	8	11	**26**	7	6	7	**20**
Performance	30.0%	63.6%	38.9%	**48.0%**	53.3%	68.4%	56.3%	**60.0%**

3.0 CHILDREN'S SERVICES

Staff at HDFT contributed fully to the CQC Thematic Review into Children & Young People's mental health for HWBB North Yorkshire over a 4 day period. The final brief feedback indicated excellent representation from the various groups. It was clear that staff and system leaders had a great understanding of the strengths but also identified the gaps and deficits which aligned with the issues identified by parents and young people. It was noted that the new CAMHs crisis team had not had an opportunity to bed in as yet. However, it is hoped that when it is fully up and running that it will have a positive affect on support for the mental health crisis for young people in North Yorkshire. Formal written feedback will be available in approximately one month's time.

4.0 EMERGENCY DEPARTMENT PATIENT SURVEY

The results of the sixth Emergency Department Survey 2016 were published in September 2017 and involved 137 acute and specialist NHS trusts with a Type 1 accident and emergency department. Responses to the survey questionnaire were received from 325 HDFT patients which equates to a HDFT response rate of 36%.

HDFT's average score for all questions in the survey this year increased to 8.2, compared to 7.9 in 2014 and 7.8 in 2012. In comparison to the 2014 survey, HDFT improved scores for 27 questions, scored the same in 3 questions and reduced scores in 5 questions.

The CQC highlighted the following points for HDFT:

1. HDFT rating of the overall experience was rated as 8.6 out of 10 which scored above the previous survey results of 8.2.
2. The category 'Respect and dignity was the highest performing section for HDFT with an overall score 9.3 out of 10 with the highest number of respondents of 320.
3. Patients felt more reassured and involved in their care and treatment with an increase in scores by 1.0 in the majority of questions in comparison to previous year's results.
4. The category 'Tests' was the most improved section as all results for these questions were much better than previous years.

Compared to the past survey results, HDFT reduced scores in the following questions:

- Q5. How long did you wait with the ambulance crew before your care was handed over to the emergency department staff?
- Q8. How long did you wait before you first spoke to a nurse or doctor?
- Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?
- Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?
- Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?

However the decrease in scores for these questions weren't significantly high as the average decrease was around 0.3.

The national data set published on the 17th October shows that out of 137 participating Trusts, HDFT scored joint first. The team in ED and all services supporting them should be congratulated for these excellent results.

5.0 SENTINEL STROKE NATIONAL AUDIT PROGRAMME (SSNAP)

The latest SSNAP results for the Apr – Jul 17 period have been published. HDFT has been rated D overall, no change on the previous publication. HDFT's overall score is 56, compared to 55 in the last publication. HDFT's score has been impacted by the data quality adjustment - our score prior to the data quality adjustment (62) would have placed us in band C.

Of the 10 domains in the SSNAP data set, three have seen an improvement since the last report:

- Specialist assessment (D to C)
- Occupational Therapy (B to A)
- Physiotherapy (C to B).
-

One domain has seen deterioration:

- MDT working (C to D).
-

The other six domains stayed at the same score.

A number of metrics deteriorated in July – particularly those around timely access to appropriate clinical staff. The "time to scan" metrics deteriorated and the proportion of

patients arriving on the stroke unit within 4 hours deteriorated – with the most significant deterioration seen in July. However the percentage of patients spending at least 90% of their time on the stroke unit improved to 85% (69% last quarter).

All eligible patients were thrombolysed – 46% within 1 hour (compared to only 21% in 1 hour in the last publication).

The Trust is continuing to work closely with the STP Stroke group in relation to the sustainability of services.

6.0 INFORMATION GOVERNANCE PERFORMANCE SUBMISSION – 2017/18

The Information Governance Toolkit is a Department of Health Policy delivery vehicle that NHS Digital is commissioned to develop and maintain. The IG Toolkit is separated into six categories:

- Information Governance Management
- Confidentiality and Data Protection Assurance
- Information Security Assurance
- Clinical Information Assurance
- Secondary Use Services Assurance
- Corporate Information Assurance

The Trust is required to carry out self-assessments of their compliance against the IG requirements. The purpose of the assessment is to enable organisations to measure their compliance against the law and central guidance and to see whether information is handled correctly and protected from unauthorised access, loss, damage and destruction.

Information Governance Toolkit	2015/16 Final Submission	2016/17 Final Submission	2017/18 Performance Update
1. Information Governance Management	86%	86%	86%
2. Confidentiality and Data Protection Assurance	87%	87%	87%
3. Information Security Assurance	73%	73%	73%
4. Clinical Information Assurance	100%	100%	100%
5. Secondary Uses Assurance	91%	87%	87%
6. Corporate Information Assurance	77%	77%	77%
Total	**84%**	**83%**	**83%**

83% = Satisfactory, Evidenced Attainment Level 2 or above on all requirements

Attainment Levels				
Level 0	**Level 1**	**Level 2**	**Level 3**	**Not Relevant**
0	0	22	22	1

Changes
There have been no changes to this version of the IG Toolkit.

Concerns
The level for requirement 112 is dependent on 95% of Trust staff being up-to-date with their Information Governance (Data Security) mandatory training. Currently the Trust is at 79.3%. This time last year the Trust was at 84%.

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Harrogate and District
NHS Foundation Trust

Date of Meeting:	25 October 2017	**Agenda item:**	9.0
Report to:	Board of Directors		
Title:	Report by the Director of Workforce and Organisational Development		
Sponsoring Director:	Mr Phillip Marshall, Director of Workforce and Organisational Development		
Author(s):	Mr Phillip Marshall, Director of Workforce and Organisational Development		
Report Purpose:	**Decision** [ ] **Discussion/ Consultation** [✓] **Assurance** [✓] **Information** [✓]		
Executive Summary:	• Clinical Workforce Strategy quarterly update • End of appraisal period report • Update on Staff engagement, including the NHS National Staff Survey		

Related Trust Objectives					
To deliver high quality care	✓	**To work with partners to deliver integrated care:**	✓	**To ensure clinical and financial sustainability:**	✓

Key implications	
Risk Assessment:	Any identified risks are included in the Directorate and Corporate Risk Registers and the Board Assurance Framework.
Legal / regulatory:	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
Resource:	None identified.
Impact Assessment:	Not applicable.
Conflicts of Interest:	None identified.
Reference documents:	Nil

Action Required by the Board of Directors:

It is recommended that the Board:

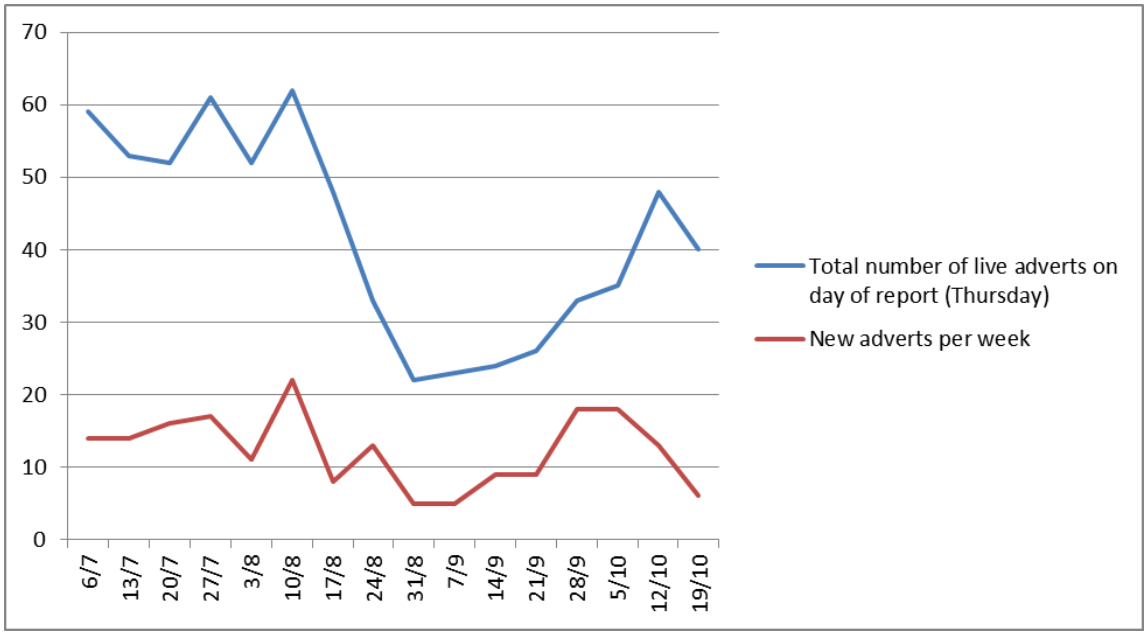
- *Notes items included within the report*

a) Financial Constraints

The Workforce and Organisational Development team continues with implementation of measures which have been put in place to improve the financial position of the Trust. These include where possible the cessation of all above-cap agency recruitment to inpatient wards to cover staff shortages, reviewing professional and study leave for Consultants, and temporary measures on controlling training expenditure.

Enhanced recruitment controls remain in place and vacancies which are deemed essential are reviewed weekly at the Vacancy Control group meeting. There are six groups where approval is normally given – for other vacancies a significant and compelling case must be made at the weekly Vacancy Control group meeting every Friday morning. The chart and graph below show the changes in recruitment activity since the recruitment controls were put in place:

	6/7	13/7	20/7	27/7	3/8	10/8	17/8	24/8	31/8	7/9	14/9	21/9	28/9	5/10	12/10	19/10	26/10	2/11
Headcount including bank	4509					4511				4481				4507				
Headcount excluding bank	4213					4209				4189				4207				
Whole time equivalent	3433.16					3431.36				3418.3				3415.02				
Total number of live adverts on day of report (Thursday)	59	53	52	61	52	62	48	33	22	23	24	26	33	35	48	40		
New adverts per week	14	14	16	17	11	22	8	13	5	5	9	9	18	18	13	6		
Interviews undertaken in reporting period	16	24	13	8	8	12	9	16	13	10	10	4	3	3	9	14		
Awaiting shortlisting on day of report										6	8	6	9	8	7	8		
Candidates undertaking pre-employment checks										85	90	77	64	52	40	46		
Candidates awaiting a start date										8	10	14	15	11	9	8		
Candidates awaiting contracts										18	14	8	6	7	3	2		
Candidates with confirmed start dates awaiting induction, including internal candidates										98	64	73	57	53	23	43		



b) Sickness Absence

In August 2017 the overall sickness absence rate across the Trust increased from 3.92% to 4.20%, which is above the level of August 2016.

We have continued to see a decrease in sickness rates across two of the Directorates. Corporate Services has reduced from 2.56% to 2.34% and Long Term and Unscheduled Care has reduced from 3.98% to 3.58%; however, there has been an increase in absence within the other two Directorates, with Children's and Countywide Care increasing from 3.86% to 5.31% and Planned and Surgical Care seeing a further increase from 4.85% to 5.10%.

Hot spot areas continue to be targeted and within the Planned and Surgical Care Directorate the next target is Theatres and the Day Surgery Unit, which has been identified as having high absence rates, and to ensure consistency in managing employees effectively back to work. Targeted work has been done on Woodlands ward and it was identified in September that there has been an error and employees on annual leave had been incorrectly coded as being absent from work in Woodlands on Rosterpro. This has now been rectified and we should therefore see a decrease in absence rates on Woodlands ward from September, thus having an impact on the overall sickness percentage. Work will continue with adult and community services to provide support with absence levels in this area. Overall across the Trust 21 long term sickness cases were resolved in August 2017.

c) Appointment of new Chairman

The Extraordinary meeting of the Council of Governors on 25 September approved the appointment of Mrs Angela Schofield as Chairman of the Trust. Mrs Schofield will take up the role on 1 November 2017, following the retirement of Mrs Sandra Dodson on 31 October.

d) Clinical Workforce Strategy

The Trust is working in partnership with The University of Leeds as a placement provider for the Physician Associate (PA) programme, which is a Postgraduate MSc programme as the students have already completed a science-based degree. HDFT will support the clinical training element of their postgraduate PA Programme, running concurrently with the existing undergraduate medical training programme. From September 2017 through until to 2018 the Trust will have a mix of three to six students at any one time for a six week placement in General Medicine, Surgery, Obstetrics and Gynaecology, Paediatrics, Acute Medicine, Elderly Medicine, Trauma and Orthopaedics and the Emergency Department.

The first cohort of six Advanced Clinical Practitioners qualified in January 2017 and a seventh qualified in September 2017. They are now working on progression pathways to work at FY2 level as part of a retention strategy. A workshop was held in the Emergency Department on 6 October and a workshop with the Clinical Assessment Team is currently in the planning stage. A second cohort of between four and six Advanced Clinical Practitioners is planned to start January 2018 - recruitment is currently underway, with 20 strong candidates who were due to be shortlisted for interview on 19 October.
Additionally, the Trust is supporting three individuals to undertake a Masters-level Advanced Practice Qualification as a part of a retention strategy; one in Theatres, one in Rheumatology and one in Cancer Services - using ACP funding which had not otherwise been utilised.

Turning to apprenticeships, two Band 4 Apprenticeship Trainee Theatre Practitioners started their 2 year programme in September 2017, in support of the Theatre Staffing Strategy. An external advertisement is currently running for six further posts, to start in September 2018, or earlier if possible. Two Band 4 Apprenticeship Trainee Assistant Practitioners are in place in Surgical Outpatients. Four Health Care Assistant apprentices started work on 25 September and a further two have been recruited and are due to start on 13 November. Interviews were scheduled for 13 October for an additional eight places.

Four Engineering apprenticeships have been agreed with York College, to provide staff development and retention in Estates & Facilities. Five Business Administration apprenticeships will start in November/December 2017 and the aim is to open up apprenticeships to existing staff – e.g. Level 3 clinical healthcare apprenticeship (to be rolled out more widely) and one in business administration - as a retention strategy.

Finally, the Children's and Countywide Community Care Directorate held a Clinical Workforce Strategy review workshop on 28 September, on the theme of Leading with Care - based on personal resilience. Options are currently being explored to embed this workshop on a wider basis across the Trust.

e) Job Planning

The Job Planning Group met on 10 October. The latest Job Planning figures, for the end of September, show a slight improvement in the overall number of completed Job Plans. The outcome of audits against the requirements of Schedule 15 of their contract has been that three doctors (shown not to have completed one or more of an appraisal, a Job Plan and their Mandatory and Essential training at their incremental date) are being recommended to the Chief Executive and Medical Director for delay in their pay progression.

The Group discussed the detail of the trial of allocating annual leave by Direct Clinical Care Professional Activity (PA) sessions rather than days and clarification of the process for approving study leave and professional leave. It was also agreed that all proposed changes to PAs, whether as the result of a job plan review or not, should be considered and approved by the Directorate Vacancy Control group (including the relevant General and Finance Managers) before approval and forwarding to the Compliance and Revalidation Manager for recording and Payroll action.

OCTOBER 2017 JOB PLANNING CENTRAL REPORT - CONSULTANTS										
Directorate	**Number of Consultants**	**Job Plans within 12 months**	**%**	**Job Plans older than 12 months**	**%**	**Number of Consultant with no Job Plans recorded**	**%**	**In progress**	**Notes**	**RAG**
C & CWCC	11	10	90.91%	1	9.09%	0	0.00%	0	Slightly worse	
LT & UC	55	42	76.36%	12	21.82%	1	1.82%	5	Better	
P & SC	70	52	74.29%	10	18.75%	8	1.56%	0	Slightly worse	
Total	**136**	**104**	**76.47%**	**23**	**16.90%**	**9**	**6.63%**	0	Better	

OCTOBER 2017 JOB PLANNING CENTRAL REPORT - SAS GRADES										
Directorate	**Number of SAS Doctors**	**Job Plans within 12 months**	**%**	**Job Plans older than 12 months**	**%**	**Number of SAS Doctors with no Job Plans recorded**	**%**	**In progress**	**Notes**	**RAG**
C & CWCC	8	8	100.00%	0	0.00%	0	0.00%	0	No change	
LT & UC	12	10	83.33%	1	8.33%	1	8.33%	0	Slightly worse	
P & SC	37	14	27.50%	6	16.22%	17	45.95%	0	No change	
Total	**57**	**32**	**56.14%**	**7**	**12.28%**	**18**	**31.58%**	0	Better	
Change from previous month (in-date JPs)		**Improved**		**No change**		**Worse**				

f) Personal Resilience

Staff health and wellbeing is a key part of the Workforce & Organisational Development strategy and there is research evidence that shows psychological wellbeing as the most powerful and reliable predictor of performance and turnover. Staff health and wellbeing is a critical factor in operational delivery, reducing sickness absence, increasing retention rates and sustaining our workforce. The Workforce and Organisational Development Steering Group has considered a paper outlining a proposal for personal resilience training for our medical students and staff and have recommended that a business case is developed. The personal resilience training being proposed (Acceptance and Commitment Training) has been proved to help improve psychological well-being of staff and would equip both our students and staff with skills to help them manage the difficulties and pressure of their jobs. The business case will be submitted for consideration in due course**.**

g) Collaborative Bank Workshop

A workshop was held on 13 October to explore how West Yorkshire and Harrogate (WY&H) Trusts can work together in collaboration to make best use of their existing medical workforce by enabling workforce flexibility through a collaborative staff bank. This was designed as a first stage of addressing affordability of the current medical staff pay bill (especially high locum and agency spend) and longstanding shortages of clinical and support staff, which are two of the six strategic workforce challenges in the WY&H Health Care Partnership plan. A further event will be held on 29 November, with the intention of developing a business case for change.

h) Reward and Health and Wellbeing

To support our recruitment and retention activity as well as progressing towards our Health and Wellbeing CQUIN it was agreed by the Workforce & Organisational Development Steering Group that a number of steps would be taken to improve the communication of our current reward offer and to continue development of the offer to further support staff in the future. It has been agreed that we will move the information about benefits currently held on the intranet to the Trust website. This will enable current staff to access the information from home and will help to support our recruitment and onboarding activity. It was agreed to develop the current Health and Wellbeing brand to encompass reward and benefits, changing the wording to Health and Benefits. We will also be developing a financial wellbeing offer with links to appropriate advice websites eg Citizens Advice, Money Advice Service to further develop our benefits offer, as well as working with finance colleagues on the introduction of a relationship with a credit union. The introduction of Champions, to support the communication of Health and Benefits offers throughout the Trust - especially to colleagues in the community – is also under consideration.

i) Professional Leave

An application process for professional leave for medical staff was launched during September. The application form is accompanied by explanatory notes confirming the authorisation process for completed forms. This form should now be used for all professional leave and includes a section to record where lost DCC sessions will be worked back. A monthly panel will consider applications to ensure consistency across Directorates. The process was discussed at the Local Negotiating Committee (LNC) meeting in September and is subject to continuing discussions. The British Medical Association (BMA) has raised

concerns relating to the Trust's approach to both professional leave and study leave stating that they consider this to be outside of contractual provisions. Further discussions outside of the LNC are due to take place in October to discuss legal advice the BMA has received on the matter. A further update will be available following this meeting.

j) Appraisal rates

Due to the successful concentrated appraisal period, between 1 April and 30 September this year, our overall 12-month appraisal compliance rate has increased by 13.49% when compared with last year. The appraisal period has allowed managers to concentrate on spending time with their staff, reviewing the hard work they are doing and setting clear objectives to help reach our goals as the Trust enters the busy winter period.

1 April – 30 September 2017

DIRECTORATE	Assignments Appraised	Number of Assignments	% Appraised
PAEDIATRICS, SCBU AND WOODLANDS	34	42	80.95%
CORPORATE SERVICES	493	594	83.00%
LONG TERM AND UNSCHEDULED CARE	833	994	83.80%
PLANNED AND SURGICAL CARE	503	700	71.86%
TOTAL	1,863	2,330	79.96%

The appraisal on a page has received fantastic feedback and is proving to be a user -friendly approach to completing appraisals. Colleagues provided valuable feedback on this approach. The toolkit was updated earlier in the year and, by request, both the longer detailed version and 'on the page' versions are available for use.

The appraisal period which ran from the 1 April to the 30 September was a new approach for 2017 and was designed to assist appraisal compliance rates in having a concentrated period in which appraisals were completed. This has seen a fantastic contribution from all colleagues in achieving a 79.96% compliance rate during the six months. It has been a period of huge staff challenges, and to continue to achieve this rate demonstrates the commitment and value that is place by managers on developing and reviewing our colleagues.

The Trust will review the success of the appraisal period with managers over the new few months and will plan how best to support them within the appraisal period in 2018 to make this even more successful. Follow up arrangements are in place for those members of staff yet to receive an appraisal.

k) Staff Engagement

We currently measure our staff engagement through the two national surveys - the annual National Staff Survey and the quarterly Staff Friends and Family Test.

<u>2017 National Staff Survey:</u>

The 2017 National Staff Survey (NSS) opened on 9 October 2017 and will run until 1 December 2017. The survey has been circulated to a random selection of 1,250 staff who are eligible to participate in the survey. It is our intention to achieve an increase on our response rate of 54% (2016) but to maintain our 2016 Staff Engagement score of 3.92

(which was the highest rank possible in the category of Combined Acute & Community Trusts), given the current financial climate within the Trust.

We have developed a communications plan that commenced prior to the launch of the survey, and which will continue throughout the period that it is live, to encourage staff to complete it. Our communications plan will range from the recent 'You said, we did' style campaigns (which supports the staff feedback loop by demonstrating our commitment to improving staffs experience of working within the Trust), to a series of posters using the Trust's values to encourage staff to complete the survey, e.g. Are you *Passionate* about improving staff and patient experiences at HDFT?

Consideration was given to providing an incentive to staff as a way of increasing our response rate, similar to last year where we provided £1 for every completed survey in the form of a training budget to the Directorate with the highest response rate. This year we have decided to shift the incentive from a financial one to one of promoting the benefits of participating in the survey and the resultant feedback, in so far as demonstrating some of the actions we have taken this year following the results from the 2016 NSS. We hope that aligning the feedback to the Trust's values during and beyond the survey closing date will help increase participation.

2017/18 Staff Friends & Family Test:

The Staff Friends and Family Test for Quarter 1 2017/18 was open from 19 June to 7 July 2017 with 3,888 staff being invited to participate (HDFT currently employs 4022 staff). There were 731 respondents which is the equivalent to a 19% response rate. Nationally, the average response rate for the same quarter was 12.9%.

We launched Quarter 2 using a multi-mode approach of a paper-based questionnaire and an open URL. The survey remained anonymous but allowed individuals more flexibility to complete the survey at home or at work, or by using the QR Code for anyone who has a Smartphone device. The result for Quarter 2 was a response rate of 24%, which accounted for a significant increase in responses of 336.

- Results by Directorate

From the 731 responses received for Quarter 1, the lowest participation rate in Quarter 1 2017/2018 was from Planned and Surgical Care at 14% and the highest participation rate was from Children's and County Wide Community Care at 31%. Long Term and Unscheduled Care and Corporate each achieved a response rate of 27%. Quarter 2 showed a significant increase for Planned and Surgical Care from 14% to 32%, whilst conversely Children's & County Wide Community Care decreased from 31% to 17%.

Directorate	Quarter 1 - Number of Respondents	Quarter 1 - % of Respondents	Quarter 2 - Number of Respondents	Quarter 2 - % of Respondents
Corporate Services	194	27%	215	29%
Children's and County Wide Community Care	225	31%	203	17%

Long Term and Unscheduled Care	201	27%	283	19%
Planned and Surgical Care	104	14%	346	32%

- Results by Question

From the 731 respondents 85.2% would recommend the Trust to friends and family for the standard of care provided (this is a 1.8 point decrease from Quarter 4 which was 87%). Whilst this is a decrease from Quarter 4, the Trust results are higher than the national figure of 81%.

For the other question, 69.2% of staff would recommend the Trust as a place to work (this is a 1.6 point decrease from Quarter 4 at 70.8%). Again, whilst this is a decrease from Quarter 4, the Trust's results are higher than the national figure of 64%.

We are currently awaiting the results for Quarter 2 from Capita, which administers the survey for the Trust.

- Results by Thematic Analysis:

Staff additionally had the opportunity to provide verbatim comments to supplement the two mandatory questions. An analysis of the key themes arising from the verbatim comments found the majority of these to be reflected within the 2017/18 Staff Engagement Action Plan as well as Directorate operational priorities for this financial year. Continuing themes however, are the comments about staff shortages, low morale and increased work pressures.

- Updated Staff Engagement Action Plan:

The Staff Engagement Action Plan has been updated to reflect the actions that have been completed since the plan was finalised in June 2017. This shows that eight actions have been completed, with a further two due to be completed in October 2017. A copy of the Action Plan is attached at the Appendix.

l) Pennies from Heaven

Staff at Harrogate and District NHS Foundation Trust have raised a total of £2,416.85 over the past three years for the Yorkshire Air Ambulance (YAA), simply by donating the 'extra' pennies from their pay packets every month. Individual members of staff sign up to a scheme called Pennies from Heaven, where every month their salary is rounded down to the nearest pound with the pennies donated to charity. The most someone can ever give is 99p every time they are paid, but the overall amount soon adds up.

I visited the YAA base at Nostell, accompanied by Hillary Levitt, representing the trades unions at the Trust, to present a cheque to Helen Callear, YAA's Regional Fundraising Manager. She said: "It was lovely to welcome Phillip and Hillary down to Nostell so they

could see first-hand how the money their colleagues donate through the Pennies from Heaven scheme is used to help keep our service operational. We are extremely grateful for their support and I'd like to thank everyone who donates their 'pennies' to help raise these vital funds."

m) Flu Campaign 2017

The 2017/18 flu vaccination campaign commenced on 2 October.

The Flu Vaccination intranet page has been revised and continues to be updated regularly as new information becomes available regarding vaccination sessions and trained Flu Champions. Staff Bulletins, email and the intranet page are being used to promote the campaign, and to provide clinical evidence for vaccination in healthcare workers, and myth-busting information.

Occupational Health are delivering drop-in sessions in Harrogate District Hospital daily Monday – Friday during the first three weeks of October, and continuing support to facilitate Flu Champions to act as peer vaccinators in the hospitals and community. The North Yorkshire & York and Durham/Darlington/Middlesbrough area Childhood Immunisation Teams are providing significant support to improve vaccination access for community teams. Requests for vaccinator attendance at team events/meeting etc will be met as far as possible.

Charitable funding has been made available to provide chocolate confectionery to give away at the point of vaccination and an iPad to be the main prize for a prize draw of vaccinated staff (along with some donated vouchers) as an incentive to partake.

Mandatory uptake reporting will take place monthly from early November – early March for the period September – February. The Trust denominator is being reviewed in line with updated guidance issued in early October.

The associated CQUIN target is to achieve 70% uptake amongst frontline healthcare workers, with partial payment being released for uptake of 50% or more.

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Harrogate and District NHS Foundation Trust

Date of Meeting:	25 October 2017	**Agenda item:**	10.0
Report to:	Board of Directors		
Title:	Chief Nurse Report		
Sponsoring Director:	Jill Foster, Chief Nurse		
Author(s):	Jill Foster, Chief Nurse		

Report Purpose:

Decision	✓	Discussion/ Consultation	✓	Assurance	✓	Information	✓

Executive Summary:

- Monitoring of nurse recruitment and retention continues to show a challenging but improving position
- There has been three Patient Safety Visits but no Director Inspections in September.
- The number of unavoidable, as opposed to avoidable, category 3 pressure ulcers is increasing as per Trust target
- Complaints year to date are lower.
- Update on the work being undertaken to gain accreditation for being Baby Friendly
- Work undertaken to date to ensure impact assessment of the annual efficiency programme
- Work undertaken by the Equality Stakeholder Group to recruit new representatives
- The number of very significant drivers for improving impact assessments and for giving more focus and priority to equality within the Trust

Related Trust Objectives

To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓

Key implications

Risk Assessment:	Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF 1: risk of a lack of medical, nursing and clinical staff; BAF 3: risk of failure to learn from feedback and incidents and BAF 13: risk of insufficient focus on quality in the Trust.
Legal / regulatory:	None identified.
Resource:	None identified.
Impact Assessment:	Not applicable.
Conflicts of Interest:	None identified.

Action Required by the Board of Directors:

- Be **assured** by the monitoring of nurse recruitment and retention and the governance process for assuring safe staffing levels
- **Note** the reporting of Director Inspections and Patient Safety Visits
- Be **assured** of progress toward the Trust pressure ulcer target
- **Note** the decrease in numbers of complaints received by the Trust year to date compared to 2016/17.
- **Acknowledge** the work to improve standards for mothers and babies and the excellent

achievement of the Special Care Baby Unit

- **Note** work undertaken to date to ensure impact assessment of the annual efficiency programme
- **Note** work undertaken by the Equality Stakeholder Group to recruit new representatives
- **Acknowledge** the number of very significant drivers for improving impact assessments and for giving more focus and priority to equality within the Trust
- **Approve** the recommendations for improving impact assessments and developing focus on equality as well as quality

The Chief Nurse report provides an overview of care quality, activities underpinning care and assurances on staffing arrangements. More details on key performance metrics are provided in the Integrated Board Report.

Patient Safety

1. Nurse Recruitment

1.1 The Trust's recruitment and retention working group continue to work toward zero vacancies. A recruitment event was held on the evening of 16th October 2017, 8 people attended and were interviewed. Offers were made to 4 Registered Nurses (RN) and 4 Student Nurses qualifying in March, July and September 2018.

1.2 The next event is planned in November 2017.

1.3 The Trust has welcomed 21 newly qualified nurses in September and October. There are 13 student nurses starting in January and March 2018.

1.4 Four nurses have started in the Trust from the Global Exchange Scheme. They are currently working as Band 3 Care Support Workers (CSW's) whilst they are being supported to achieve the OSCE examination the final requirement for NMC registration

1.5 Long Term and Unscheduled Care (LTUC) currently has 29.65 WTE RN vacancies and 13.44 WTE CSW vacancies. There are 7 RN's to start in October and 1 to start in January 2018. Job offers have been made to 22 CSW's with start dates to be confirmed.

1.6 Planned and Surgical Care have 15 RN vacancies across their in-patient areas with no CSW vacancies

1.7 In Main Theatres there are 10.7 WTE Band 5 vacancies with one ODP starting in November.

1.8 In September we advertised for experienced Assistant Practitioners (Band 4 roles) to work on the Acute Floor. We had 17 applicants and shortlisted 7 excellent candidates. An interview date has been set. We plan to advertise for Assistant Practitioners for the Frail Elderly wards next.

1.9 As I reported last month the current number of vacancies means there are significant gaps in the planned rosters for the wards. On a daily basis we continue to take action to mitigate the risk due to staffing gaps by:

- Maximising effective rostering
- All shifts out to NHSP and agencies within cap
- All shift gaps published at ward level
- Incentive scheme offered
- Staffing gaps reviewed daily and staff moved to minimise risk
- Bed closures where feasible

1.10 The number of 'hours owed' to the Trust is decreasing.

1.11 The result of these actions are reported in the actual versus planned staffing levels in Appendix One

2 Unannounced Directors' Inspections 2017-2018

2.1 The rolling programme of unannounced Directors Inspections is designed to provide assurance on care standards with particular regard to infection prevention and control.

2.2 The following services have been inspected and rated as 'green' during 2017/18:

Date of inspection	Ward/Dept. visited	Risk Rating
21/04/17	Trinity	Green
12/05/17	Granby	Green
18/05/17	Wensleydale	Green
01/06/17	Selby MIU	Green
16/06/17	ITU	Green
16/06/17	Littondale	Green

2.3 There has been no Director Inspection Visits in July, August and September 2017. A full programme of inspection is being arranged from November.

3 Patient Safety Visits

3.1 Patient Safety visits are scheduled visits designed to provide assurance regarding patient safety. They have a unique purpose and value in encouraging a positive safety culture. Visits are designed to encourage staff to raise any concerns in a forum which is supportive, building good communication and establishing local solutions to minimise risk whenever possible. Key findings are followed up by the directorate teams, any high priority actions are considered through the appropriate corporate group such as the 'Improving Patient Safety Group'.

Date	Area	Key Findings
25/04/17	Littondale	• Pressure of work due to staffing levels for both medical and nursing staff, good feedback regarding the contribution of the ACP • Showers leaking and concern about increased falls risk – estates aware • Ward is paperless for rostering • Still some delays for ward attenders
23/04/17	Granby	• Nurse staffing levels concern as staff often work through break and stay late • There is limited space on ward but potential to convert unused rooms • Alternative methodology for cannula care audit was discussed • Staff believe patients would benefit from therapy provision at weekends • Staff could use OT room when not in patient use for breaks • Staff would like to push forward 'End of PJ Paralysis' campaign
06/06/17	Byland	• Nurse Staffing -The ward felt that Nurse staffing gaps were the greatest risk to patient safety in the department but recognised that this was reflected on the departmental, directorate and corporate risk registers. • Medical Staffing - Whilst the ward has daily consultant ward rounds, there is limited cover from 2 junior doctors and no middle grade support. • Falls - The ward is a high risk fall area. The ward tries to cohort patients at high risk of falling however this often requires an additional CSW to special. • Pressure Ulcers - The ward area hasn't had any hospital acquired pressure ulcers for a while. • MDT meetings - The visiting team were informed that MDT meetings are held daily where the ward team run through each patient's needs. The ward is using the Expected Discharge Dates in order to manage the clinical team's expectations and priorities.

		• Therapy Service provision - No therapy service input over the weekend. Reduced SALT provision.
21/06/17	Pharmacy	• Carter Review - Recommended that 80% of pharmacist resources are utilised for direct medicines optimisation – current performance is 84% and know we can improve on this in the next few months • We have improved the % of medicines reconciliation done within 24 hours – Feb 2016 at 80%, currently at 87% aiming for 90% by April 2018. We are the best in the region. • We have increased the number of pharmacists actively prescribing. Feb 2016 – 10%, currently 17% and once all those who have completed the course are ratified – 30%. If all pharmacists are accepted on the courses they have applied for by next year – 58% • Summary Care Record – aiming for new junior doctors to be trained and then rolled out to all relevant medical staff • Still need to improve the % of non-pharmacist ward based activity – should improve post September when two student technicians qualify and the new support workers that we have recruited recently will be fully up and running - so this should make the ward based team service sustainable. We are training more student technicians with (hopefully) 5 qualifying next year. ePMA • Reports now available for: Antibiotics prescribed, allergy not recorded, patients' Medicines on Admission / prescribed warfarin and when patients are discharged we ensure that info on Dawn (warfarin software) is updated / fax TTOs to relevant AC Service.
27/06/17	Main Out-Patients Dept	• A&E patients continue to be sent to clinic to be seen by specialists inappropriately. • Outpatient Administrative Support looks ahead at coming clinics to manage appointments of patients requiring Patient Transport Service • A number of the clerical support staff have worked in the department for an extended period of time however the department was in the process of recruiting to a 19hour clerk post for Ophthalmology and ENT clinic. • Taxis that are used to transfer staff to/from outreach clinics continue to be an issue. There was an incident recently where a driver started to fall asleep at the wheel putting staff at risk. Patient Waiting Times • Long waiting times for patients in clinic is a recurrent FFT theme. The most common cause for this is understood to be as a result of clinicians not arriving to clinic on time and overbooked clinics due to urgent appointments. Limited Space • The department suffers from limited space form storage and waiting areas. There was some discussion around developing the courtyard space between East and West Waiting. Disabled Toilet • Following the adjustment to the seat pan, the disabled toilet continues to be out of order. • There had also been some issues raised relating to the door which can be opened outwards into the corridor in order to allow wheelchair uses to easily get through the door. The department have put signage on the doors to warn visitors. • There was a discussion about changing places facilities and the support that is available to patients who require these. LD patients • Lynn made the visiting team aware of an incident where by a patient had been sent multiple follow up appointment letters following an urgent attendance but had DNA'd. It transpires tha the patient had Learning Disabilities but had not been flagged. There were concerns around the safety netting of vulnerable patients requiring 2 week wait appointments. FFT feedback • • Poor car parking facilities • • Long appointment waiting times • • Lack of Patient WiFi. Outpatient Department Project • Screens used in waiting areas to present relevant patient information regarding the department, appointment and facilities. • New signage to be put up and waiting areas renamed to reduce confusion and to be compatible with Web-V checking stands. • Since the directorate restructure all outpatient services had been moved under one directorate. There was now good communication between surgical, medical and outreach outpatient departments. • The department has noticed that whilst there appears to have been a lot of progress in discussions around the project, it appears to have quietened down. It was though this might be linked to operational pressures and capacity within the directorate management teams as project managers are pulled back into directorate rolls. There was also a Gap without a Matron currently responsible for the department. • However it was understood that a number of changes were due to come into place in the near future. Admissions Office • Treatment booking forms were not being completed properly with very limited information. An example of an incomplete booking form was shared with the group. It was suggested that this would be raised at the Improving Patient Safety Steering Group and that there was potential for auditing the quality of these forms.

06/07/17	Endoscopy	• No written report. Chairman and Director of Workforce and Organisational Development following up issues raised.
28/07/17	General Office	• **Changes to Front Entrance** The team had concerns around the new plans for the construction works that s due to be undertaken and were disappointed that they had not been involved in any of the consultation. Concerns include: Provision of Bereavement Rooms which the team currently has to share. Security concerns relating to the location of the new front desk Safety concerns relating to the location of car park payment machines • **Wheelchair Availability** Wheelchair availability continues to be an issue with wheelchairs not readily available for patients at the front of the hospital. This had been escalated recently to the Equality & Diversity Group who had been informed about the purchase of additional chairs. The visiting team were made aware of instances where patients had been turned away from clinics because they were late to their appointment although it wasn't clear if this was associated with the lack of available wheelchairs and/or delays in the car park • **Death Certificates** Not all deaths are being reported by clinicians where appropriate to the Coroner and this has meant that the General Office staff have had to chase doctors to ask that this is done he team were aware that they can escalate to Dr Scullion if a clinician refuses to report a death to the Coroner, and were encouraged to report any incidents on datix. There continued to be some delays in producing death certificates but it was better than it had been in the past. It was known that Dr Milward provides some training at junior doctor induction on death certification and it was suggested that it would be helpful to feedback progress to her. Staff noted that a stamp was being used on Byland to remind clinicians to do a death certificate. This would be followed up with Byland Ward to look at potentially rolling this out to other areas. • **Car Park** Road markings are wearing out and there is limited signage - so staff report regular instances when people drive the wrong way around the car park especially when they are trying to find their way round to the ramp to the 2nd floor. • **No Smoking Policy** Patients and relatives regularly stand outside the front of the hospital next to the front doors to have a cigarette. Other patients complain. General Office staff report seeing inpatients escorted by ward staff to have a smoke outside the front entrance. Staff do not always feel empowered or confident to enforce this policy. • **Internal Signage** Staff reported that there appears to be no oversight or overall control of internal signage in the organisation. Departments are responsible for their own signage but there is a risk of having no continuity across the site.
10/08/17	Main Theatres	• **Theatre 2 refurbishment** Theatre 2 refurbishment was in the process of being signed off. The work had been undertaken using a mixture of internal staff and external contractor and had been achieved in a 4 week turnaround. • **WHO Checklist** The department was re-launching the WHO checklist. This included developing posters and a declaration of understanding which was being sent to theatre staff with an expectation that they sign and return. • **SSD refurbishment** S Burns was not aware of any incidents directly related to the temporary move of the SSD service offsite during the department's expansion. The ODPs mentioned an incident where a set of artery forceps were missing from an obstetric set however this was felt more likely to be related to human error rather than attributable to offsite SSD. • **Store Room** As the service has expanded so has the amount of equipment required and the store cupboard which was previously fit for purpose is full. • **Transfer of Staff to support wards.** ODPs described frustrations about being transferred to staff wards on nights and feel it is an unsafe practice. Described being specialist trained staff and that their skills are not to deliver nursing care. During nights, the ODPs are emergency bleep holders and reported concern about what their responsibilities are if the bleep goes off when they are staffing a ward .Described not feeling appreciated when they do turn up to wards and that often the nursing staff do not appear to be busy. Reported that a number of ODPs have left the organisation because they are being used to staff wards. D Scullion reassured the staff that moving them from theatres to help maintain safety on the wards was a decision taken as a last resort, and that their concerns were known and appreciated and regularly discussed at a senior level. If they are asked to support a ward - they should expect clarity about what they are being asked to help with and they need to clarify if they are holding the emergency bleep that they need to respond to that. • **Equipment** Staff reported out of date camera stack systems with no contingency for immediate back up. The trust has arrangements for repair/backup within 24hours however this may result in patients being cancelled and may risk patient safety if system was to fail during an operation. The staff suggested holding a universal floating camera stack in reserve as back up but they can cost between £30,000-£60,000. It was noted that this had been on the departmental risk register for some time but not recently reviewed.
22/08/17	Oakdale	• **Staffing** Ward staffing is number one issue impacting on patient safety due to medication administration, observations and moving/turning patients being delayed.

		There is just one stroke nurse on the HASU - holds the stroke bleep, staffs the unit and provides Oncology on call cover. Staff turnover - contributing factors include leavers, secondments and retirements. Ward managers rarely have the opportunity to meet their peers meetings are regularly cancelled as they are unable to leave the ward .Ward managers are often counted as part of the staff nursing numbers. All agreed it would be useful to meet peers for support and to share practice and learning. Actions being taken to address staffing discussed. • **Care Support Workers** The ward was fully established with Care Support Workers however they are currently unable to do observations. Some CSWs are keen for personal development whilst others are content with their current roles and responsibilities. It was recognised that across the organisation CSWs had different responsibilities. The ward had recently changed the way that Registered nurses and CSWs work together and some CSWs felt that they were working in isolation without support from nursing staff, and sometimes need more physical support to move very immobile stroke patients. May be expected to provide1-to-1 care for one patient, but also expected to care for other patients in the bay. It was noted that a meeting between the Ward Manager and the CSWs had been arranged to discuss their concerns. • Good communication with Medical Team and are able to escalate high risk patients quickly. No pressure ulcers on the ward for at least 10 months - really impressive considering the long stay and immobile patients on the ward. The ward nutritionist was very good and enthusiastic - had developed noticeboard with good information. • **Equipment** Staff report falls sensors being not effective or efficient. In the past 10months, two patients have had falls resulting in a FNOF. Noted that the Trust has in the past contacted manufacturers who have said that they haven't had reports of issues from other organisations. It was suggested that they might come on site to see the issues first hand. Different types of falls sensors are used in different wards. ePMA is slow and delays the administration of drugs. Ward manager took 2hours to administer 8 patients' drugs that morning. Issues with ePMA and the reliability of the CoWs (computers on wheels). Previous week 2 of the 4CoWs was out of order. The ward was encouraged to continue to report issues as soon as they arise. Noted that issues with ePMA and CoWs are known about and being followed up at IT Steering Group • **Physiotherapy** The department had used charitable funding to build a gym where physiotherapy can be delivered to patients on the ward. Very useful but due to the ward staffing pressures, physios spend a lot of time getting patients ready for their therapy sessions .Other physio equipment was also reported to be getting old and tired. There are insufficient suitable chairs - impacting on the team's ability to rehabilitate patients by sitting them out of bed. It was suggested that charitable funding might be looked at to replace it. The team previously had 10 wheelchairs but this has reduced to 2, perhaps as a result of patients taking them home on discharge, as well as being taken to other wards and not returned. There were a number of suggestions to reduce this including maintaining a borrow book on the ward where specialist equipment is signed out and back in as well as addressing the return of wheelchairs in the discharge process. • **Fundamental Care** Some of the staff felt that sometimes there was insufficient emphasis on some of the basic care needs for patients such as washing as these are often the first things to be forgotten when there are pressures. The visiting team thought this was testament to the ward staff that they understood the importance of delivering fundamental care.

Patient Outcomes

4 Pressure Ulcer Target 2017/18

4.1 As I discussed in July the pressure ulcer reduction target this year, in both the hospital and the community, is to reduce the number of avoidable category 3 and 4 pressure ulcers. This target has been identified from the root cause analysis of category 3 and 4 pressure ulcers in 2016/17 which determined, in both the hospital and community, 66% of category 3 and 4 pressure ulcers analysed were deemed avoidable. The table below provides further detail of results to date.

April-Sept 2016 and April - Sept 2017 Comparison

Community Datix	2016	2017	Comparison
Category 2	88	92	4.5% ↑
Unstageable / Cat 3	43	37	14% ↓
Category 4	2	0	100% ↓

Community RCA	2016	2017	Comparison
Avoidable	27	8	70.4% ↓
Unavoidable	17	25	32% ↑
Total	44*	33**	

*Note two incidents investigated under one SIRI
**Note two incidents investigated under one SIRI, 4 x Community RCAs pending

Hospital Datix	2016	2017	Comparison
Category 2	75	88	17.3 % ↑
Unstageable / Cat 3	18	21	16.6% ↑
Category 4	0	0	N/A

Hospital RCA	2016	2017	Comparison
Avoidable	12	7	41.6% ↓
Unavoidable	6	8	33.3% ↑
Total	18	15*	

*Note 6 x Hospital RCAs pending

5 Children's and Adult Safeguarding

5.1 in September I reported there was a CQC's thematic review of mental health services for children and young people currently underway in North Yorkshire involving some services provided by HDFT. The inspection went well and the verbal feedback on the day raised no concerns for care provided by HDFT.

Patient Experience

6 Complaints

6.1 The number of complaints received in September 2017 is 16.

Of the 16 complaints received in September 2017, 13 have been graded Yellow and 3 green.

Of particular note in September 2017:

- 7 complaints about communication & attitude
- 6 complaints about delay / failure or dispute over diagnosis
- 4 complaints about discharge process
- 3 complaints about injury sustained during treatment/operation

6.2 The number of complaints received by month, year to date (YTD) compared with 2016/17 and 2015/16 is shown below.

Total number of complaints by month for 2017/18 compared to 2016/17 and 2015/16													
	April	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**	**Total**
2017/18	16	20	16	11	22	16							
2016/17	18	16	24	21	25	19	19	18	9	14	26	25	**234**
2015/16	26	18	30	15	17	26	11	9	12	12	21	16	**213**

6.3 The total number of complaints YTD is **101.** The total number of complaints for the same period of time in 2016/17 was **123**.

7 Baby Friendly Initiative

7.1 Last month I reported about the UNICEF Baby Friendly global initiative. This accreditation programme is recognised and recommended in numerous government and policy documents across all four UK nations, including NICE. Baby Friendly accreditation is a nationally recognised mark of quality care for babies and mothers.

7.2 Neonatal Standards –since 2013 bespoke Baby Friendly standards for neonatal units have been developed. These standards are around supporting close and loving relationships, breast milk and breastfeeding and valuing parents as partners in care. In August we were assessed to these standards for the first time. The assessors were very impressed. I am happy to confirm the Determination Panel awarded the Special Care Baby Unit (SCBU) with baby Friendly accreditation. The SCBU is only the second unit nationally to receive accreditation.

7.3 Maternity - what happens next? Following the assessment where the Maternity Unit maintained accreditation the unit was invited to work towards a gold award. This is a new award and involves a further assessment around the leadership, culture, monitoring and progression in the unit.

The gold assessment is booked for the 14th November 2017, where the Baby Friendly team will look over our application in the morning and then speak to the team. We expect they will feed back the results on the same day.

8 Impact assessments

8.1 Currently there is a requirement that I update the Board annually regarding the Quality Impact Assessments undertaken in support of the Trust's Cost Improvement Programme (CIP). The final part of my paper reviews the impact assessment process for the annual efficiency programme 2017/18 and informs the Trust Board of the key national drivers for improving quality and equality impact assessments. At the end of the paper there is a summary of what the Board is asked to note and recommendations for further actions.

8.2 Review of impact assessment process for annual efficiency programme 2017/18

During September 2016 the documentation relating to the assessment of risk to quality of CIPs in 2015/16 and 2016/17 was reviewed. Whilst an appropriate process was undertaken and post implementation monitoring via existing arrangements was designed to be inclusive of areas subject to CIP, the documentary evidence was not robust.

Further work was undertaken to strengthen the process and aimed to include:

- Impact assessment of transformation schemes and service development proposals as well as CIPs;
- Equality impact assessment as well as quality impact assessment.

A screening step has been included to identify schemes that have no or minimal impact and do not require the detailed impact assessment. The full impact assessment requires more detail than before, including a consideration of stakeholders affected by the change, clinicians involved in the impact assessment, mitigations required and metrics to be monitored.

Quality assurance of both screening and assessment stages are required at Directorate Board level, and then at corporate level by the Medical Director and Chief Nurse. More detail including further review of risk, opportunity, mitigation, details of metrics to enable monitoring of impact, or consultation with staff or other stakeholders may be requested at this stage prior to a decision being made on implementation.

The final draft documentation was to be piloted by the directorates and within the Project Management Office, with the aim of using feedback and experience to further strengthen the new process and documentation.

An update was provided to Quality Committee in October 2016 to address recommendations from the independent review of governance against the Well-led Framework undertaken by Deloitte (December 2015), to standardise and strengthen the arrangements for post-implementation monitoring and provide assurance reporting of the quality impact of CIPs at the Quality Committee. It was agreed that there would be a six monthly report to provide assurance reporting of the quality impact of CIPs at the Quality Committee and to confirm:

1. Completion of the initial round of CIP quality impact assessment, and that additional schemes are also assessed and signed off:
2. If any additional indicators of quality have been identified for monitoring and how this is being undertaken.

However this is currently on the Board reporting timetable and there has not been a subsequent report to Quality Committee.

<u>Evidence</u>

Children and County wide Community Services Directorate
The impact assessments for schemes identified so far during 2017/18 have been reviewed. The initial schemes were approved by the directorate board meeting on 15 June 2017 and passed the Chief Nurse and Medical Director for approval in August. Further schemes identified following this were approved by the directorate board meeting 21 September 2017. The highest negative impact on screening for quality and equality was 1 = minimal impact.

Planned and Surgical Care Directorate
All CIPs at the start of the year were assessed using the impact assessment spread sheet and none indicated a requirement for full impact assessment following screening. CIPs developed since April need to be impact assessed.

Long Term and Unscheduled Care Directorate
The directorate undertook an impact assessment screening for their initial CIPs and then met with the Chief Nurse and Medical Director to discuss. They requested more comprehensive impact assessments for the schemes related to infection control, ward changes, and Trinity ward. These were undertaken and submitted.

Corporate directorate
Alison Mayfield, Deputy Chief Nurse and Sylvia Wood, Deputy Director Governance met with leads for corporate functions and reviewed impact assessment screening processes and outcomes and detailed impact assessments where appropriate. There is summary documentation available of the corporate directorate impact assessment screening and detailed impact assessments. Where there was an identified risk to quality or equality, plans for mitigation and subsequent risk were assessed. One proposal to implement a 25% reduction in portering staff undertaking patient movement from 6am to 10pm was rejected as having a significant negative impact on quality.

<u>What worked well</u>
There is evidence of some effective impact assessment being undertaken in relation to CIP, with the majority of proposed schemes implemented with appropriate monitoring of impact on quality, and a small number of schemes rejected as likely to cause a significant negative impact.

<u>What needs to improve</u>
1. Documentation for undertaking and recording impact assessments needs further improvement – the templates are to be reviewed and simplified.
2. Guidance for undertaking equality impact assessments needs to be implemented. David Plews, Deputy Director – Improvement and Transformation and John Haigh, Project Manager - Improvement & Transformation are contributing to this work, supporting the development of an integrated quality and equality impact assessment process, documentation and guidance, with an integrated toolkit to help staff undertake equality impact assessments. See appendix for the draft toolkit. This uses examples and links to information, research and resources already available locally and nationally about different protected groups.
3. When there is any significant service change there is a risk of impact to the quality of service delivery, and an impact on people protected by the Equality Act 2010. Impact assessments need to be extended from being largely focused on CIPs, to become part of all significant service change, service development, business planning and transformation and there needs to be a supported roll-out for this process, with key messages to develop cultural ‘buy-in’.

4. There remains in use in the Trust a separate equality impact assessment template that was developed under the Single Equality Scheme for policy development. The process for this needs to be incorporated into the integrated quality and equality impact assessment process, so this covers all proposed changes to policies, procedures and practices.

8.3 Drivers for improving impact assessments and developing focus on equality as well as quality

Equality Duty

On 5 April 2011, the public sector equality duty (the equality duty) came into force. The equality duty was created under the Equality Act 2010. There is an obligation on public authorities to positively promote equality, not merely to avoid discrimination. Public sector organisations are required to demonstrate that they are giving 'due regard' to the needs of protected groups. This means that equality issues must be considered and evidenced in the decision making process.

The protected groups outlined in the Act are:

- Age - taking account of all age groups to understand whether age groups will experience disproportionate impacts;
- Disability – this includes physical, sensory and mental impairments;
- Gender reassignment - understanding the differential impacts for transgender people;
- Pregnancy and maternity – understanding any differential impacts for women who are pregnant, new mothers (those under 26 weeks), or breastfeeding;
- Race / ethnicity – includes ethnic or national origins, colour or nationality, understanding the different impacts on Black, Asian and minority ethnic groups (BAME);
- Religion or belief - assessing the proposals to see whether they impact on individuals because of a person's religion or faith and includes people who have no belief;
- Sex / gender - assessing impacts on men and women;
- Sexual orientation – assessing the impacts on lesbians, gay men and people who are bi-sexual; and
- Marriage and civil partnership – only in respect of eliminating unlawful discrimination.

Those subject to the equality duty must, in exercise of their functions, have due regard to the need to:

1. Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
2. Advance equality of opportunity between people who share a protected characteristic and those who do not.
3. Foster good relations between people who share a protected characteristic and those who do not.

These are sometimes referred to as the three aims or arms of the general equality duty. The Act explains that having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

The Equality Act makes it clear that the aims of the duty must be met prior to decision making and not afterwards. However, there is no established process for assessing how and to what extent public authorities uphold the duty.

The Equality and Human Rights Commission: Making fair financial decisions – Guidance for decision-makers (2015) is a short document that should be recommended reading for senior managers and the Board. It clarifies:

> "The public sector equality duty (the equality duty) does not prevent you from making difficult decisions such as reorganisations and relocations, redundancies, and service reductions, nor does it stop you from making decisions which may affect one group more than another group. The equality duty enables you to demonstrate that you are making financial decisions in a fair, transparent and accountable way, considering the needs and the rights of different members of your community. This is achieved through assessing the impact that changes to policies, procedures and practices could have on people with different protected characteristics.
> Assessing the impact on equality of proposed changes to policies, procedures and practices is not just something that the law requires, it is a positive opportunity for you as a public authority leader to ensure you make better decisions based on robust evidence."

By law, our assessments of impact on equality must:

- Contain enough information to enable us to demonstrate 'due regard' to the aims of the equality duty in our decision-making,
- Consider ways of mitigating or avoiding any adverse impacts.

If presented with a proposal that has not been assessed for its impact on equality, we should all question whether this enables us to consider fully the proposed changes and its likely impact. Decisions not to assess the impact on equality should be fully documented, along with the reasons and the evidence used to come to this conclusion. This is important as authorities may need to rely on this documentation if the decision is challenged.

It is also important to remember that the potential impact is not just about numbers. Evidence of a serious impact on a small number of individuals is just as important as something that will impact on many people.

The recent inclusion of impact assessment on the front page of Board and committee papers aims to prompt a consideration of whether there is sufficient evidence of an appropriate and robust impact assessment, and is one of the requirements of EDS2.

Support for staff in undertaking equality impact assessments is being developed.

Contractual standards

Some equality considerations are included in national health contracts – such as:

- NHS Workforce Race Equality Standard;
- Equality Delivery System 2;
- Accessible Information Standard – a legal requirement for publicly funded health and adult social care services.

NHS Workforce Race Equality Standard (WRES)

In April 2015, after engaging and consulting with key stakeholders including other NHS organisations across England, the WRES was mandated. WRES has been part of the NHS standard contract since 2015/16 and NHS trusts have to produce and publish WRES data annually. The NHS is mandated to show progress against a number of indicators of workforce equality, including a specific indicator to address the low numbers of BME board members.

To note, and as recommended by the Equality and Diversity Council, the NHS Standard contract team has included a requirement in their consultation document for providers to comply with the new national Workforce Disability Equality Standard (WDES) from April 2018.

HR have recently completed the annual WRES return for 2017. Actions include:

- Relaunching of the Workforce Equality Group which is now to meet quarterly with revised terms of reference. The focus for the next 6 months will be to appoint Equality Champions to help us to begin to engage with staff around a number of areas which have been highlighted through WRES and EDS2 data sets.
- Refreshing of the Single Equality Scheme as this is now past its review date. It is likely this will be replaced with a strategy as opposed to another equality scheme which will have much more focus around inclusion and engaging with under-represented groups.
- Developing reporting for the Gender Pay Gap.

EDS2

The original Equality Delivery System (EDS) was commissioned by the national Equality and Diversity Council in 2010 and launched in July 2011. A refreshed EDS – known as EDS2 – was made available in November 2013 following an evaluation and engagement with NHS and key stakeholders.

EDS2 is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010. The main purpose of the EDS2 was, and remains, to help local NHS organisations, in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS2, NHS organisations can also be helped to deliver on the Public Sector Equality Duty.

Organisations are required to assess their performance in relation to the 4 goals and 18 outcomes, and the 9 groups whose characteristics are protected by the Equality Act, and consider whether people from those protected groups fare as well as people overall. HDFT completed and published self-assessment against EDS2 in January 2016 and January 2017, on each occasion following a review of evidence and consultation with local stakeholders. We developed equality objectives linked to each of the EDS2 goals for 2016 - 2018. These are:

EDS2 goal	**HDFT objective**
Better health outcomes	To ensure that our services provide effective and safe treatment and care that is sensitive to people's personal and cultural needs as well as appropriate to their clinical condition.
Improved patient access and experience	To seek effective feedback about the experiences of people with protected characteristics who use our services in order to improve access and experience, and improve staff awareness and communications about equality.
A representative and supported workforce	To utilise the workforce equality group to deliver action plans focused on improving the availability of workforce equality information to assess our progress towards ensuring we have a representative and supported workforce.
Inclusive leadership	To ensure that Trust leaders have the right information and skills to promote equality within and beyond the organisation and to support their staff to work in a fair, diverse and inclusive environment.

The HDFT Equality and Diversity Group has an annual work plan and leads on promoting specific work to make progress against these objectives and as a result to be able to demonstrate continuing progress with EDS2. The objectives will be reviewed in the work to prepare a new self-assessment against EDS2 for approval by the Board in January 2018. The Equality Stakeholder Group has recruited a number of new representatives of people with protected characteristics during 2017. This group provides feedback to the Trust

regarding the experiences of people with protected characteristics who use our services, and we hope the group will contribute the future to consultations relating to specific equality impact assessments.

The HDFT Equality and Diversity Group and the its two subgroups, Workforce Equality Group and Stakeholder Equality Group, comprise a number of enthusiastic staff, however the pace of work is limited by the lack of dedicated time within job roles or an E&D lead.

Accessible Information Standard

Organisations are required to comply with the standard in full from 1 August 2016, see the NHS England » Accessible Information Standard Implementation Guidance. The AIS is based on the requirement to implement:

1. **Identification of needs**: consistent approach to identification of patients, carers and parents information and communication needs where they relate to a disability, impairment or sensory loss
2. **Recording of needs**: as part of patient / service user records and PAS systems
3. **Flagging of needs**: establishing and using e- flags or alerts to indicate that an individual has a recorded information and/or communication need and to prompt staff to take appropriate action and /or trigger auto-generation of information in an accessible format
4. **Sharing of needs**: inclusion of recorded data as part of existing data-sharing processes and as routine part of referral, discharge and handover
5. **Meeting of needs**: taking steps to ensure the individual receives information in an accessible format and any communication support which they need.

We have made progress in relation to people with learning disabilities, and are able to meet the requirements for people with other communication needs, but have further work to do to have a systematic and effective process in relation to this standard. There is a small working work progressing:

- A generic risk flag on iCS to indicate "accessible information need"
- Linking this flag to a register of the patients detailed information and communication needs using a specific module for AIS within the Synertec appointment letter software we already have. This is already linked to iCS, as well as Radiology and some Podiatry appointments. It would enable the recording of specific needs including:
-
    - Specific contact method - to indicate alternative communication / contact methods e.g people who are d/Deaf may not be able to use a telephone to book / amend appointments and alternatives including email, SMS, telephone and text relay can be specified.
    - Specific information format e.g. need to send correspondence or provide information in an alternative, non-standard format.

- Communication professional needed: e.g. BSL interpreter, lipspeaker, interpreter for Deaf/blind people
- Communication support: use of aids or equipment e.g. hearing aids, hearing loop etc
- Alternative formats for information for the patient and the carer.

The aim is to concentrate initially on iCS, focusing on building the flagging and register for people we are already aware of and gradually increasing the identification of others with communication needs. In the future, Web-V will become the system of choice to flag and record needs but we are some months off being able to start to do that. Eventually we will seek to capture information that can be shared from GP systems and integrate into our own records.

Some technical work is required to enable this process to be implemented, and we need to establish who will apply flags and add the detail of information needs. Once in place there will need to be an awareness raising campaign in order that staff recognise the AIS flag and know where to look for detail of information needs, and how to meet those needs.

CQC equality objectives

The CQC has published equality objectives for 2017-19. This is another short document and recommended reading for senior managers and Board members. The objectives focus on the CQCs regulatory role to improve equality for everyone. The objectives are:

1. **Person-centred care and equality**: There is strong evidence that person-centred care is the cornerstone of good equality practice – and good care – but that leadership is needed to make person-centred care a reality for people in some equality groups. For example, people with some protected characteristics, (including disabled people, people from Black and minority ethnic groups, lesbian, gay and bisexual people and younger people and those aged over 75) are less likely to say that they are involved in their care across a range of sectors. A specific question has been added to the PIR, and inspectors will examine these issues on inspection. The initial focus in year 1 (2017/18) will be on how providers ensure person-centred care for lesbian, gay, bisexual and transgender (LGBT) people who use adult social care and mental health inpatient services, for people with dementia in acute hospitals and older BME people using GP practices. In year 2 (2018/19) we will review our progress in the areas above to determine our focus.
2. **Accessible information and communication**: When people can't understand information and don't get the support they need to communicate, it can stop them getting a correct diagnosis, attending appointments, receiving safe and effective care or treatment, being treated with dignity and respect, being listened to and involved in their care. All publicly-funded providers must now meet the Accessible Information Standard. This aims to improve the lives and life expectancy of people who need information to be communicated in a specific way. Assessment frameworks will include key lines of enquiry, prompts and ratings characteristics on the standard and

from October 2017, all inspection reports include how providers are applying the standard

3. **Equality and the well-led provider**: The equality aspects of the well-led key question are now better developed in the key lines of enquiry (KLOEs), prompts and ratings characteristics in CQC's new assessment frameworks. Equality in the well-led key question will be embedded and implemented as part of an end-to-end inspection process for health care providers in 2017/18. As well as improved prompts to gather evidence of workforce equality, inspectors are also prompted to look for evidence that providers take account of equality characteristics for people using their services, for example when engaging with them.
4. **Equal access to pathways of care**: We will support inspectors to look at how people in specific equality groups are supported during referral, transfer between services, including adult social care services and health services, and at discharge from hospital and in primary care. We will use our Integration, Populations, Pathways and Place programme to look at how partners in local areas can reduce barriers to accessing primary care services for migrants, asylum seekers, Gypsies and Travellers.
5. **Continue to improve equality of opportunity for our staff and those seeking to join CQC.**

The CQC reviewed their assessment frameworks in 2017, working with NHS Improvement to strengthen the focus on equality in the "well-led" question for all health and social care services.

The CQC are equipping regulatory staff to consider and act on equality and human rights by building equality and human rights into their "intelligence" i.e. the evidence that we have available about services for inspectors to use, learning and development for inspection teams and equipping inspectors with methods, tools and information that cover equality and human rights with a range of support from guidance to specialists on hand to answer technical queries.

The content of the CQC equality objectives was shared at Senior Management Team in August 2017, and the draft PIR has been shared widely within the Trust. Some inspection preparation has been undertaken including sharing the assessment frameworks and key lines of enquiry.

CQC Equally outstanding: Equality and human rights – good practice resource
This publication Equally outstanding: Equality and human rights - good practice resource | Care Quality Commission demonstrates how those services that have the improvement of equality and the recognition of human rights at their core, provide better services for the public. It suggests that in times of financial constraint, we often see equality and human rights as a challenge, and rarely as a solution. It suggests that equality and human rights for people using services and staff needs to play a central role in improving the quality of care, and that there is evidence that some of the best providers are doing this successfully, even in times of constraint.

The resource guide aims to help providers put equality and human rights at the heart of improvement work so that the quality of care gets better for everyone. It provides examples of services rated as outstanding that have also developed practices that deliver equality and safeguard human rights for both the public and staff.

None of the common 'success factors' in the best providers took a large amount of resources. Their success was based on changing behaviours and thinking about issues. In particular:

- Leadership committed to equality and human rights
- Putting equality and human rights principles into action
- Developing a culture of staff equality and using staff as improvement partners
- Applying equality and human rights thinking to improvement issues
- Putting people who use services at the centre
- Using external help and demonstrating courage and curiosity.

The document links these common success factors to CQC key lines of enquiry.

8.4 Summary
The Board is asked to note:

- Work undertaken to date to ensure impact assessment of the annual efficiency programme, and the plans for further developing and strengthening impact assessments of all significant service development, with an integrated toolkit (see appendix) to provide staff with guidance, examples and resources.
- Work undertaken by the Equality Stakeholder Group to recruit new representatives of people with protected characteristics, providing feedback to the Trust and developing external resources to inform specific equality impact assessments.
- The number of very significant drivers for improving impact assessments and for giving more focus and priority to equality within the Trust. We should expect a focus on equality, person-centred care particularly in relation to dementia, accessible information and communication, workforce equality and equal access to pathways of care within our next CQC inspection, particularly the Trust wide well-led inspection.
- That the accessible information standard is an area of weakness and there is a need for further work to meet all of the requirements.
- That there is a lack of dedicated resource to the equality agenda which means staff involved have to integrate with other work and progress is slow.
- The common 'success factors' in the best providers from CQC inspections was based on changing behaviours and thinking about issues. In particular:

    - Leadership committed to equality and human rights;
    - Putting equality and human rights principles into action;
    - Developing a culture of staff equality and using staff as improvement partners;
    - Applying equality and human rights thinking to improvement issues;

- Putting people who use services at the centre;
- Using external help and demonstrating courage and curiosity.

I would recommend:

1. That the Board has an important role and Board members need to be informed about equality and human rights thinking, and to demonstrate leadership, commitment and an expectation that equality and human rights principles are put into action.
2. That the Trust needs to develop a strategy for inclusion and engagement with under-represented staff and public groups, and consideration needs to be given to the best approach to take to achieve this. Currently a public participation and engagement strategy is planned, and there is an opportunity to include engagement with people and groups with protected characteristics in this. In addition, HR are considering a staff equality strategy as opposed to another equality scheme – to have much more focus around inclusion and engaging with under-represented groups of staff.
3. That there is consideration given to the promotion of a culture of staff equality. Implementation of the final strategy would be an opportunity, but shorter term measures might be needed in order to make progress prior to a CQC inspection.
4. That there is a need to review and consider equality and human rights training for staff, including members of Board, and how this could be resourced.
5. That equality and human rights thinking needs to be applied to any change or efficiency process/project across the Trust (i.e. Cost Improvement Programme, Transformational change, Service Development improvements and/or Business Development), with further development of the integrated process for quality and equality impact assessment, documentation and the associated toolkit. The draft toolkit for impact assessments is provided in the BoardPad Reading Room for information.

Jill Foster
Chief Nurse
October 2017

Appendix One

Actual versus planned nurse staffing - Inpatient areas

The table below summarises the average fill rate on each ward during **September 2017.** The fill rate is calculated by comparing planned staffing hours and actual staffing achieved.

In addition we are required to submit information on the total number of patients that were on each ward throughout the month – this is then used to calculate the "Care Hours per Patient Day" (CHPPD) metric. Our overall CHPPD for September was **7.90** care hours per patient per day.

	Sep-2017						
	Day		**Night**		**Care hours per patient day (CHPPD)**		
Ward name	**Average fill rate - registered nurses/ midwives**	**Average fill rate - care staff**	**Average fill rate - registered nurses/ midwives**	**Average fill rate - care staff**	**Registered nurses/ midwives**	**Care Support Workers**	**Overall**
AMU	95.6%	114.1%	92.1%	161.1%	4.00	3.20	7.20
Byland	97.7%	83.0%	67.8%	107.8%	2.80	3.80	6.70
CATT	87.8%	111.7%	92.1%	86.0%	4.40	3.00	7.40
Farndale	98.3%	130.6%	100.0%	108.3%	3.70	3.60	7.40
Granby	91.9%	157.5%	101.7%	141.7%	2.80	3.70	6.40
Harlow							
ITU/HDU	106.5%	-	114.7%	-	21.70	1.60	23.30
Jervaulx	95.5%	89.3%	67.8%	104.4%	2.70	3.80	6.50
Lascelles	96.6%	90.7%	100.0%	103.7%	4.10	3.60	7.60
Littondale	86.3%	121.3%	87.8%	123.3%	3.40	2.40	5.80
Maternity Wards	99.5%	78.3%	97.2%	88.3%	11.10	2.90	14.00
Nidderdale	105.9%	118.9%	100.0%	100.0%	3.70	3.80	7.60
Oakdale	80.5%	135.6%	88.3%	156.7%	3.90	3.70	7.60
Special Care Baby Unit	87.6%	17.9%	95.0%	-	26.50	1.70	28.20
Trinity	93.6%	100.0%	100.0%	91.7%	4.40	4.30	8.70
Wensleydale	86.3%	134.2%	100.0%	120.0%	3.30	2.90	6.20
Woodlands	75.0%	73.3%	85.6%	86.7%	6.90	2.00	8.90
Trust total	**92.8%**	**108.8%**	**93.3%**	**112.2%**	**4.60**	**3.30**	**7.90**

ED	86%	210%	83%	107%

Further information to support the September data

On the medical wards Jervaulx, Byland, CATT, AMU and Oakdale, where the Registered Nurse (RN) fill rate was less than 100% against planned; this reflects current band 5 Registered Nurse vacancies and is reflective of the local and national position in particular regarding the difficulties in recruiting Registered Nurses. The Trust is engaged in an extensive recruitment plan in response to this.

The Harlow Suite was closed during August and re-opened on the 18 September. During this time Harlow staff were deployed to Farndale ward and on re opening mid-September the staffing was managed flexibly across these two wards. Therefore for the purposes of this month's data collection the data has been merged and reported in the Farndale numbers.

The ITU/HDU staffing levels reflect periods of increased activity within the unit during September.

The planned staffing levels on the Delivery Suite and Pannal ward (maternity wards) have been combined 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. Some of the care staff gaps were due to sickness and vacancies; however a professional assessment was made on a shift by shift basis to ensure that nurse staffing numbers matched the activity.

On Littondale ward although the day and night time RN hours were less than planned, 8 beds were closed at the beginning of September for one week and this enabled staff to assist in other areas when available.

In some wards the actual care staff hours show additional hours used for 1:1 care for those patients who require intensive support. In September this is reflected on the wards; AMU, CATT, Granby, Littondale, Oakdale and Wensleydale.

For the Special Care Baby Unit (SCBU) although the day and night time RN hours and the day time care staff 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.

On Wensleydale ward the daytime RN hours were less than planned due to RN vacancies.

The staffing complement for the children's ward, Woodlands, is designed to reflect varying levels of occupancy. Although the day and night time RN hours are less than 100% in September due to staff vacancy and sickness, and the care staff hours due to vacancies, the ward occupancy levels vary considerably which means that particularly in this area the number of planned and actual nurses is kept under constant review.

Harrogate and District NHS Foundation Trust

Date of Meeting:	25 October 2017	**Agenda item:**	11.0
Report to:	Board of Directors		
Title:	Report from the Medical Director		
Sponsoring Director:	Dr David Scullion, Medical Director		
Author(s):	Dr David Scullion, Medical Director		

Report Purpose:

Decision		Discussion/ Consultation		Assurance	✓	Information	✓

Executive Summary:

- Revalidation quality visit took place on 18 October 2017, fundamental trigger for the visit was a falloff in medical appraisal rates.
- The HSMR has increased to 108.6 (107.6) for the period ending July 2017. This remains just within expected levels. The consistent and single subspecialty trigger remains Geriatric Medicine.
- SHMI has fallen fractionally to 89.87 and remains below expected levels. The crude mortality rate continues to fall slowly over time.
- The first "STP wide" GIRFT seminar was held in Leeds on 9 October 2017; focused on Orthopaedics, ENT, Maxillo-facial surgery and Vascular Surgery.

Related Trust Objectives

To deliver high quality care	✓	To work with partners to deliver integrated care:		To ensure clinical and financial sustainability:	✓

Key implications

Risk Assessment:	None identified.
Legal / regulatory:	None identified.
Resource:	None identified.
Impact Assessment:	Not applicable.
Conflicts of Interest:	None identified.
Reference documents:	None.

Action Required by the Board of Directors:

It is recommended that the Board received and notes the report.

1. **Revalidation update:**

A planned quality visit to the Trust from the Higher Level responsible Officer (HLROQR) took place on 18 October 2017. In attendance was myself, Mr David Lavalette and Mr Andrew Forsyth. The QR team were led by Dr Paul Twomey, Joint MD NHSE (North) who has responsibility for oversight of the revalidation process in the North of England.

The fundamental trigger for the visit was a falloff in medical appraisal rates. This is almost solely due to a decrease in non-Consultant grade doctor appraisals in the last 12 months. The meeting was long and detailed, with a number of different subjects discussed. NHS England are facilitative and constructive in their approach. At the time of writing the detailed notes and actions arising from the meeting are still in preparation. Once these have been received, I will be requesting the Revalidation Officer to provide a detailed summary for information to the Board.

2. **Mortality update:**

The HSMR has increased to 108.6 (107.6) for the period ending July 2017. This remains just within expected levels. The consistent and single subspecialty trigger remains Geriatric Medicine. The retrospective case note review of 30 randomly selected elderly deaths is ongoing. To date 22 of the 30 notes have been reviewed, with a further 8 to come. Due to current clinical pressures and leave within the specialty I have agreed to extend the review period till mid-November.

I have spoken to the Consultant leading the review. A verbal update from the lead clinician indicates that no major lapses in care have been identified to date and that, as expected, these patients were both frail and with multiple co-morbidities. No deaths to date have been recorded as being avoidable (scores 5/6) with one possible harm relating to delay in administering antibiotics. A more detailed report on the review process will follow upon completion.

I have not been made aware of any major discrepancies in the coding process.
SHMI has fallen fractionally to 89.87 and remains below expected levels. The crude mortality rate continues to fall slowly over time.

Drs Claire Taylor and Jo McCreanor have kindly agreed to attend the RCP Tier 2 Structured Judgement Review Training in Sheffield on December 2nd. Their expertise will be then utilised to extend the knowledge and breadth of case note reviewers within the Trust.

3. **Quarterly report from the Guardian of Safe Working:**

Report from Dr Carl Gray attached at agenda item 11.1.

4. **Getting it Right First Time update (GIRFT):**

The first “STP wide” GIRFT seminar was held in Leeds on 9 October 2017. There was good clinical and managerial engagement from all of the WYAH acute Trusts.

The morning focus was on Orthopaedics with breakout afternoon sessions involving ENT, Maxillo-facial surgery and Vascular Surgery. Whilst this Trust has a stake in all of these, it is fair to say that the greatest potential impact for change lies in Orthopaedics.

A number of themes emerged from the Orthopaedic event:

- Establishment of revision arthroplasty networks
- Centralise fractured neck of femur services
- Centralisation of low number procedures in specialist centres
- Critical review of "procedures of limited value"
- Understanding variable length of stay across the STP. Learn from best practice.
- Standardisation of equipment use (arthroplasty devices)

Some local highlights for HDFT arising from the GIRFT data are:

- Understanding of patient related outcome measures variation (PROMS)
- Deep infection rates
- Data completeness for NJR

I am now officially the GIRFT Trust champion. Clinical areas will have their own GIRFT leads. At a national level the project is fast gaining momentum. Regional hubs are in the process of being set up to support GIRFT aims locally and smooth variation in quality.

5. 7 day working update:

The Trust has again recently taken part in the national audit (01/10 to 07/10). The specific standard audited was senior clinical review within 14 hours of admission. The collection of data is a not inconsiderable administrative burden and I am grateful to my colleagues in information services and clinical effectiveness for their support. At the time of writing the audit results have not been released.

6. BBC NHS-tracker:

Launched to some fanfare and not inconsiderable media publicity on 18 October 2017. The value of this metric is yet to be evaluated, the impact on ED 4hr waiting times in a given locality being particularly unpredictable. HDFT is green on 2 of the 3 metrics, fractionally missing the ED target of 95% (according to the BBC website). However the metric is crude and does not align realistically with the manner in which this is measured nationally. Therefore I am not of the view it is a true reflection of a performance that stands up very well with regional peers and those further afield.

7. Guidelines for the completion of Death Certificates:

I have received communication from NYCC regarding timely and accurate completion of death certificates. The need for guidance has been reinforced due to examples of delays in the registration of deaths as a direct result of ambiguous or incomplete information provided to the Registrar of Deaths. This is clearly unacceptable and very distressing for the bereaved. I have disseminated the guidance and once again reinforced the need for accurate and timely completion of such tasks. The communication was a general one. No specific concerns have been received within this Trust.

8. Regional Leadership Event at Calderdale and Huddersfield FT (CHFT):

The Medical Director and Chief Nurse of Calderdale and Huddersfield FT have invited Professor Ted Baker (newly appointed Chief Inspector of Hospitals) to an engagement event to discuss in detail the plans for focused well led reviews of Trusts, a key element of the new CQC inspection process. The event takes place on 3 November 2017. CHFT have kindly opened up the invitation to WYAAT Trusts. Both Dr Sylvia Wood and Jill Foster have accepted. I am attempting to rearrange my diary in order that I can also attend.

Harrogate and District
NHS Foundation Trust

Date of Meeting:	25 October 2017	**Agenda item:**	11.1
Report to:	Board of Directors		
Title:	Report by the Guardian of Safe Working Hours		
Sponsoring Director:	Dr David Scullion, Medical Director		
Author(s):	Dr Carl Gray, Guardian of Safe Working Hours		
Report Purpose:	**Decision**		**Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓
Executive Summary:	• The Guardian has no on-going concerns. • The number of Exception Reports is below the national average • The Guardian attended the third regional meeting in Leeds • There are regional/national concerns at under-reporting. GMC survey data shows a different picture. • There is a continuing national recruitment crisis in trainee doctors but vacancies in this Trust are 7.4%, which is comparatively low		

Related Trust Objectives					
To deliver high quality care	✓	**To work with partners to deliver integrated care:**	✓	**To ensure clinical and financial sustainability:**	✓

Key implications	
Risk Assessment:	Any identified risks are included in the Directorate and Corporate Risk Registers and the Board Assurance Framework.
Legal / regulatory:	None identified
Resource:	None identified.
Impact Assessment:	Not applicable.
Conflicts of Interest:	None identified.
Reference documents:	Nil

Action Required by the Board of Directors:

It is recommended that the Board:

- *Notes items included within the report*

Harrogate and District
NHS Foundation Trust

Q2 2017-18 QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

October 2017

Executive summary

This is the fourth quarterly report of the Guardian of Safe Working Hours. Its purpose is to report to the Board of Directors the state of safe working of doctors in training ('junior doctors') in relation to their working hours, gaps in rotas and their educational experience. This report covers the period 1 July to 30 September 2017.

The report provides the Board with up-dated quarterly evidence to support its assurance that the issues of safety within the Guardian's remit are in a satisfactory state.

The Trust now has all trainee doctors employed on the new 2016 Terms and Conditions of Service (TCS) contract.

Thirty-five exception reports have been received from trainees and dealt with [Q1 2017-18: 25]. These have mainly concerned over-runs of working hours ['hours and rest'] owing to the busy state of the wards and to individual patient matters. Four reports of educational deficiency have been received. Exception reporting is low in this Trust and in decline regionally overall, although highly variable.

There having been no breach of the European Working Time Directive; no fine has yet been levied.

National trends in medical post-graduate training continue to be adverse.

The Guardian has attended the third regional Guardians' meeting. Trainee doctors' forums have been held bi-monthly jointly with the Deputy Director of Medical Education.

Regional concerns are discussed.

This is the key quality assurance statement for the board: the Board is advised that overall working hours across the organisation are satisfactory and that there are presently no unaddressed specific concerns in departments or directorates. One doctor has lately put in a batch of exception reports: this is under enquiry.

Introduction

This is the fourth quarterly report of the Guardian of Safe Working Hours which presents the Trust's statistics in brief form: more detailed data are held in the DRS computer system and are available on request.

Its purpose is to report to the Board of Directors the state of safe working of doctors in training ('junior doctors') in relation to their working hours, gaps in rotas and their educational experience. The quarterly report is a contractual duty upon the employer under the 2016 TCS.

The report provides the Board with up-dated quarterly evidence to support its assurance that the issues of safety within the Guardian's remit are in a satisfactory state.

The Trust now has all trainee doctors employed on the new 2016 TCS which started in December 2016.

High level data

Number of doctors / dentists in training (total established posts):	121 [last quarter: 121]
Number of doctors / dentists in training on 2016 TCS (total):	121 [last quarter: 34]
Number of doctors / dentists in training actually in post:	112[last quarter: 105]
Amount of time available in job plan for Guardian to do the role:	1.5 PAs per week
Admin support provided to the Guardian (if any):	none [assistance from HR Department]
Amount of job-planned time for educational supervisors:	0.5 PAs per trainee

Exception reports

Exception reports are individual notifications by trainee doctors who have had a problem occasion causing them to vary their working hours from the contracted rota by more than 30 minutes. Exception reports have a time-limited process for response by the Trust. At any one time there will usually be reports awaiting attention by individual clinical supervisors; unusually nine are in this state on the date of writing.

This is a full quarter covering the period 1 July - 30 September 2017.

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Gen Medicine	0	30	21	9
Gen Surgery	0	5	5	0
Total	0	35	26	9*

*This includes a batch of seven reports for one doctor received on 16 October 2017.

The exception reports are from FY1, FY2 and CT1 doctors. The majority of exceptions reported concern overtime working ['hours and rest']. There have been just four exception reports mentioning defective educational experience. These usually relate to missed teaching sessions owing to excessive ward work. Some doctors put in batches of exception reports; others never put in any.

Exception reports have risen from 25 in Q1 to 35 in Q2; but the doctors covered by 2016 TCS have also increased from 34 in Q1 to 121 in Q2 so the reporting rate has fallen from 0.7 reports per doctor per quarter to 0.3 reports. [Comparisons: York NHS FT: 60 per quarter; Sheffield Teaching Hospitals NHS FT: 546 per quarter.]

Exception reporting has a potential procedural barrier. Doctors new to the Trust must activate their password on the DRS system within seven days. If they do not do so they are locked out and must get a new password. This may account for some delay in reporting exceptions; some doctors tend to batch them.

Work schedule reviews & interventions

Work schedule review

A work schedule review would be undertaken to investigate any case of systematic or repeated over-working of contracted hours where the planned schedule itself is questioned. No work schedule review has been necessary to date.

Interventions

Specialty Y

In this specialty, exception reports are fewer this quarter. There was no enthusiasm in the trainees for any survey or monitoring process. They emphasise that they do not wish to upset their consultants.

Consultants in this specialty have had some feedback from the Deanery Trainees Survey last year which mentioned late working and also perceived discouragement to report exceptions. This has been discussed with the Director of Medical Education.

Specialty Z

This quarter's figures are distorted by a single doctor submitting on the day before writing [16 October] a batch of seven different retrospective exception reports for dates in August-September 2017. This CT1 doctor and her clinical supervisor are being investigated by HR in the first instance. This batch accounts for the unusual number of unaddressed reports at the time of writing.

Vacancies

There were nine vacancies in September 2017 [7.4% of 121 established posts overall; comparison: York TH NHS FT: 53 vacancies in Q1: 2017-18].

In February and August each year there are planned cohort changes; at other times of year there are always a few doctors coming and going for personal reasons. At any one time, there are gaps owing to failure of recruitment and vacant posts are at different stages of re-advertisement and recruitment. One gap is a doctor on maternity leave returning this month. Three gaps are in specialties which for one reason or another are not intending to recruit this time round. For example, Histopathology: a trainee has dropped out of programme leaving a gap which cannot be filled by this Trust in the short term. A new trainee will join the scheme in due course.

Of course, rota gaps add to the strain on the trainees in post and add to the Trust's workforce costs by necessitating locum and other temporary employees.

The percentage of vacancies is far worse in other Trusts: we are doing relatively well.

Fines

The Guardian has the contractual power to penalize departments/directorates for failure to ensure safe working hours and particularly repeated breaches of the Working Time Directive. This section should list all fines levied during the previous quarter, and the departments against which they have been levied. Additionally, the report should indicate the total amount of money levied in fines to date, the total amount disbursed and the balance in the guardian of safe working hours' account. A list of items against which the fines have been disbursed should be attached as an appendix.

No fine has been necessary to date. There have been no identified breaches of the Working Time Directive.

Working time rules may of course change after BREXIT.

[Comparisons: Sheffield Teaching Hospitals NHS FT was charged fines by their Guardian of £20,420 in Q4: 2016-17; Barnsley Hospital NHS FT: fines of £1,311.78 in Q1: 2017-18; York TH NHS FT: one fine of £147.18 in Q1: 2017-18.]

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
£0	£0	£0	£0

Qualitative information

Regional Meeting

The Guardian attended the third Health Education England regional meeting for guardians on 3 October 2017 in Leeds.

It was agreed that exception reporting has declined regionally overall but with some hot-spots breaking the trend. Trainees in some instances are thought to be reluctant to use the contractual mechanism. Instances of discouragement by seniors had been detected. National advice to seniors has been issued to urge the welcoming of exception reports.

Numerous small points of contractual detail were put to the NHS Employers representative. This was more HR business than that of the Guardians.

An analysis of quarterly reports from Guardians around the region was presented. Yorkshire and the Humber has wide variation in exception reporting rates and the issuing of fines to Trusts by Guardians. The range of exception reports was 1 to 546 per quarter. The highest fine bill was £20,420 at Sheffield TH NHS FT.

Some centres with large rates of exception reporting attributed this to having unusually active trade union [BMA] representatives.

Various points were put to our representative [not me] who will attend a national consultation shortly.

No plans have been announced for any national meeting for Guardians of Safe Working Hours in 2018.

GMC training survey 2017

Triangulation with other data suggests that exception reporting greatly underestimates overtime working.

The GMC Trainees Survey ['*2017 national training surveys summary report: initial results on doctors' training and progression*', p.5] stated that, '*Last year we also focused on questions relating to doctors' workloads and found that an increasing number rated their workload during the day as heavy or very heavy. This year, it appears that the situation has somewhat improved – although reports of heavy workloads remain common.*'

From Table 3, p. 5: '*How would you rate the intensity of your work, by day in this post? [Heavy/very heavy responses)*': England: 2016: 44.1%; 2017: 41.56%.

The summary report continues: '*Again – although the situation appears to have improved across the UK in 2017 – roughly 50% of doctors in training are still reporting that they work beyond their rostered hours on a daily or weekly basis. And, other than in Northern Ireland, which has seen improvement, these results have been fairly stable over time*.'

Professionalism for junior doctors includes a degree of flexibility. Exception reports treat overtime situations by definition as significant if over half an hour. No-one starts on the dot of 9.00, and ward duties or sudden changes in patients' condition can necessitate staying beyond 5.00. Flexibility cuts both ways: there should be time to get a haircut or visit the dentist just as at other times medical duties exceed rostered hours for good reasons. Chronic over-working has been traditional in medical training; this is continuing under the new contract. Exception reporting appears to be a blunt tool for monitoring and addressing overtime issues.

Morale of junior doctors

The Guardian – jointly with the Deputy Director of Medical Education – has held the regular bi-monthly forums for doctors in training in the Doctors' Mess, most recently 11 September 2017. This forum had a larger attendance than previously; this was a new 'house' of doctors. The work of the Guardian in relation to safe working hours has been introduced. No substantial issue has ever been raised and the trainees in this Trust are low-key and in good heart. Their BMA representative is reasonable and helpful and their BMA professional advisor is a serious and realistic person.

But it is beyond doubt that the current generation of junior doctors is embittered by the industrial dispute and overwork. This is finding expression in recent publications which may be of interest to members of the Board of Directors:

'Rachel Clarke: Cheap, undervalued, expendable – junior doctors in 2017?' *BMJ Blog*: http://blogs.bmj.com/bmj/2017/07/27/rachel-clarke...

Clarke, R; McKee M. Suicides among junior doctors in the NHS. *BMJ* 2017; 357:j2527 doi: 10.1136/bmj.j2527 (Published 2017 May 26).

Dr Clarke has now elaborated her views and experience into a polemical book:

Rachel Clarke. Your life in my hands. London: Metro Publishing, 2017, ISBN: 9781786064516.

Workforce

Systematic problems of recruitment of trainees continue to be intractable regionally and nationally leading to widespread gaps in rotas in many important specialties. But this Trust had just 7.4% vacancies gaps in September 2017. Many mainstream medical specialties in large teaching centres are failing to fill their training posts.

Trusts have been urged by the Deans to consider all possible means of staffing their hospitals with professionals other than trainee doctors. Schemes to develop 'physician assistants' to replace junior doctors are in progress. The Royal College of Pathologists is working on a plan to allow non-medical scientists eventually to train to consultant level in histopathology. This is already possible in Biochemistry and other pathological sub-specialties.

Each trust should be appointing a 'Champion of Flexible Training' to support the needs of less-than-full-time trainees.

Disclosure

These quarterly Guardian reports are submitted to Health Education England at their request. A regional summary is assembled and discussed at the regional meeting each time. Guardians assume that their quarterly reports to their boards of directors are open to the public domain.

CQC

Two Guardians of Safe Working Hours mentioned that they had been requested to participate in CQC Inspections at their respective Trusts. One was an in-depth enquiry into the exception reporting data. The other merely, '…*discussed the weather*.'

Issues arising

1. The Trust is in comparatively good standing. We have had a below-average rate of exception reporting.
2. There is an on-going problem of delayed or non-response to exception reports from clinical supervisors. Consultants have never warmed to this task imposed upon them by the juniors' contract without their agreement. The Guardian has had to overrule these cases to avoid breaking the contractual obligation to respond within set time limits. Prolonged non-response is very discouraging to trainee doctors.

3. Reluctance in trainees to report exceptions exists regionally and nationally but there is wide local variation. GMC data shows that over 50 per cent of trainees report overtime working on a daily or weekly basis [see above].
4. It is suggested that the new national contract [2016 TCS] is bedding down and that trainees are settling in. The initial hostility from the BMA has ameliorated with most trainees getting on with their training pragmatically and not wanting to rock any boats. Published work continues to emphasize the misery of medical training.
5. Exception reports are being received and processed.
6. There are gaps in rotas owing to failed recruitment. This a worsening issue throughout medical specialties especially in the North of England, but this Trust is doing relatively well.
7. All Trust medical trainees are now on the 2016 TCS.
8. Disclosure: Guardian of Safe Working Hours quarterly reports to boards of directors are submitted to Health Education England at their request for their information. CQC inspectors are known to have asked for quarterly reports.

Actions taken to resolve issues

1. No intervention or fine has been necessary this quarter.
2. Probably the majority of trainees work overtime occasionally but none to a dangerous degree. Exception reports are widely viewed as an under-estimate of actual overtime working owing to reluctance to make exception reports.
3. One doctor has retrospectively put in a batch of seven retrospective reports: these are under enquiry.
4. At the date of reporting, the Board of Directors is assured from the evidence available that:
    1. The exception reporting system is operational for all trainees who are now all on the 2016 TCS.
    2. No systematic problem exists: GMC data suggests that chronic low level overworking is the new normal.
    3. No individual problem of unsafe working hours is known to exist currently.
    4. The Guardian can only intervene on notified problems.

Questions for consideration by the Board of Directors

1. *The Board is asked to receive the report and to consider the assurances provided by the Guardian.*
2. *There are presently no issues outlined in the report which are not being (or cannot be) tackled.*
3. *The Guardian makes no request for escalation, internally, externally or both, which might be recommended in order to ensure that safe working hours would not be compromised in the future.*
4. *Issues of medical manpower planning are a strategic challenge to the Trust and to the entire NHS.*
5. *The Trust always has vacancies gaps in trainee doctor posts; these currently run at 7.4 per cent.*

Harrogate and District NHS
NHS Foundation Trust

Board Committee report to the Board of Directors

Committee Name:	Finance Committee
Committee Chair:	Maureen Taylor, NED
Date of last meeting:	12th October 2017
Date of Board meeting for which this report is prepared	25th October 2017

Summary of live issues and matters to be raised at Board meeting:

1. Month 6 figures were reported which show the Trust is £5.57m behind plan compared to £5.21m at month 5.
2. The Trust will not secure S & T funding until the current deficit is brought back on track.
3. The Committee were updated on the meeting with NHSI, earlier in the week, including the slide presentation.
4. The Committee received an update on model hospital, reference cost and purchasing price index benchmarking and were advised that a number of work-streams are in place within HDFT and WYAAT to progress areas where potentially, improvements could be made
5. The Committee considered budget planning scenarios across the Harrogate health system. Planning assumptions for the next 4 years were considered, comparing the Trust position to HaRD CCG.
6. An update on the Carbon Energy Fund project was received. It showed that energy savings are slightly behind plan but that the contract is being robustly managed. A final report will be brought to Finance Committee in March.
7. A progress update on the Private Patients work was received. Significant progress has been made in gathering information to inform the project. Work is continuing towards finalising the project plan and developing a full business plan, to be presented to Finance Committee in January.
8. The Committee received a verbal update on tenders that the Trust has responded to or is working towards.

Are there any significant risks for noting by Board? (list if appropriate)

- Receipt of S & T money is dependent on getting back on track financially and achieving our budgeted surplus. Failure to do this will impact on our capital programme.

Matters for decision

None

Action Required by Board of Directors: None

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Board Committee report to the Board of Directors

Committee Name, NED**:**	Quality Committee (QC)
Committee Chair:	N M McLean, NED
Date of last meeting:	4 October 2017
Date of Board meeting for which this report is prepared	25 October 2017

Summary of live issues and matters to be raised at Board meeting:

Concern at effect of Recovery Plan on quality.
An extensive discussion took place on the actual and potential effects of the financial recovery plan on quality of service and care with concern expressed from a number of areas although no adverse effect on current quality of care were highlighted. Particular concerns were noted relating to the effect on clinical staff relating to study and professional leave restrictions although it was noted that some of the proposals had been reversed. It was agreed that this issue should be a standing item on the Committee agenda going forward.

Request from the Board for further assurance in respect of falls.
Mrs Foster advised that the August and September increases in falls would be the subject of a formal report to the November Quality Committee.

Committee effectiveness
A survey had taken place on various issues relating to the effectiveness of the committee with generally very favourable results. There were a small number of areas which are to be further examined for improvement.

Reports and updates received
1. Pharmacy medicines incidents - some concerns but good progress in relation to prescribing and administration errors.
2. Provision of high quality stroke care – fluctuating performance with some considerable challenges. Rigorous action plan in place and being monitored. External review of area stroke services ongoing.
3. Antenatal and Newborn Screening Programme – a complex report prepared in anticipation of peer review was noted with confirmation that the screening programme was of a high standard. The associated action plan to address any necessary improvements or modifications would be overseen by the Maternity Services Board.
4. Progress with actions from external reports – a detailed report was received and some further updates given. Some revision to the report was however required before the committee could be fully assured as to the position and adequate progress and a further update is to be prepared.
5. Updates and clarifications relating to previous reports were received.

Are there any significant risks for noting by Board? (list if appropriate)

Concern as to the risk of adverse effects on the quality of service and care arising from the effects of the financial recovery plan.

Matters for decision

None

Action Required by Board of Directors:

To note this report.

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Harrogate and District NHS Foundation Trust

Date of Meeting:	25 October 2017	**Agenda item:**	14.0
Report to:	Board of Directors		
Title:	Infection Control Update		
Sponsoring Director:	Dr David Scullion, Medical Director		
Author(s):	Dr Jenny Child, Director of Infection Prevention and Control		
Report Purpose:	**Decision**		**Discussion/ Consultation**		**Assurance**	✓	**Information**	
Executive Summary:	• The annual objective/ceiling for *C .difficile* infection (CDI) remains at twelve for 2017/2018. The first half of the 2017/2018 has been good, with only two Trust apportioned cases, both in September 2017. *C difficile* has not disappeared, and it may well be that we will start to see more cases from now onwards. • 2017/2018 is showing signs of being a bumper year for *E. coli* bacteraemia, with a 33% increase over the same period last year. Most of the increase this year is in the community. • Since September 1 2017 two confirmed flu A cases and five with parainfluenza virus, one of which required critical care. • Antimicrobial stewardship activities continue including engagement with relevant teams. • The report confirms the number of deep cleans undertaken by the domestic department.		

Related Trust Objectives

To deliver high quality care	✓	**To work with partners to deliver integrated care:**		**To ensure clinical and financial sustainability:**	

Key implications	
Risk Assessment:	None identified.
Legal / regulatory:	None identified.
Resource:	None identified.
Impact Assessment:	Not applicable.
Conflicts of Interest:	None identified.
Reference documents:	None.

Action Required by the Board of Directors:

It is recommended that the Board notes the Infection Control Update.

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Harrogate and District NHS
NHS Foundation Trust

October 2017

INFECTION PREVENTION AND CONTROL REPORT

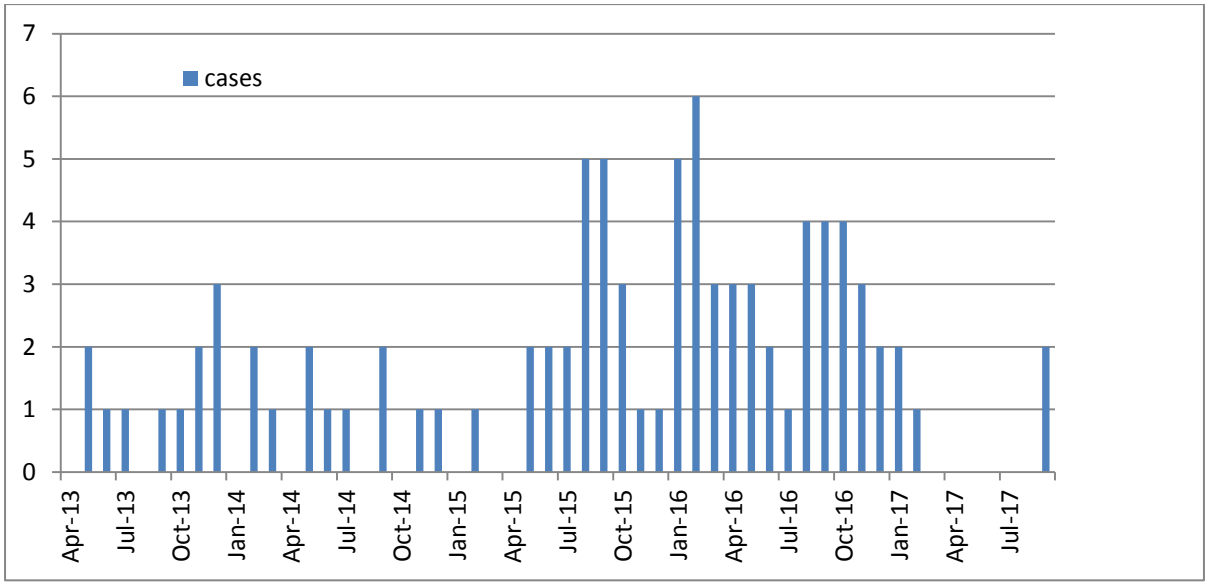
Monthly IPC dashboard October 2017

Month	CDI		MSSA BSI		MRSA BSI		*E.* coli BSI		Klebsiella BSI		Pseudomonas A. BSI		CPE carriers
	HAI	CAI	HAI	CAI	HAI	CAI	HAI	CAI	HAI	CAI	HAI	CAI	
April	0	2	0	1	0	1	2	8	2	3	0	0	
May	0	2	1	2	0	0	0	12	0	3	1	0	
June	0	0	0	5	0	0	3	10	0	3	0	0	
July	0	1	0	4	0	0	1	14	1	2	1	0	1
August	0	0	1	1	0	0	3	15	0	4	0	0	
September	2	2	1	3	0	0	2	12	1	1	0	2	
October													
November													
December													
January													
February													
March													
Running total	2	7	3	16	0	1	11	71	4	16	2	2	

C. difficile

Our annual objective/ceiling for *C .difficile* infection (CDI) remains at twelve for 2017/2018. Last year, we exceeded this by the end of August. The first half of the 2017/2018 has been good, with only two Trust apportioned cases, both in September. There have however, been four new cases in the past week, all likely to be CCG apportioned. Three are in the community. The take-home message is that *C difficile* has not disappeared, and it may well be that we will start to see more cases from now onwards.

Trust Apportioned *C.difficile* cases, April 2013 - September 2017



***E. coli* bacteraemia**

Every year in E&W, there are approximately 40,000 Gram-negative bacteraemias, of which over half are *E. coli*. These are associated with a 14% all-cause mortality at 30 days.

NHS Improvement (NHS I) and Public Health England (PHE) have announced a national improvement plan to reduce the number of Gram-negative bacteraemias across the whole healthcare economy by 50% by 2020/2021, with CCGs being asked to deliver a 10% reduction year on year across the whole healthcare economy until then. Unfortunately, so far 2017/2018 is showing signs of being a bumper year for *E. coli* bacteraemia, with a 33% increase over the same period last year. (Table 2) Most of the increase this year is in the community.

Table 2: *E. coli* bacteraemias, community and hospital apportioned, April – September, by year

YEAR	Community apportioned	Hospital-apportioned	total
13/14	51	11	62
14/15	44	8	52
15/16	67	11	78
16/17	48	9	57
17/18	75	11	86

Flu

We are starting to see more patients admitted with respiratory infections, several of whom have been admitted to ITU/HDU. So far, since September 1 2017, we have had two confirmed 'flu A cases and five with parainfluenza virus, one of which required critical care.

Antimicrobial stewardship report for SMT (Dr Jessica Martin)

Antimicrobial stewardship activities continue including engagement with the CATT team, urologists, GPs, elderly care team, advanced nurse practitioners and Foundation year doctors in the past few months. Regular antibiotic bulletins deliver key messages.

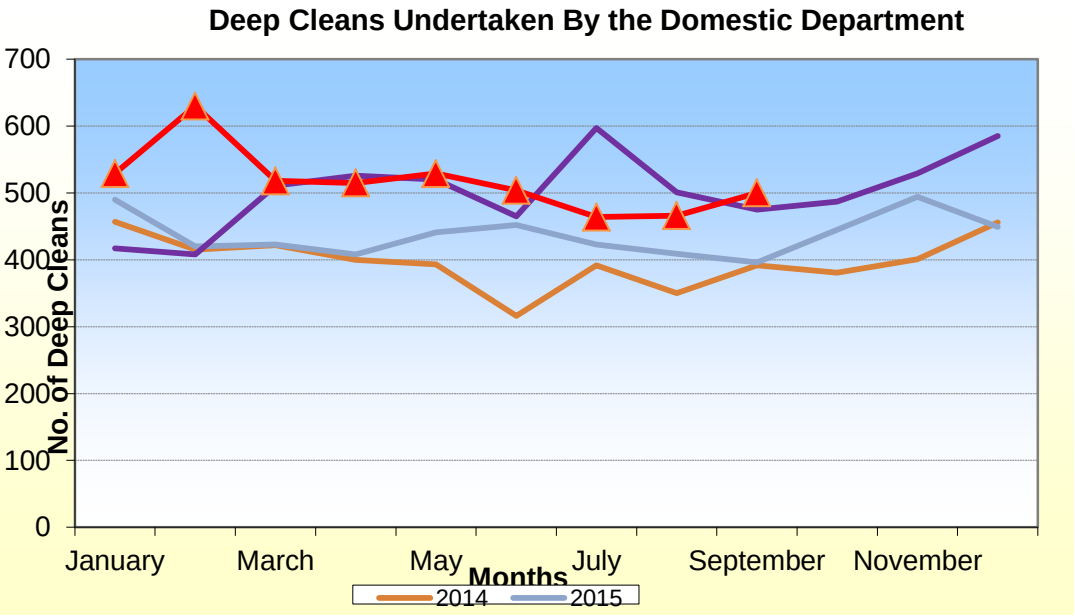
Audit data demonstrate good prescribing generally, though only 60% antibiotic prescriptions meet all criteria, work is needed on review/stop dates (see CQUIN below). A full point prevalence audit is planned for late October to address this.

Guideline updates have been circulated to Antimicrobial Prescribing Sub Group (APSG) members, many are in response to antibiotic availability and adherence to national guidance. There is a new diabetic foot guideline, created in collaboration with York. No clinicians attended the last APSG (and the previous one was cancelled) so these changes could not be ratified. JM recirculated (4/10/17) for agreement via email.

Antibiotic CQUINs – the piperacillin-tazobactam reduction is likely to be met, current usage is very low. The meropenem reduction targets may be met, usage is borderline currently. The total antibiotic usage CQUIN is less certain, the main reason being that in many areas of guidance, piperacillin-tazobactam has been replaced by two or three different agents. Clinical engagement with this is required as reduction in unnecessary antibiotics (previously audits suggest this is 10% prescriptions) and reduction in inappropriately long durations are required to help meet this target.

Sepsis CQUINs are being monitored by anaesthetics team.

Cleaning



Dr J Child, Director of Infection Prevention and Control
18th October 2017

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Date of Meeting:	25 October 2017	**Agenda item:**	**15.0**
Report to:	Board of Directors		
Title:	Business Planning Update		
Sponsoring Director:	Jonathan Coulter, Deputy Chief Executive/Finance Director		
Author(s):	Jonathan Coulter Deputy Chief Executive Angela Gillett, Deputy Director of Planning and Business Development		
Report Purpose:	**Decision**	**Discussion/ Consultation**	**Assurance**	**Information** ✓		
Executive Summary:	The Board of Directors is asked to:- • Note the work that is ongoing with the development of the Operational Plan for 2017/18 – 18/19 and the associated timescales.		

Related Trust Objectives					
To deliver high quality care	✓	**To work with partners to deliver integrated care:**	✓	**To ensure clinical and financial sustainability:**	✓

Key implications	
Risk Assessment:	None Identified
Legal / regulatory:	None Identified
Resource:	None Identified
Impact Assessment:	Not Applicable
Conflicts of Interest:	None Identified
Reference documents:	None Identified

Action Required by the Board of Directors:
The Board is asked to **note** and **comment**, where appropriate, on the information in this report.

1. Introduction

1.1 Work has commenced to develop the Operational Plan for 2018/19 - 2019/20. A planning meeting was held on 16 October 2017 with Executive Directors, Operational Directors and Corporate Teams to discuss the process to be adopted for this year's planning round. Regular fortnightly meetings have now been scheduled to enable completion of the draft Operational Plan by the end of December 2017.

2. Planning Environment and Guidance

2.1 No formal guidance has been issued by NHSI to date. However, indications are that given the 2017/18 plan was a two year plan, this year's submission will be based on the refresh of Year 2 of the plan with a forward look. It is also understood that a refresh of the STP is to be carried out.

2.2 It is anticipated that following the budget in November 2017, more financial details will be forthcoming and whether any additional funding to support new initiatives (such as a relaxation of the pay cap) will be new monies or will need to be sourced through efficiency gains in the system.

3. Timetable and Process

3.1 In the absence of any new guidance, we are internally working to develop a final draft of the Operational Plan by Christmas. This will then be refined in Quarter Four in line with any further national requirements, tariff information, STP developments etc. This will need to be aligned with the agreement of contracts for services for 2018/19.

3.2 Work has started internally to review the following:-

- Activity
- Capacity Planning
- Review of services to determine key challenges, aspirations, growth opportunities or steady state
- Future workforce requirements
- Physical capacity requirements
- Risks
- Development of an efficiency programme and cost pressures identified

3.3 As part of this work, we will incorporate the current activity and financial delivery plans and transparently agree activity assumptions for 2018/19. Compromises between setting challenging activity delivery plans and challenging cost reduction requirements will be explicit and will be discussed through the Finance Committee and at the full Board of Directors.

3.4 Key dates to note are as follows:-

Activity Assumptions first cut	w/c 16 October
Review of services complete	w/c 30 October
Financial Framework	w/c 30 October
Capital Priorities	w/c 30 October

3.5 A workshop with Clinical Directorates and Corporate Teams is scheduled for 1 December 2017, when Directorates will be invited to present their proposals for the

next two years. In addition, discussions will focus on capital priorities, our workforce strategy and business development opportunities.

3.6 A detailed timetable of the key tasks to be taken forward over the planning period are attached at Appendix A.

4. Engagement with the Board of Directors and Council of Governors

4.1 A governor working group has been established, with regular meetings scheduled to update Governors on the development of the Operational Plan.

4.2 A draft of the plan will be presented to the Board of Directors and Governor working group for information, with the final draft plan submitted to the December Board for sign off. It will also be discussed at the December Finance Committee.

4.3 It should be noted that detailed budgets that reflect the operational plan will be prepared as usual for final approval at the Board in March.

5. Conclusion

5.1 The Board of Directors is asked to:-

- Note the work that is ongoing with the development of the Operational Plan for 2018/19 - 2019/20 and the associated timescales.

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Appendix A

OPERATIONAL PLAN 2018/19 - TIMELINE:

Assumptions made in relation to national requirements. Guidance still awaited.

Date	Actions/discussions
Sep 17	• Introduce the Annual Business Planning Process for 18/19 • Introduce the capacity and activity plans for completion
Oct 17	• Initial meeting with Governors • Agree process for capital priorities • Receipt and discussion of capacity and activity plans • First cut of Efficiency Programme • BoD Meeting paper
Nov 17	• Confirm activity and capacity plans • Identify potential service developments • Identify potential capital developments • Identify quality priorities • QIA Completed with Directorate, Medical Directors and Chief Nurse • BoD Meeting paper to update progress • Sign off Service and Capital priorities • Finalise Efficiency Programme requirements
Dec 17	• Workshop with Clinical Directorates and Corporate Team • Sign off activity and capacity plans (ALL) • Sign off Efficiency Programme • Tariff and planning guidance to be issued • Sign off capital and service priorities • SMT to agree draft Operational Plan • Finance Committee Review • Meeting with Governors • BoD meeting to sign off draft Plan for approval and endorsement by CoG
Jan 18	• NHSI Financial templates to be issued • Update on Efficiency Programmes • Outline key messages included in the plan • Meeting with the Governors • Contract negotiations • BoD meeting paper to update on progress
Feb 18	• Budgets signed off and financial plans finalised • Sign off Directorate business plans • Sign off quality priorities • SMT review of progress • Finance Committee review • BoD Meeting paper to update progress • Meeting with the Governors
Mar 18	• Quality Committee review and confirmation of priorities • BoD to sign off budgets for 2018/19 • Meeting with Governors • Develop Summary Annual Plan
	Strategy – BoD timeout date to be agreed

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