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**The meeting of the Board of Directors held in public will take place on
Wednesday 28 September 2016 in the Boardroom, Harrogate District Hospital,
Lancaster Park Road, Harrogate, HG2 7SX
Start: 9.00am Finish: 12.45pm**

AGENDA			
Item No.	Item	Lead	Paper No.
8.30am Patient Story – IN PRIVATE			
9.00am – 11.00am			
Board Pre-brief Rapid Process Improvement Workshop Update		Mr D Plews, Deputy Director of Partnerships & Innovation	-
1.0	Welcome and Apologies for Absence <i>To receive any apologies for absence</i>	Mrs S Dodson, Chairman	-
2.0	Declarations of Interest and Register of Interests <i>To declare any interests relevant to the agenda and to receive any changes to the register of interests</i>	Mrs S Dodson, Chairman	2.0
3.0	Minutes of the Board of Directors meeting held on 27 July 2016 <i>To review and approve the minutes</i>	Mrs S Dodson, Chairman	3.0
4.0	Review Action Log and Matters Arising <i>To provide updates on progress of actions</i>	Mrs S Dodson, Chairman	4.0
Overview by the Chairman		Mrs S Dodson, Chairman	-
5.0	HDFT Vision, Mission and Objectives <i>To approve the revised narrative</i>	Dr R Tolcher, Chief Executive	5.0
6.0	Report by the Chief Executive <i>To receive the report for comment</i>	Dr R Tolcher, Chief Executive	6.0
6.1	Harrogate and District Sustainability and Transformation Plan Update <i>To receive the update for comment</i>	Dr R Tolcher, Chief Executive	6.1
7.0	Integrated Board Report <i>To receive the report for comment</i>	Dr R Tolcher, Chief Executive	7.0
8.0	Report by the Finance Director (including quarterly Cost Improvement Plan Update) <i>To receive the report for comment</i>	Mr J Coulter, Deputy Chief Executive/ Finance Director	8.0
11.00am – 11.10am – Break			
11.10am – 12.45pm			

9.0	Report from the Chief Operating Officer <i>To receive the report for comment</i>	Mr R Harrison, Chief Operating Officer	9.0
10.0	Report from the Chief Nurse <i>To receive the report for comment</i>	Mrs J Foster, Chief Nurse	10.0
11.0	Report from the Medical Director <i>To be considered for comment</i>	Dr D Scullion, Medical Director	11.0
12.0	Report by the Director of Workforce and Organisational Development <i>To receive the report for comment</i>	Mr P Marshall, Director of Workforce & Organisational Development	12.0
13.0	Oral Reports from Directorates 13.1 <i>Children's and County Wide Community Care</i> 13.2 <i>Long Term and Unscheduled Care</i> 13.3 <i>Planned and Surgical Care</i>	Dr N Lyth, Clinical Director Mr A Alldred, Clinical Director Dr K Johnson, Clinical Director	-
14.0	Committee Chair Reports 14.1 <i>To receive the report from the Quality Committee meetings held 3 August 2016 and 7 September 2016</i> 14.2 <i>To receive the report from the Finance Committee meeting held 5 September 2016</i> 14.3 <i>To receive the report from the Audit Committee meeting held 8 September 2016</i>	Mrs L Webster, Non-Executive Director/ Quality Committee Chair Mrs Maureen Taylor, Non-Executive Director/ Finance Committee Chair Mr Chris Thompson, Non-Executive Director/ Audit Committee Chair	14.1 14.2 -
15.0	Council of Governor meeting 18 May 2016 <i>To receive the minutes for information</i>	Mrs S Dodson, Chairman	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 <i>To receive an update on any matters of compliance:</i> 16.1 <i>To approve Annual Statement of Compliance for Revalidation</i> 16.2 <i>To approve the Emergency Preparedness Resilience and Response Core Standards self-assessment and statement of compliance</i> 16.3 <i>To approve the Procurement Transformation Plan</i> 16.4 <i>To approve the Treasury Management Policy</i>	Dr D Scullion, Medical Director Mr R Harrison, Chief Operating Officer Mr J Coulter, Deputy Chief Executive/Finance Director	16.1 16.2 16.3 16.4
17.0	Any other relevant business not included on the agenda <i>By permission of the Chairman</i>	Mrs S Dodson, Chairman	-
	Board Evaluation	Mrs S Dodson, Chairman	-
Confidential Motion – the Chairman to move: <i>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.</i>			

BOARD OF DIRECTORS – REGISTERED DECLARED INTERESTS

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

The register is maintained by the Foundation Trust Office.

Name	Position	Interests Declared
Mrs Sandra Dodson	Chairman	<ol style="list-style-type: none"> 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	<p>Specialist Adviser to the Care Quality Commission Member of NHS Employers Policy Board</p>
Mr Jonathan Coulter	Deputy Chief Executive/ Finance Director	None
Mrs Jill Foster	Chief Nurse	None
Mr Robert Harrison	Chief Operating Officer	<ol style="list-style-type: none"> 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	None
Mr Neil McLean	Non-Executive Director	<p>Director of:</p> <ul style="list-style-type: none"> - Northern Consortium UK Limited (Chairman) - Ahead Partnership (Holdings) Limited - Ahead Partnership Limited - Swinsty Fold Management Company Limited - Acumen for Enterprise Limited - Yorkshire Campaign Board Chair Maggie's Cancer Caring Centres Limited
Professor Sue Proctor	Non-Executive Director	<ol style="list-style-type: none"> 1. Director and owner of SR Proctor Consulting Ltd 2. Chair, Safeguarding Board, Diocese of York 3. Member – Council of University of Leeds 4. Member – Council of NHS Staff College (UCLH) 5. Associate – Good Governance Institute 6. Associate – Capsticks

Dr David Scullion	Medical Director	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
Mr Ian Ward	Non-Executive Director	1. Vice Chairman and Senior Independent Director of Charter Court Financial Services Limited, Charter Court Financial Services Group Limited, Exact Mortgage Experts Limited, Broadlands Financial Limited and Charter Mortgages Limited 2. Chairman of the Board Risk Committee and a member of the Remuneration and Nominations Committee, the Audit Committee and the Funding Contingent Committee for the organisations shown at 1 above 3. Director of Newcastle Building Society, and of its wholly owned subsidiary IT company – Newcastle Systems Management Limited 4. Member, Leeds Kirkgate Market Management Board
Mrs Lesley Webster	Non-Executive Director	None
Mr Andrew Alldred	Clinical Director UCCC	None
Dr Kat Johnson	Clinical Director EC	None
Dr Natalie Lyth	Clinical Director IC	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 W & OD	None
Mr Jordan McKie	Deputy Director	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 Performance and Infomatics	None

September 2016

Report Status: Open**BOARD OF DIRECTORS MEETING**

Minutes of the Board of Directors meeting held in public on Wednesday 27 July 2016 8.45am in the Boardroom, Trust Headquarters, Harrogate District Hospital

Present:

- Mrs Sandra Dodson, Chairman
- Dr Ros Tolcher, Chief Executive
- Mrs Jill Foster, Chief Nurse
- Dr David Scullion, Medical Director
- Mr Phillip Marshall, Director of Workforce and Organisational Development
- Mr Jordan McKie, Deputy Finance Director (*representing Mr J Coulter*)
- Mr Philip Sturdy, Deputy Director of Estates (*representing Mr R Harrison*)
- Mrs Beth Barron, Operational Director for Planned and Surgical Care Directorate (*representing Mr R Harrison*)
- Professor Sue Proctor, Non-Executive Director
- Mr Neil McLean, Non-Executive Director
- Mr Chris Thompson, Non-Executive Director
- Mr Ian Ward, Non-Executive Director
- Mrs Lesley Webster, Non-Executive Director

In attendance:

- Ms Debbie Henderson, Company Secretary
- Mrs Joanne Crewe, Operational Director for Long Term and Unscheduled Care (*representing Mr Andrew Alldred*)
- Dr Natalie Lyth, Clinical Director for Children's and County Wide Community Services
- Dr Kat Johnson, Clinical Director for Planned and Surgical Care
- Mr David Plews, Deputy Director of Partnerships and Innovation (*Board briefing only*)
- Mrs Annie McClusky, Matron – *Patient Story*
- Mrs X – *Patient Story*
- Mrs Jenny Child, Director of Infection Prevention and Control

Board Briefing – Clinical Transformation Board

Mr Plews and Mr McKie provided the Board with an update on progress of the Clinical Transformation Board Programme. Mr McKie discussed the impact of the programme in terms of supporting the efficiency challenge for the Trust and provided examples including reduction of length of stay.

The Board were provided with an update on projects which had been actioned as well as those which had been planned, and the challenges of implementing schemes and maintaining momentum was acknowledged. The Board also recognised the need to ensure that the Trust had the appropriate expertise in place to ensure schemes could progress from development stage to delivery. Mr McKie noted the increasing challenges around some of the transactional schemes.

In the context of the West Yorkshire Sustainability and Transformation Plan (WYSTP), Professor Proctor asked if a mechanism was in place to support shared learning across the system. Mr McKie noted that the system had started to establish various groups to focus on specific areas

including workforce and finance. Dr Tolcher reminded Board members of the shared ambition of the WYSTP to share and explore opportunities to replicate good practice within the footprint. Dr Tolcher also referred to the challenges relating to transformational change in terms of the transferability of methodology and applicability in different organisations.

Mrs Dodson thanked Mr Plews and Mr McKie for the update and congratulated the teams on progress of the programme, and confirmed that the Board would continue to receive regular updates on the work of the Clinical Transformation Board.

1. Welcome and Apologies for Absence

Apologies for absence had been received from Mrs Maureen Taylor (Non-Executive Director), Mr Jonathan Coulter (Deputy Chief Executive/ Finance Director) and Mr Robert Harrison (Chief Operating Officer).

Mrs Dodson welcomed three Governors to the meeting, Ms Amy Worsfold, Graduate Trainee Manager and Mr David Earl in his role as Deputy Medical Director.

2. Declarations of Interest and Board Register of Interests

There were no declarations of interest relevant to items on the agenda. Dr Scullion confirmed his membership of the 'Yorkshire' Radiology Group and asked for 'London' to be deleted from the Register and minutes.

3. Minutes of the meetings of the Board of Directors on 29 June 2016

The draft minutes of the meetings held 29 June 2016 were accepted as a true record, subject to the following amendment:

Paragraph 7.2 – Dr Tolcher requested the first sentence to be amended to state *“HaRD CCG colleagues had undertaken a high level Quality Impact Assessment based on an incomplete service specification”*.

APPROVED:

- **The Board of Directors approved the minutes of the meeting held 29 June 2016 as an accurate record of proceedings subject to the amendment to paragraph 7.2**

4. Review of Actions Schedule and Matters Arising

4.1 With regard to the completed action relating to a request for further information regarding health visiting for new born visits, Dr Lyth provided a verbal update to support a briefing circulated in advance of the meeting, and noted that the report highlighted the expected variation in outcomes for services commissioned in different areas. Mrs Dodson stated that the report provided important assurance that services were safe and further assurance would be provided as part of the Integrated Board Report.

4.2 Dr Tolcher also took an opportunity to advise the Board that the briefing reflected her personal observation on the flexibility of working shown by the teams within the service following an opportunity to shadow staff, Dr Tolcher commended the staff who continually worked within challenging, often highly emotive circumstances within the community.

4.3 Mrs Foster advised that an update on e-rostering would be provided within the Chief Nurse Report under item 11.

4.4. Dr Johnson provided a verbal update for action number 2 regarding inadequate clinical cover arrangements for planned leave in theatres, and noted that the annual leave arrangements were managed at departmental level and confirmed that during August, 14 theatre sessions would be closed due to theatre maintenance. Dr Johnson advised that discussions had commenced with regard to reviewing the approach to managing annual leave including the introduction of annualised job plans.

4.5 Mr Ward expressed disappointment that the issue remained a concern and no clear solution had been identified. Dr Johnson referred to issues of morale within the consultant body and the challenges with regard to reliance on consultants undertaking additional lists. Dr Scullion emphasised the importance of ensuring a balance between pragmatic approaches to the management of annual leave and commitment to the achievement of the Trust's objectives. Dr Scullion had circulated proposals regarding the management of annual leave.

4.6 Mr McLean suggested that the concerning issue remained a sense of lack of commitment to support the Trust in achieving its objectives. Dr Tolcher reminded members of the Board that it remained the responsibility of the senior management team to manage leave appropriately, and noted that historically the Trust had relied on staff working over and above contracted hours to deliver the service required and this should be recognised. Dr Scullion confirmed that the issue would continue to be monitored and the Board would be kept informed on progress.

There were no other matters arising.

Overview by the Chairman

Mrs Dodson confirmed receipt of the Care Quality Commission (CQC) report which was available on the CQC website. Mrs Dodson was delighted to reflect on a strong and affirming report which confirmed a rating of 'good' overall. Mrs Dodson particularly highlighted the incredible achievement of a rating of 'outstanding' for the caring domain, and stated that it was a fitting tribute to all of the staff who delivered outstanding care, every day.

Mrs Dodson also acknowledged the 'outstanding' rating for: critical care; outpatients and diagnostic imaging; community health services for adults; and community health dental services. On behalf of the Board, Mrs Dodson took an opportunity to thank all members of staff across the Trust for their continued hard work and dedication to the delivery of high quality care.

Mrs Dodson outlined the overarching themes for the meeting, as identified by the Non-Executive Directors as; in-year delivery of financial performance to achieve the Trust's control total; actions to increase elective activity to help achieve financial performance; and ensuring the right staff, in the right place, at the right time to deliver services.

5. Report by the Chief Executive

Dr Tolcher presented the report which had been circulated in advance of the meeting and was taken as read.

5.1 Dr Tolcher provided an update on the contractual negotiations with Harrogate and Rural District CCG (HaRD CCG). With regard to the acute contract an outstanding issue remained in respect of funding underpinning systems resilience (SRG). Dr Tolcher noted that performance in 2015/16 had relied upon £480k income related to SRG funding which would not be available to the Trust for 2016/17. Discussions would continue with commissioners to explore options of ensuring achievement of performance with less resource. Should actual activity deviate by more than 2% from commissioned activity, the terms of the National Contract would trigger dialogue

and resolutions. Dr Tolcher noted the specific risk relating to the A&E 4 hour waiting time standard and emergency department performance and safe delivery of care, particularly at evening and weekends. The matter would be managed via contract management meetings.

5.2 With regard to the community contract, a Quality Impact Assessment meeting took place to review the service schedule on 7 July. Dr Tolcher reflected on the purpose of the meeting, to provide an opportunity to review the proposed schedule and receive confidence with regard to the accepted levels of risk related to patient care and safeguards for staff, to allow the Trust and commissioners to mobilise the proposed contract. The meeting specifically provided an opportunity to review the risks associated with capacity and workforce. Following verbal agreement in the meeting, commissioners have been asked to formally agree to the acceptance of the risks at which stage, mobilisation could commence.

5.3 Dr Tolcher provided the Board with an update on the criteria for allocation of the national Sustainability and Transformation (S&T) Funding, and emphasised the focus on financial performance to achieve the full allocation.

5.4 An update on progress of the development of the WYSTP confirmed that it continued at pace. Following submission of the draft plan on 30 June, a meeting had taken place with the WY Leadership Team and Chief Executives of NHS England and NHS Improvement (Arms' Length Bodies) in July to receive feedback. Dr Tolcher confirmed that West Yorkshire Association of Acute Trusts (WYAAT) Chief Executive's had commissioned external support TO help develop the case for changes and inform the final plan prior to submission by 30 September. Mr Coulter had been identified as one of two Finance Director leads' responsible for oversight of this work.

5.5. Dr Tolcher also referred to correspondence received by all Trusts from NHS Improvement regarding the sustainability of clinical services, back office functions and pathology services. Mr Robert Harrison had been invited to attend a session on 27 July to discuss proposals in further detail.

5.6 Dr Tolcher recapped on the outcome of the CQC report and made particular reference to the rating of 'outstanding' for four core services and the caring domain overall. Dr Tolcher also noted that a majority of Trust services were rated as 'good' and staff should be commended across the Trust.

5.7 Dr Tolcher noted that the report identified areas at service level where the Trust were yet to reach a level of 'good' and acknowledged the commitment to ensure these areas would be addressed moving forward. The Board were reminded that the report did not reveal any issues which had not been previously identified by the Trust, particularly with regard to the 'safety' domain which received a 'requires improvement' rating overall. There had been no evidence of harm to patients and Dr Tolcher urged the Board to use the 'requires improvement' rating as an early warning indicator to focus on the improvement of care delivery going forward.

5.8 Dr Tolcher took an opportunity to specifically thank Dr Sylvia Wood, Deputy Director of Governance, Mr Michael England, Governance Officer and Mrs Jill Foster, Chief Nurse for their leadership of the process and to Governors and members of the public who took time to contribute their views. Mrs Dodson reflected on the diligence and professionalism of the team. Dr Tolcher reminded members of the Board that the CQC Quality Summit would take place on Friday 29 July to allow the Trust to clarify the next steps on the improvement journey.

5.9 Professor Proctor asked if the Trust had appropriate mechanisms in place to capitalise on opportunities to communicate the CQC outcome. Dr Tolcher and Mrs Dodson noted that a proactive communication plan was in place. Mr McLean suggested expanding communication of the outcome on a national as well as a local platform to help encourage recruitment and promote

the Trust as an employer of choice. Dr Lyth also suggested sharing the report and outcomes with the Trust's commissioners in the County Durham, Darlington and Middlesbrough footprint.

5.10 Mr Ward asked if information was available nationally to enable the Trust to benchmark its position. Dr Tolcher advised that less than half of acute Trusts had received a 'good' rating and approximately five Trusts had received an 'outstanding' rating. Mrs Foster also confirmed that the CQC were planning to publish a 'state of the nation' document which would enable the Trust to benchmark its position.

5.11 Dr Tolcher noted that the work of the Clinical Board continued to progress and referred to the three parallel 100 day workstreams, with a view to supporting CCGs in reducing elective care spend.

5.12 With regard to the quarter 1 2016/17 financial position, Dr Tolcher confirmed that the Trust delivered a year-to-date planned surplus of 165k. Dr Tolcher informed members of the Board that the Trust had taken a different approach to the application of contingency funds for the period in order to ensure attainment of the S&T national funding for quarter 1. Dr Tolcher and Mr McKie provided assurance to the Board that the approach taken had been in line with appropriate accounting procedures.

5.13 Dr Tolcher reported an underspend in respect of pay, but also reported a shortfall in income with some Cost Improvement Programme (CIP) schemes progressing slowly. In summary, the Trust reported a strong quarter 1 position in comparison to quarter 1 2015/16, however, she emphasised that financial performance remained a significant risk for the Trust and a continued focus on financial performance was required, particularly in terms of controls on expenditure, optimising income and managing the shortfall in CIP.

5.14 Mr Thompson supported the Trust's decision to take an alternative approach to managing contingency funds in the best interest of the Trust in the longer term, and suggested it had been consistent with the intention of the regulators.

5.15 Mr Ward noted that the income shortfall appeared higher when compared to quarter 1 2015/16. Mr McKie confirmed that acute income, although behind plan, was 5% ahead when compared to 2015/16 and reminded Board members of the impact of challenges in quarter 1 including the agency cap, and junior doctor industrial action. Mr McKie also confirmed that the S&T national funding secured in quarter 1 was now protected as part of the process to release funds on a quarterly basis.

5.16 Mr McLean referred to the management and reporting of contingency funds and asked if there could be consequences in the future in terms of regulation. Dr Tolcher and Mr McKie advised the Board that there would be a quarter 1 review with NHS Improvement which would provide an opportunity to discuss any concerns, however, both were of the opinion that there would be no regulatory consequences to the approach taken. Mr McKie also confirmed that other providers had taken a similar approach.

5.17 Dr Tolcher asked Board members to remain focused on the need to achieve £2.2m planned surplus at the year-end and took an opportunity to be clear that the Trust had taken a legitimate and transparent approach to the management and reporting of the accounts for quarter 1.

5.18 Professor Proctor suggested the Board receive an update in September on the outcome of the NHS Improvement consultation of the Single Oversight Framework, and any impact on the Trust.

5.19 Dr Tolcher referred to the request for the Board to note the formal lease agreement between the Trust and York Teaching Hospitals NHS Trust (YTHT) for the occupation of accommodation on the first floor of Heatherdene for the provision of Contraception and Sexual Health (CaSH), and Genito Urinary Medicine (GUM) services. The lease would be signed by Dr Tolcher and Mrs Dodson under the auspices of the Trust's seal.

5.20 Dr Tolcher referred to changes to the Corporate Risk Register and reductions in the risk score of risks CR5, CR7, and CR8. Dr Tolcher took an opportunity to thank staff for their efforts in achieving the mitigation of risk. The Board also noted an increase in the risk score for CR11.

ACTION

- **An update on the NHS Improvement consultation and proposals for a Single Oversight Framework to be provided to the September Board meeting**

APPROVED:

- **The Board of Directors noted the formal lease agreement between the Trust and YTHT for the occupation of accommodation on the first floor of Heatherdene and approved delegation for signing of the lease to Dr Ros Tolcher, Chief Executive and Mrs Sandra Dodson, Chairman under the requirements of the Trust Seal.**

6. Performance Against Strategic Key Performance Indicators

Dr Tolcher presented the report which had been circulated in advance of the meeting and was taken as read.

6.1 Mrs Dodson referred to the meeting of the Shadow Board on 25 July at which the report had been considered alongside the Integrated Board Report (IBR). Mrs Dodson had found the discussions insightful and it was noted that the report continued to be developed and the Board agreed that a refresh was required in order to be clear about the purpose and value of the report. Mrs Dodson suggested that the Shadow Board could be used as a sounding board for the purpose of reviewing the report.

6.2 Dr Tolcher agreed to a review of the presentation of the Trust's Strategic Key Performance indicators (KPIs) and the need to identify suitable indicators to demonstrate progress to achieving the Trust's vision and ambition. Dr Tolcher noted that a discussion took place at the Executive Away Day on 22 July regarding redefining the Trust's goals to include the larger footprint and ambition for the Trust, i.e., children's services, research and development, workforce, and the private patient income strategy. It was agreed that the executive team would review the Strategic KPIs and submit a proposal to the October Board for approval.

ACTION

- **Undertake a review of the Strategic Key Performance Indicators and submit a proposal to the October meeting of the Board for approval, giving consideration to input from the Shadow Board**

7. Patient Story

Mrs X attended the Board meeting to share her experience as the carer of her late mother, during her mother's time as a patient with the Trust. The detail of the patient story was shared with the Board.

7.1 Mrs Dodson thanked Mrs X for attending the Board and sharing a very emotional experience. Dr Tolcher reflected back on the lapses of care during the patient's time with the Trust and emphasised the learning relating to ensuring patients' care was delivered in the right place at the right time.

7.2 Dr Scullion expressed concern at the lack of consideration given to the opinions of carers and relatives and highlighted the need to ensure staff understood the importance and value of listening to and respecting their views. It was acknowledged that further training and awareness was required in this area.

7.3 Mrs Crewe also highlighted the importance of considering those patients who do not have family or visitors to speak on their behalf.

7.4 Mrs Webster reminded the Board of the 2015/16 quality objective around communication and an initiative to make it easy for people to raise issues, and asked that the Trust ensure the objective remained a priority to improve the capability of the workforce to listen to, and respond to families and carers appropriately.

7.5 Mrs Foster referred to the importance of continuing to develop strong leadership at ward level and noted the patient story as affirmation of the need to maintain good leadership and ensure the right staffing levels on the wards.

7.6 Dr Lyth emphasised the importance of a fresh pair of eyes in terms of making one diagnosis and ensuring other symptoms are taken into consideration. Dr Lyth also raised the importance of being non-judgmental and taking into account the personal circumstances of families and carers.

7.7 Professor Proctor referred to the Trust's commitment to learning from patient experience and suggested the same level of attention be considered with regard to 'carer' experience. Mrs Dodson also suggested using mechanisms such as the volunteering service to support those patients who do not have the support of families and carers.

The Board thanked Mrs X for attending the meeting and sharing her story with the Board.

8. Integrated Board Report (IBR)

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

8.1 Mrs Webster referred to the removal of Sepsis as a national CQUIN indicator for 2016/17 and asked how this would be monitored as one of the Trust's quality objectives for the year. Mrs Foster confirmed that performance would be monitored on a quarterly basis via the Quality Committee and updates would also be provided in the Medical Director's Board report.

8.2 Mr Ward referred to staff appraisal rates and stated that very little assurance could be taken from the information provided, and asked for an update detailing the actions to be taken to achieve 90% compliance by December. Dr Tolcher agreed that performance had been disappointing and the narrative did not reflect the significant amount of work which had been undertaken. The Senior Management Team had a clear focus on improvement and compliance had been included within individual objectives of those responsible for undertaking appraisals. Dr Johnson also stated that the focus had been acknowledged at directorate level.

8.3 Mr Thompson commended the improvement relating to staff turnover rates, however noted the increase in sickness rates and asked if more contemporary information was available regionally to benchmark performance. Dr Tolcher noted that the primary reason for sickness

absence related to stress and anxiety and peer organisations had noted a similar increase. Mr Marshall confirmed that the Trust's sickness absence rate remained below the regional average and reassured members of the Board that actions were underway to address persistent short term absence. The Trust continued to roll out resilience training to support staff and further efforts had been put in place to promote the awareness of the wellness programme across the Trust.

8.4 Mrs Dodson asked if specific areas had been identified with high levels of sickness absence relating to stress and anxiety. Mr Marshall suggested that cases were consistent across the Trust but advised that work had commenced to review the quarter 1 Staff Friends and Family Test narrative to gain further insight into issues for staff. Mrs Dodson asked for a brief update on the outcome of the review at the September meeting of the Board.

8.5 Professor Proctor referred to staff appraisals and noted that Children's Services staff had not been included. Mr Marshall confirmed that the process of data cleansing would be complete and information would be included from September. Dr Lyth confirmed that due diligence suggested a positive position for the service.

8.6 Mr Marshall confirmed that a positive response had been received following e-mail communication regarding appraisals, and noted that discussions were taking place with Trade Union colleagues to explore options to include appraisal compliance in the criteria for pay progression for managers.

8.7 Referring to falls resulting in harm, Professor Proctor acknowledged the relatively low numbers, but requested assurance following the increase in June. In comparison to quarter 1 2015/16 Mrs Foster confirmed that there had been a 20% reduction in falls resulting in harm and noted that of the five such falls during 2016/17 year to date, only one had resulted in a fracture compared to six for the same period in 2015/16.

8.8 Mrs Crewe referred again to staff appraisals and emphasised the need to ensure that appraisals are of a good quality. In relation to sickness absence, Mrs Crewe provided assurance on behalf of the directorates that data had been scrutinised at directorate board level including the identification of areas as potential hotspots for review.

8.9 With regard to reducing readmissions in older people, Mr McLean acknowledged the work ongoing and asked when information would be available to monitor progress. Mrs Barron confirmed that a case note review had commenced and a further report would be available for the September Board.

8.10 Mrs Dodson referred to the variation in performance in Children's Services and commissioning. Dr Lyth stated that the variation related to areas of greater social deprivation and the associated requirement for higher staffing ratios and smaller caseloads. Dr Lyth stated the data required further scrutiny to ensure the efficient and effective delivery of the service.

8.11 As Non-Executive Director lead for Children's Services, Mr McLean referred to the target for new birth visits by the Health Visiting team within 14 days of birth, and noted that whilst the commissioners were satisfied with performance, a target had yet to be identified. Dr Lyth confirmed that commissioners had agreed to analyse data of current performance prior to identifying targets. Dr Tolcher requested assurance that the Trust would not be subject to any penalties associated with the contract as a result of having no threshold in place. Dr Lyth confirmed that no such penalties existed in the contract.

8.12 With regard to mandatory training rates, Mrs Webster noted current compliance rates at 89% and 79% for Information Governance (IG) training and asked if these were reasonable

levels to support the IG Toolkit submission of 84% as identified within the Chief Operating Officers report. Mrs Webster also asked whether the Trust would consider the application of an internal stretch target with regard to IG training. Mr Sturdy agreed to seek clarity in Mr Harrison's absence with regard to the requirements of the IG Toolkit and Dr Tolcher's opinion was that a stretch target would not be required as there was no evidence to suggest that IG reflected an area of concern or high risk for the Trust at the current time.

ACTION:

- **An update on the review of the Staff Friends and Family Test narrative outcome for quarter 1 to be provided to the September meeting of the Board.**
- **A further update on reducing readmissions in older people to be submitted to the September meeting of the Board.**
- **Assurance to be sought from the contracts team that no penalties associated with the contract could be implemented as a result of having no threshold target in place for new birth visits by the Health Visiting team within 14 days of birth.**
- **Clarity to be sought to ensure that the current compliance rates for Information Governance Mandatory training support the requirements of the July Information Toolkit submission.**

9. Report from the Chief Operating Officer

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

9.1 Mrs Barron highlighted the positive feedback from the National Cancer Patient Experience Survey noting that the Trust was ranked third out of 146 Trusts achieving an average score of 80%.

9.2 As part of the transfer of Children's Services from County Durham and Darlington NHS Foundation Trust (CDDFT), Mrs Barron noted that the former verbal agreement to transfer the role of Named Nurse for Child Protection would not be honoured. Contingency plans would be implemented until an appointment could be made including utilisation of named nurses from other localities to ensure activities are being completed in the interim.

9.3 In response to a request for assurance from Mr McLean regarding the safety of the service in the interim, Dr Lyth expressed her confidence that services would remain safe in the interim and confirmed that an appointment had been made.

9.4 Mrs Barron referred to positive progress on the elective care rapid testing programme in collaboration with commissioners, and reminded Board members of its purpose to: improve referral accuracy; reduce the need for multiple hospital appointments; improve use of technology; reduce unnecessary outpatient appointments; increase shared decision-making; and improve patient experience, choice and outcomes.

9.5 Mr Ward suggested that improvements could be made to the narrative to enhance the Board's understanding of the projected position, any areas of concern looking forward and assurance of plans in place to address low areas of activity. Dr Johnson confirmed that the adverse activity levels in theatres had been due to a lack of anaesthetist staff, and confirmed that recruitment would commence in October to improve levels of activity. Mrs Barron confirmed a significant amount of work had been undertaken at directorate level, with input from clinicians, to address issues of reducing activity levels. Mr McKie suggested that further work be undertaken to triangulate information for Board members in terms of activity and income variance.

9.6 In the context of service activity and the low level of responses from the Leeds CCG survey, Mr Thompson suggested that further work be undertaken to market the Trust in the Leeds area. Mr Thompson also noted that the Trust remained strong at maintaining agency spend within the cap, but was concerned that other Trusts were not taking a similar approach. Dr Tolcher confirmed that the Trust had adjusted its approach and a further update would be provided in the confidential session of the Board.

9.7 Mrs Webster referred to service activity information within the report and requested an interim report regarding the reduction in activity and associated recovery plans. Although the Board agreed to receive detailed information at Board by exception, Mrs Dodson agreed that service activity was key to the Trust's performance therefore the additional report would be appropriate.

9.8 The Board were asked to approve the Information Governance Toolkit baseline of 84% compliance for the July submission.

9.9 The Board were asked to approve the Governance declaration as 'Green' against Monitor's Risk Assessment Framework for Quarter One.

ACTION:

- **Assurance to be provided to the Board relating to service activity and recovery plans.**

APPROVE:

- **The Board of Directors approved the Information Governance Toolkit baseline submission of 84% compliance for July**
- **The Board of Directors approved the Governance declaration as 'Green' against Monitor's Risk Assessment Framework for Quarter One**

10. Report by the Director of Finance

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

10.1 Mr McKie noted that whilst the Trust had delivered the quarter 1 financial control total and would receive the S&T funding for quarter 1, the operational budgetary position remained at over £600k behind plan.

10.2 Pay expenditure remained at a favourable variance to date with ward nursing continuing to be the major adverse variance and Mr McKie confirmed that actions were in place to address the areas of overspend.

10.3 Mr McKie made particular reference to the adverse variance relating to CIP which had been due to plans not being actioned. Mr McKie reassured members of the Board that CIP achievement remained a key area of focus for all directorates.

10.4 The Trust reported a cash balance of £12m behind plan predominantly due to the changes in profile following agreement of the acute contract with HaRD CCG. As a result of the contract agreement the planned cash profile would be revised for the next report.

10.5 Mr McKie summarised that the Trust's financial performance for June resulted in a Financial Sustainability Risk Rating (FSRR) of 4, and confirmed that the Trust would maintain a FSRR of at least 3 over the next 12 months.

10.6 In response to a query from Mr McLean, Mr McKie confirmed that the Trust continued to be paid for delivery of the community contract. Dr Tolcher confirmed that the Trust had entered into an implied contract due to the ongoing negotiations relating to the community services contract for 2016/17.

10.7 The Board were asked to approve the Financial Sustainability Risk Rating submission of '4' against Monitor's Risk Assessment Framework for quarter 1.

APPROVE:

- **The Board approved the Financial Sustainability Risk Rating submission of '4' against Monitor's Risk Assessment Framework for quarter 1**

11. Report from the Chief Nurse

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

11.1 Mrs Foster referred to the Director inspections and the areas with a risk rating of 'Red' relating to cannula care. Mrs Foster confirmed that work was ongoing to ensure compliance with policies and procedures and an update following the Internal Audit limited assurance report would be presented to the Audit Committee meeting in September.

11.2 Dr Tolcher confirmed that the issue relating to non-compliant chairs in the treatment room and waiting room in the Medical Day Unit had been resolved. On behalf of Mrs Maureen Taylor, Non-Executive Director, Mrs Dodson referred to comments made regarding Computers on Wheels (COWs). Dr Scullion noted that an issue had been raised regarding use of equipment and work was in hand to develop a programme to support staff using the equipment.

11.3 Mrs Foster referred to the continued downward trend in the number of complaints, but referring to the patient story, emphasised the need to avoid complacency and drive forward the vision of delivering personalised care, in the right place, at the right time.

11.4 Mrs Foster provided an update on current staffing levels and informed the Board that activity remained high and staff continued to experience pressure particularly on the medical wards. Following a review, it had been forecast that 20 vacancies on in-patient wards would remain by mid-October, equating to one member of staff per shift. Mrs Foster noted that the Trust was committed to continuing the recruitment campaigns including: using the CQC outcome in recruitment material; a recruitment event to coincide with the Trust's Open Day in September; EU recruitment initiative; and the Glasgow recruitment event in October.

11.5 Mrs Foster reported on actual versus planned staffing and highlighted that the figures disguised the heroic efforts of senior staff to ensure appropriate staffing levels were in place. Mrs Foster confirmed that risks continued to be managed as appropriate and had not resulted in patient harm.

11.6 Mr Marshall provided the Board with an update on his recent visit to India to support the development of the partnership with Health Education England (HEE) regarding commissioning for the future workforce via the establishment of a global health exchange programme. Mr Marshall highlighted the benefits for both health economies and Mrs Dodson congratulated Mr Marshall and highlighted the development as supporting the sustainability of the Trust's plans for the future workforce.

11.7 Dr Johnson noted that concern had been raised at the Quality and Governance meeting at directorate level regarding low staff morale and the challenges faced by members of staff relating to accessibility to training.

11.8 Professor Proctor referred to the Clinical Transformation Board briefing and opportunities to share clinical best practice across the West Yorkshire footprint and asked how the insight gained from the partnership with HEE would be shared. Mr Marshall confirmed the intention to share learning and outcomes with the WYAAT. Dr Tolcher also reminded Board members of her role as lead for the Local Workforce Action Board (LWAB) on behalf of the West Yorkshire STP and noted the partnership had been acknowledged as having great potential for replicability. Professor Proctor suggested that WYAAT nominate a Director Lead for nursing and Dr Tolcher agreed to put forward the suggestion for discussion with WYAAT Chief Executive colleagues.

11.9 Professor Proctor referred to the development of a mandatory training programme for nursing and domestic staff and asked if consideration had been given to the impact of an additional requirement for mandatory training, given the challenges currently being experienced in terms of capacity to undertake current training programmes. Mrs Foster confirmed that the programme would be used to enhance current training and would not represent an additional requirement on staff time.

11.10 Mrs Foster confirmed that metrics relating to e-rostering update would be included in the report from September.

ACTION:

- **The suggestion to nominate a Director lead for Nursing for WYAAT to be taken forward for discussion at the next WYAAT CEO meeting**
- **E-rostering implementation update to be included in the September Chief Nurse report**

11.1 Infection Prevention and Control Annual Report 2015/16

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

11.1.1 Mrs Child delivered a presentation to the Board on Clostridium Difficile cases throughout 2015/16. Dr Tolcher referred to Barnsley NHS Foundation Trust and suggested that contact be made to explore shared learning of prevention.

11.1.2 Mrs Foster referred to targets used to reduce harm including Clostridium Difficile, pressure ulcers and falls and stated that where reliable comparisons cannot be made, the Trust should endeavour to improve its own performance year-on-year.

11.1.3 Dr Tolcher referred to the Annual Report and the HCAI (Healthcare Associated Infections) plan to introduce legionella water testing as per national guidelines and sought assurances that the Trust was already undertaking testing. Mr Sturdy confirmed that the Trust were currently compliant with guidelines and were exploring best practice from other Trusts. It was agreed to clarify the Trust's current level of compliance with Mr Harrison on his return.

11.1.4 Mrs Webster thanked Mrs Child for the update on Clostridium Difficile given the recent concerns raised by the Board and confirmed that the quarterly Infection Control report was scheduled for review by the Quality Committee. Mrs Webster suggested that an opportunity be taken to triangulate issues from the Annual Report to enable a broader view of actions to be taken to address Infection Prevention and Control across the Trust i.e., E. coli.

ACTION:

- **Provide confirmation of the Trust's current compliance with legionella water testing**

12. Report from the Medical Director

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

12.1 Dr Scullion confirmed that an appointment had been made to the Consultant Histopathologist post.

12.2 With regard to the National Emergency Laparotomy Audit and the 'red' rating of medical care of the elderly input to acute surgical services, Dr Earl confirmed that the audit did not highlight any unexpected outcomes, and Dr Scullion noted that the numbers included in the audit had been relatively small, and provided assurance that there were no areas of significant concern.

12.1 Responsible Officer Appointment

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

12.1.1 Dr Scullion noted that Dr Gray had resigned as the Trust's Responsible Officer due to a decision to undertake an alternative corporate role for the Trust. Dr Scullion confirmed that the statutory role of Responsible Officer was a Board appointment which must be recorded and reported to NHS England and the General Medical Council. The Board of Directors were asked to approve the appointment of Mr David Lavalette, Consultant Orthopaedic Surgeon, as the Trust's Responsible Officer.

12.1.2 In response to a query from Dr Tolcher as to whether there would be a financial impact as a result of the proposal, Dr Scullion confirmed that the changes would result in a marginal saving for the Trust.

12.1.3 Mr Ward asked if the Trust was required to undertake a competitive process and externally advertise the role. Dr Scullion confirmed that Mr Lavalette was appointed initially as Assistant Responsible Officer/Responsible Officer Designate with succession in mind. Dr Lyth suggested that a process commence to recruit to the Assistant Responsible Officer role to ensure continuation of appropriate succession planning in the future.

12.1.4 The Board was asked to approve the appointment of Mr David Lavalette as Responsible Officer for Harrogate and District NHS Foundation Trust.

APPROVAL

- **The Board approved the appointment of Mr David Lavalette as Responsible Officer for Harrogate and District NHS Foundation Trust**

13. Report by the Director of Workforce and Organisational Development

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

13.1 Mr Marshall referred to the recent visit to India with colleagues from other Health organisations and HEE to develop the Global Health Exchange Programme. HEE had agreed to establish an international education exchange scheme with the Apollo Group in India, and the University of Salford, with an ambition to recruit registered nurses from India to work in England

and develop their nurse education and skills. Upon completion of the programme, the registered nurses would return to India to utilise their skills and further develop the Indian health economy.

13.2 Mr Marshall informed the Board of the CQC's appointment of Dr Henrietta Hughes, as the National Freedom to Speak Up Guardian. A proposal for the appointment of the Trust's Freedom to Speak Up Guardian would be submitted to Director Team for discussion in September and subsequently to the Board of Directors in due course.

13.3 Professor Proctor briefed the Board following her attendance at a NHS Providers conference on Freedom to Speak Up Guardians and confirmed that 57 Trusts had appointed to the post using a variety of approaches. Professor Proctor had asked for further information on key performance indicators the CQC would require relating to oversight and it was acknowledged that further work was required in this regard. It was acknowledged that the role would provide independent and impartial information to the Board about concerns being raised from the clinical workforce and Professor Proctor offered to work with Mr Marshall on development of the policy.

13.4 Dr Tolcher took an opportunity to state that the Trust had in place a strong open and transparent culture, which had been supported by the CQC report and systems and processes already in place within the Trust's existing frameworks. Dr Tolcher asked that a pragmatic approach be taken with regard to an appropriate and proportionate level of resource to manage the requirements relating to the policy and role.

13.5 Mr Marshall noted that further work had been undertaken to develop the Clinical Workforce Strategy which would ensure a continued focus on establishing alternative clinical roles to support the future workforce.

13.6 Mrs Webster referred to the WYSTP and asked how collaboration with other providers could help to address workforce issues across the system. Dr Tolcher suggested the need for a fundamental review of responsibilities of doctors in training, and opportunities to explore cost effective ways to undertake key tasks. Key work programmes would be set up to look at workforce issues in more detail via the LWAB.

ACTION:

- **A proposal for the appointment of the Trust's Freedom to Speak Up Guardian to be submitted to the Board of Directors in due course**

14. Oral Reports from Directorates

Long Term and Unscheduled Care

14.1 Mrs Crewe referred to a significant number of senior vacancies within the directorate which continued to be discussed with the senior team, particularly with regard to the impact on the delivery of the transformation change programme.

14.2 With regard to End of Life Care, benchmarking had been undertaken and it was acknowledged that work had commenced across the partnership to take forward recommendations and actions.

14.3 Mrs Crewe reassured Board members that the Directorate had taken a refreshed approach to discharge following the initial meeting of the Partnership Strategy Group. The Group would also establish workstreams to ensure alignment to the new Discharge Policy.

14.4 Mrs Crewe referred to the implementation of work with assisted technology in community services and briefed the Board on a visit to Airedale to learn from best practice, particularly in care homes.

Planned and Surgical Care

14.5 Dr Johnson referred to medical workforce and staffing issues resulting in challenges to meet the Best Practice Tariff. The Long Term and Unscheduled Care directorate would continue to provide support. A recruitment process had commenced for a middle grade post following the unsuccessful recruitment of the consultant post in elderly care.

14.6 Dr Johnson also highlighted medical staffing issues in the gastroenterology service, including issues relating to the challenges in securing locum cover, and lack of ownership within the department. The team had been selected to take part in the elective care rapid testing programme to reduce demand and improve capacity for patients who need to be seen. Orthopaedic and Dermatology Services were also involved in the programme to reduce demand for follow-up appointments.

14.7 Dr Johnson raised concern regarding nurse staffing and noted the closure of the Harlow Suite due to the inability to maintain staffing levels across the wards. Appropriate actions had been identified including the opportunity to develop an orthopaedic unit.

14.8 Dr Johnson informed the Board that Mrs Beth Barron would commence her maternity leave in October and Mr Jonny Hammond, General Manager, would be acting up into the Operational Director post.

Children's and County Wide Community Services

14.9 Dr Lyth referred to the Trust's decision not to re-tender for the Wheelchair service, and the challenges which continued to be experienced by the team in terms of the provision of wheelchairs in excess of the budget available. The General Manager continued to work closely with the CCG to re-set indicative budgets and ensuring clarity regarding backlogs.

14.10 The Board were informed of an increased level of activity in the Special Care Baby Unit and Dr Lyth noted that the directorate would work closely with the Planned and Surgical Care Directorate to establish an agreed escalation policy.

14.11 Following a significant level of re-tendering opportunities, Dr Lyth highlighted the value of clinical expertise and input into the tender process.

14.12 Dr Lyth briefed the Board on a 'Putting Feet First' event in the Podiatry service. The event was well attended and resulted in potential interest from the BBC who would consider an inside out documentary on diabetes and amputation.

14.13 With regard to TACCORD (prompt to review and record Thromboprophylaxis, Antibiotics, Cannula, Catheter, Oxygen, Resuscitation status and Dementia screening) Dr Lyth confirmed that the paediatric team would look explore the introduction of a mnemonic to assist reflection by staff every day.

14.14 Mr Thompson referred to the information contained in the IBR relating to equipment deliveries and asked if information could be included on wheelchairs to help gain further understanding of the degree of delay and impact. Dr Lyth queried the value of including the information in the IBR at such a late stage and suggested a short briefing for the Board would be more appropriate.

ACTION:

- **Briefing on activity and equipment within the wheelchair service to be submitted to the Board for information**

15. Committee Chair Reports

Report from the Quality Committee meeting held 6 July 2016

Mrs Webster report had been circulated in advance of the meeting and was taken as read.

15.1 Mrs Webster referred to concerns raised by the committee regarding timely completion of action plans relating to complaints, and confirmed that strong assurance had been received in terms of the focus of directorates on completing plans within agreed timescales. Directorates had also acknowledged the need for appropriate and realistic actions and timescales. The Learning from Patient Experience Group would monitor progress on a quarterly basis.

15.2 Mrs Webster referred to the previous request from the Board that the committee provide monitoring and oversight relating to pressure ulcers, and noted that the base line for beginning to measure the reduction in avoidable cases in the community had been confirmed.

15.3 In terms of significant risk to be escalated to the Board, Mrs Webster noted the continued lack of assurance in respect of record keeping in specific areas of care. The committee would continue to maintain focus and seek assurance from Directorates.

16. Matters relating to compliance with the Trust's Licence or other exceptional items to report.

Mrs Dodson reminded the Board of the approvals given earlier in the meeting under section 9.9 and 10.7 as follows:

- Approval of the Governance declaration as 'Green' against Monitor's Risk Assessment Framework for Quarter One.
- Approval of the Financial Sustainability Risk Rating submission of '4' against Monitor's Risk Assessment Framework for quarter 1.

There were no other matters relating to compliance with the Trust's Licence or other exceptional items to report.

17. Any other relevant business not included on the agenda

17.1 Mr Thompson provided the Board with a verbal update following an extraordinary meeting of the Audit Committee held on 5 July, the purpose of which was to receive further assurance following a number of Internal Audit reports with a limited assurance rating. Mr Thompson informed the Board that the committee received strong assurance on progress made against recommendations and that a further update on the Internal Audit report relating to discharge planning would be provided at the September meeting of the committee.

17.2 Mr Thompson took an opportunity to thank Dr Tolcher for improving and maintaining the focus of Internal Audit outcomes at Senior Management Team level.

17.3 Mrs Dodson noted that the meeting was the last meeting for Mrs Crewe in her role as Operational Director for Long Term and Unscheduled Care, and took an opportunity, on behalf of

the Board, to thank Mrs Crewe for her hard work and dedication during her time with the Trust. Mrs Dodson wished her well in her new role.

There being no other business, Mrs Dodson declared the meeting closed.

18. Board Evaluation

18.1 Mrs Dodson informed that Board that during the summer period, a review of report preparation would be undertaken with a particular focus on improving the use of Executive Summary cover reports. Ms Henderson would work with Board colleagues to during August.

18.2 Mrs Webster thanked members of the Director team for providing clarity regarding the financial position and accounting approach for the period, particularly in relation to S&T Funding.

18.3 Mr McLean referred to the patient story and stated that it provided a good to balance between very high quality care as demonstrated by the CQC report, and very poor quality care, highlighting the vulnerability of the health service.

18.4 Mrs Dodson provided an update following the final Shadow Board meeting held on 25 July and reminded the Board of the purpose of the group to educate and develop senior leaders and succession plan for the future. Members of the Shadow Board would provide feedback on the programme at the Board development session in September.

18.5 Mrs Dodson stated that it had been a privilege to participate as Chair of the Shadow Board and made particular reference to the remarkable desire of the group to develop from their individual portfolios to an ability to think strategically at board level. Mrs Dodson thanked Non-Executive Director colleagues for their agreement to continue to support the programme by providing mentorship to group members for a limited period. Mrs Dodson wished all Shadow Board members well in their future development. As members of the Shadow Board, Mr McKie and Mr Sturdy thanked Mrs Dodson for her support for the programme and the time invested by other members of the Board.

ACTION:

- **Review of Executive Summary Reports to be undertaken during the summer period**
- **Shadow Board members to provide feedback to the Board Development Session in September**

19. Confidential Motion

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

The Board agreed the motion unanimously.

The meeting closed at 12.50pm

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HDFT Board of Directors Actions Schedule – September 2016
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
Undertake a refresh of the Trust's approach to raising the profile of appraisals (Apr 16)	Mr P Marshall – Director of Workforce and OD	July 2016	Complete – updates included in the DWOD report
Amendment to the Quality Committee terms of reference to reflect NED membership of both the Quality Committee and Audit Committee to ensure appropriate triangulation (Jun 16)	Dr S Wood – Deputy Director of Governance	July 2016	Complete
Responsibility for monitoring cases of Grade 3 and 4 Pressure Ulcers to be delegated to the Quality Committee (Jun 16)	Mrs L Webster, Non-Executive Director/ Quality Committee Chair	July 2016	Complete
Nursing and Midwifery Strategy to be uploaded to the Reading Room (Jun 16)	Ms D Henderson, Company Secretary	July 2016	Complete
A briefing on the patient stories to be circulated in advance of meetings for future Board meetings (Jun 16)	Ms D Henderson, Company Secretary	July 2016	Complete
Mrs Dodson to write to Kathryn Riddle, Chair of HEE on behalf of the Board (Jun 16)	Mrs Dodson, Chairman	July 2016	Complete
Progress updates on Quality Objectives to be included in the IBR (May 16)	Mrs J Foster, Chief Nurse	July 2016	Complete – within CN Report
Paper on progress of e-rostering implementation (May 16)	Mrs J Foster, Chief Nurse	July 2016	Complete – verbal update to be provided at the July meeting
Include the Trust's current position against trajectory for nurse validation in the CN report (Jun 16)	Mrs J Foster, Chief Nurse	July 16	Complete – within CN Report
Verbal update to be provided as part of the Quality Committee Chair's report on performance relating to completion of complaint action plans (Jun 16)	Mrs L Webster, Non-Executive Director/ Quality Committee Chair	September 2016	Complete
Further detail on metrics relating to health visiting for new born visits to be provided in the IBR (Jun 16)	Dr N Lyth, Clinical Director	September 2016	Complete – paper included for July meeting

Item Description	Director/ Manager Responsible	Date of completion/ progress update	Confirm action Complete
Verbal update on the approach taken to ensure adequate clinical cover for planned leave in theatres (Jun 16)	Dr K Johnson, Clinical Director	July 2016	Verbal update provided at July meeting
Submission of a Research and Development Strategy for Board approval (Mar 16)	Dr A Layton - Associate Medical Director for Research	September 2016	Complete – agenda item 10.1
An update on the NHS Improvement consultation and proposals for a Single Oversight Framework to be provided (Jul 16)	Dr R Tolcher, Chief Executive	September 2016	Complete – included in CEO Report. Consultation response uploaded to reading room
Provide confirmation of the Trust's current compliance with legionella water testing (July 16)	Mr R Harrison, Chief Operating Officer	September 2016	Included on Board Assurance Framework
Clarity to be sought to ensure that the current compliance rates for Information Governance Mandatory training support the requirements of the July Information Toolkit submission (July 16)	Mr R Harrison, Chief Operating Officer	September 2016	Complete – response circulated to Board members via e-mail 8/8/16
The suggestion to nominate a Director lead for Nursing for WYAAT to be taken forward for discussion at the next WYAAT CEO meeting (July 16)	Dr R Tolcher, Chief Executive	August/ September 2016	Complete
An update on the review of the Staff Friends and Family Test narrative outcome for Q1 to be provided to the Board (Jul 16)	Mr P Marshall, Director of Workforce and Organisational Development	September 2016	Complete – included within DWOD report
Provide assurance to the Board in relation to service activity and recovery plans (Jul 16)	Mr R Harrison, Chief Operating Officer	September 2016	Complete – within COO report

HDFT Board of Directors Actions Schedule – Outstanding Actions September 2016

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
1	June 2016	Inclusion of KPIs on Children's Services and Community Services to be included in the IBR (8.6)	Dr N Lyth, Clinical Director	July 2016	Community Services data TBC
2	July 2016	Assurance to be sought from the contracts team that no penalties associated with the contract could be implemented due to the absence of a threshold target for new birth visits by Health Visiting team within 14 days of birth (8.11)	Mr J McKie, Deputy Finance Director	August 2016	Verbal clarification to be provided under matters arising
3	May 2016/ June 2016	Progress with regard to the appointment of Consultant Elderly Care post as part of the oral directorate report (12.8)	DR K Johnson, Clinical Director	September 2016	Verbal update to be given under matters arising
4	July 2016	E-rostering implementation update to be included in the Chief Nurse report (11.10)	Mrs J Foster, Chief Nurse	September 2016	To be included in the CN report
5	June 2016 July 2016	Additional information to be included in the IBR relating to readmissions of older people (Jun 8.3) / update on reducing readmissions in older people to be submitted to the September Board meeting (8.9)	Mr A Alldred, Clinical Director	October 2016	To be included in the COO report
6	June 2016	Update on the action plan following the Alan Wood Report into Local Safeguarding Boards (12.6)	Mrs J Foster, Chief Nurse	October 2016	
7	July 2016	Undertake a review of the Strategic Key Performance Indicators and submit a proposal to the October meeting of the Board for approval, giving consideration to input from the Shadow Board (6.2)	Mr J Coulter, Deputy Chief Executive/ Finance Director	October 2016	
8	July 2016	Proposal for the appointment of the Trust's Freedom to Speak Up Guardian to be submitted to the Board of Directors (13.2)	Mr P Marshall, Director of Workforce & OD	October 2016	

9	January 2016	Review and revise questions in annual Audit Committee survey (14.1.3)	Mr C Thompson, Non-Executive Director	November 2016	
10	May 2016	Further update on progress of the Care of Frail Older People Strategy and confirm an NED Lead (11.2.3)	Mr A Alldred, Clinical Director	November 2016	
11	June 2016	Update on the programme of work to reduce hospital admissions (9.3)	Mr A Alldred, Clinical Director	January 2017	
12	January 2016	Update Board on progress with EDS2 action plan (11.10)	Mrs J Foster – Chief Nurse	January 2017	
13	March 2016	Additional information on learning from cases of C. Diff and associated action planning during 2015/16 to be included in the annual report (6.3)	Mrs J Foster, Chief Nurse	February 2017	

Report to the Trust Board of Directors: 28 September 2016	Paper No: 5.0
Title	HDFT Vision, Mission and Objectives
Sponsoring Director	Dr Ros Tolcher, Chief Executive
Author(s)	Dr Ros Tolcher, Chief Executive
Report Purpose	To seek approval for revisions to the narrative underpinning our values, objectives and annual goals in order to reflect our role in promoting health and wellbeing
Key Issues for Board Focus:	
<p>The Board are asked to:</p> <ul style="list-style-type: none"> - Acknowledge that the Trust has an important role to play as both a provider and employer in promoting healthy lifestyles - Note that the Trust holds substantial contracts for Local Authority commissioned services which have specific public health objectives - Note that the revised wording will help bring more focus to health and wellbeing across the Trust and ensure that we make Every Contact Count. 	
Related Trust Objectives:	
To deliver high quality care	Yes – by promoting health and wellbeing and healthy choices to help drive clinical outcomes
To work with partners to deliver integrated care	Yes – Local Authority colleagues have requested greater visibility of Public Health messages
To ensure clinical and financial sustainability	Yes – healthy lifestyles contribute to NHS efficiency. Contractual outcomes in Public Health services will be supported. Increased focus on wellbeing will help reduce workforce sickness absence
Risk and Assurance	Revisions, if approved, will need to be reflected within the Board Assurance Framework where appropriate
Legal implications/Regulatory Requirements	There are no legal/regulatory implications highlighted within the report.
Action Required by the Board of Directors	
<ul style="list-style-type: none"> • The Board is asked to approve the revised narrative underpinning the Trusts strategic objectives and annual goals. 	

This is us: Our Vision, Mission, Values and Objectives

Our Vision

Excellence Every Time

Our Mission

To be an exceptional provider of healthcare for the benefit of our communities, our staff and our partners

Our Values (these describe and define our culture)

Respectful

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

Responsible

We will be responsible and accountable. We will be open and honest with people. We will ensure that we have the right skills for our work and that we keep these up-to-date. We will endeavour to make 'Every Contact Count' for promoting healthy lifestyles. We will take action when things go wrong. We will seek to learn and improve continuously.

Passionate

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

Our Strategic Objectives (these are the Trust's longer-term ambitions)

1. To deliver high quality care

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

2. To work with partners to deliver integrated care

This means that we will work positively with other providers, local authorities and commissioners to ensure that the design of services offers the best possible, affordable care. We will work with partners to strive to give every child the best start in life. We will design services based on the physical, mental and care needs of local people and ensure that these are joined-up where this makes sense.

3. To ensure clinical and financial sustainability

This means that we will manage resources carefully and make sure that clinical models are robust and reliable. We will take a long-term view of financial risk and strategic planning. We will look carefully at trends in activity and align workforce and infrastructure capacity. We will seek to expand our services to a wider population where this provides greater clinical resilience. We will exercise robust financial stewardship to protect the continuity of services.

Our Annual Goals (these are the goals around which we arrange our annual plans)

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

This means that we will:

- Plan and deliver care based on the needs of patients
- Listen to feedback and make improvements on this basis
- Treat each person as an individual
- Ensure that people in our care feel safe and are treated with dignity and respect
- Support people making healthy lifestyle choices live up to our 'You Matter Most' pledge.

2. To support and engage with staff

This means that we will:

- Live our values, valuing individuals and teams
- Invest in and develop people to enable them to thrive
- Pay our staff a living wage
- Support staff health and wellbeing
- Respond to messages in the annual staff survey and staff Friends and Family Test
- Promote an open and honest culture.

3. To use resources carefully

This means that we will:

- Exercise prudent cost control
- Do things on time, right first time, ensuring that every contact with patients counts
- Support patients to optimise their health outcomes, for example through controlling weight and stopping smoking
- Signpost patients to support with healthy lifestyles
- Make decisions which help to facilitate healthy lifestyles
- Use our time effectively and respect the value of colleagues' time
- Prepare well for meetings and be 'present'.

4. To plan for the future

This means that we will:

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

This is us: Our Vision, Mission, Values and Objectives

Our Vision

Excellence Every Time

Our Mission

To be an exceptional provider of healthcare for the benefit of our communities, our staff and our partners

Our Values (these describe and define our culture)

Respectful

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

Responsible

We will be responsible and accountable. We will be open and honest with people. We will ensure that we have the right skills for our work and that we keep these up-to-date. We ~~will endeavour to make 'Every Contact Count' for promoting healthy lifestyles. will support the health of the public by making every contact with patients count.~~ We will take action when things go wrong. We will seek to learn and improve continuously.

Passionate

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

Our Strategic Objectives (these are the Trust's longer-term ambitions)

1. To deliver high quality care

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

2. To work with partners to deliver integrated care

This means that we will work positively with other providers, local authorities and commissioners to ensure that the design of services offers the best possible, affordable care.

[We will work with partners striving to give every child the best start in life.](#) We will design services based on the physical, mental and care needs of local people and ensure that these are joined-up where this makes sense.

3. To ensure clinical and financial sustainability

This means that we will manage resources carefully and make sure that clinical models are robust and reliable. We will take a long-term view of financial risk and strategic planning. We will look carefully at trends in activity and align workforce and infrastructure capacity. We will seek to expand our services to a wider population where this provides greater clinical resilience. We will exercise robust financial stewardship to protect the continuity of services.

Our Annual Goals (these are the goals around which we arrange our annual plans)

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

This means that we will:

- Plan and deliver care based on the needs of patients
- Listen to feedback and make improvements on this basis
- Treat each person as an individual
- [Ensure that people in our care feel safe and are treated with dignity and respect](#)
- [Support people making healthy lifestyle choices Help patients to see the benefits of healthy lifestyles](#)
- Live up to our 'You Matter Most' pledge.

2. To support and engage with staff

This means that we will:

- Live our values, valuing individuals and teams
- Invest in and develop people to enable them to thrive
- Pay our staff a living wage
- Support staff health and wellbeing [through structured programmes](#)
- Respond to messages in the annual staff survey and staff Friends and Family Test
- Promote an open and honest culture.

3. To use resources carefully

This means that we will:

- Exercise prudent cost control
- Do things on time, right first time, ensuring that every contact with patients counts

- Support patients to optimise ~~the benefits of their health care~~ their health outcomes, for example through controlling weight and stopping smoking
- ~~Where appropriate, signpost~~ patients to support ~~for issues relating to their lifestyles~~ with healthy lifestyles
- Make decisions which help to facilitate healthy lifestyles
- Use our time effectively and respect the value of colleagues' time
- Prepare well for meetings and be 'present'.

4. To plan for the future

This means that we will:

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

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Report to the Trust Board of Directors: 28 September 2016	Paper No: 6.0
Title	Report from Chief Executive
Sponsoring Director	Dr Ros Tolcher, Chief Executive
Author(s)	Dr Ros Tolcher, Chief Executive
Report Purpose	To update the Board of Directors on significant strategic, operational and performance matters
Key Issues for Board Focus:	
<ul style="list-style-type: none"> Progress has been made in developing the West Yorkshire Sustainability and Transformation Plan Operational performance remains strong with key Referral to Treatment Time (RTT) and Cancer Pathway targets being achieved. Performance against the Safety Thermometer improved significantly in August to 97.3% harm free care, compared to 93.4% in July SMT has agreed enhanced financial controls and directorates are developing recovery plans to strengthen confidence in attaining the 2016/17 control total requirement A draft Memorandum of Understanding for the New Care Models Partnership and a briefing on Alliance Contracts is being developed A new risk has been added to the Board Assurance Framework to reflect the need to ensure a strong critical infrastructure is in place to support delivery of safe services. 	
Related Trust Objectives:	
1. To deliver high quality care	Yes – the report reflects a sustained organisational focus on providing high quality care and ensuring robust controls and assurances on care quality.
2. To work with partners to deliver integrated care	Yes – the report provides updates on the work of the HHTB and West Yorkshire reflect partnership working in Harrogate and West Yorks areas.
3. To ensure clinical and financial sustainability	Yes – the report notes from the SMT meeting demonstrate a particular focus on financial performance
Risk and Assurance	Strategic and operational risks are noted in section 6. Risks associated with this report are reflected in the Board Assurance Framework: BAF 14: risk to deliver of integrated models of care; BAF 4: lack of interoperable systems across New Care Models; BAF 15: misalignment of partner strategic plans; and BAF 9; failure to deliver the operational plan.
Legal implications/Regulatory Requirements	There are no legal/regulatory implications highlighted within the report.
Action Required by the Board of Directors	
<ul style="list-style-type: none"> 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. The Board is asked to note that four BAF entries now have all actions completed and have attained their target risk scores. It is proposed therefore that the Board agree to remove these strategic risks from the BAF and agree the inclusion of one new BAF entry related to critical infrastructure. 	

1.0 MATTERS RELATING TO QUALITY AND PATIENT EXPERIENCE

1.1 2016/17 Contract Update

The Acute contract for 2016/17 has been signed. The Trust is transitioning to the new Community Services specification, aligned to the roll out of the New Care Model across Harrogate and Rural District. The Quality Impact Assessment underpinning the new Community Service Specification was formally signed off by commissioners in August, allowing staff engagement to commence. The date for this has been extended to the end of September to allow full engagement with all staff affected by change. There remains an issue of a proposed reduction in funding for the chronic pain service. Commissioners have proposed a full review which will take until the end of the financial year to conclude.

1.2 2017/18 – 2018/19 Operating Plan development

NHS Foundation Trusts and NHS Trusts are required to submit draft 2-year Operating Plans by the end of November 2016 and final 2-year plans by 23 December 2016. NHS Improvement has also set an expectation that contracts for the 2-year period will have been agreed by the end of December 2016. The Trust is in close dialogue with commissioners to develop plans and the Board will receive a further briefing at the Board Strategy Day on 10 October.

1.3 Operational Performance

The Patient Safety Thermometer score improved significantly in August to 97.3% harm free care. Four cases of Clostridium Difficile were reported in August bringing the year-to-date total to 13. Of the seven root cause analyses undertaken, there have been lapses in care identified in three cases.

Sustaining compliance with the 95% 4 hour A&E waiting time (Emergency Department) target remains challenging. The Trust achieved 94.9% in August. We anticipate quarter 2 overall being above 95%.

Theatre utilisation rates deteriorated slightly in August due to a higher rate of sessions being cancelled. This is in part due to compliance with the agency cap.

Overall staffing levels compared to planned were 104% with the excess being due to the additional need for support worker 'specials'. Full compliance with e-rostering has not yet been achieved in all areas, and is subject to specific actions as part of the overall financial recovery plan.

2.0 STRATEGIC UPDATE

2.1 West Yorkshire Sustainability and Transformation Plan (WYSTP)

Work to develop the West Yorkshire STP is progressing demanding a significant investment of time. The final draft submission of the STP is due to be made on 21 October. These draft plans set out a direction of travel for STP areas and will form the basis for further communication and engagement where applicable. A detailed financial template was submitted on 16 September following a very detailed piece of work. At the time of writing there is still a substantial financial gap over the term of the STP plan and considerable effort is being deployed to close this gap. Key points to note include:

- As part of West Yorkshire's approach to developing the STP and the West Yorkshire Association of Acute Trusts (WYAAT) group's response to Jim Mackey's letter dated 28 June (regarding sustainability of acute care and consolidation of back office functions), PwC was commissioned to deliver a project which helps to build the case for increased collaboration

between the six acute trusts in the WYAAT Group. Financial, quality and sustainability issues were reviewed in order to establish the potential opportunities available through closer collaboration. This work is now informing a more detailed analysis in those specialties where opportunities are apparent.

- The combined potential savings from the clinical priorities identified at the start of STP planning and the six local STPs do not close the full five year projected financial gap. Additional steps to close this gap through acute collaboration, reducing variations and enhancing primary and community care are being pursued.
- WYAAT is exploring options for formalising its governance from simple Terms of Reference ('The Association') to a formal Memorandum of Understanding.
- Executives are continuing to liaise with colleagues in the Humber Coast and Vale STP footprint to ensure that fruitful collaboration is pursued in all areas.
- The October STP submission will also include more detail on potential mergers of so-called 'back office' functions.
- There are no indications at present that any of the Local Authority commissioned services provided by HDFT will be directly impacted by STP decision making.

I continue to communicate regularly with local MP's Julian Smith and Andrew Jones in order to keep them abreast of developments affecting the Trust. Julian Smith has asked that I share with the Board of Directors his willingness to help represent issues or concerns which the Trust has with the Government.

2.2 Urgent and Emergency Care (U&EC) Acceleration Zone

The Secretary of State has selected West Yorkshire as the National U&EC Acceleration Zone. The aim of this work will be to deliver the Emergency Department (A&E) 95% standard at West Yorkshire level by March 2017. Workstreams encompass ambulance response times; mental health crisis and liaison; enhanced primary care; Emergency Department streaming and improved discharge. Initial work has identified patient flow, attendance avoidance and Emergency Department capacity as priorities. Achieving an aggregate position of 95% is a significant challenge and we are currently exploring the actions required and support offered to achieve this.

2.3 Care Quality Commission (CQC) Report and Action Plan

Further to my last formal report to the Board of Directors, the Quality Summit went ahead on 29 July. This was attended by senior NHS England, NHS Improvement and commissioning colleagues as well as other stakeholders. The Trust was commended for a very strong rating of 'Good' overall and for the strength of the Trust's leadership. A detailed action plan was submitted to the CQC within the required timescale and we are awaiting formal feedback. Discussions have been held with the CQC regarding their revised inspection regime. A further update will be provided at the Board meeting.

3.0 NATIONAL COMMUNICATIONS RECEIVED AND ACTED UPON

3.1 Single Oversight Framework

On 28th June, NHS Improvement published its consultation on the Single Oversight Framework. The consultation document set out the approach NHS Improvement proposes to take in overseeing providers using a Single Oversight Framework for both NHS Trusts and NHS Foundation Trusts and shaping the support they provide. The Trust responded to the consultation and below is a summary of some of the key changes which have been made following consultation:

- For providers in segment 1 (segment 4 being special measures), although some data will be collected monthly, NHS Improvement will only review data on a quarterly basis for segmentation purposes
- NHS Improvement will focus on overseeing a number of national targets and standards, and also look at wider data to inform the tailored support package required on an individual Trust basis
- NHS Improvement have changed the language of the framework to describe segment 1 ('maximum autonomy') in more positive terms and to describe segments 2 and 3 in terms of 'levels of support'
- Agency spend will now be part of the finance and use of resources score – this applies from quarter 3 2016/17
- Segment 4 will now exclusively consist of providers in special measures

NHS Improvement has undertaken shadow segmentation based on how organisations would have performed under the framework over the last two months. Over the next couple of weeks NHS Improvement regional teams will contact Trusts to discuss their shadow segment.

The Trust's response to the consultation on the Single Oversight Framework is available in the Reading Room.

4.0 WORKING IN PARTNERSHIP

4.1 Harrogate Clinical Board: Elective Care Rapid Testing Programme

Work continues across the three clinical specialties participating in this project. Teams from dermatology, gastroenterology and orthopaedics have agreed high level goals and specific 'ambitions' for each of the three themes of: rethinking referral models; shared decision making and transforming outpatient appointment. Quantitative and qualitative data is being used to inform decisions.

4.2 Harrogate Health Transformation Board (HHTB)

Since the July meeting of the Board, HHTB met on 28th July and 17th August. A spending plan to roll out the New Care Model across the district was agreed with funding being identified from the national Vanguard Transformation fund allocation and savings made as a health and care system. This will ensure the needs of local people are managed in a more proactive and controlled way, whilst avoiding attendance at the Emergency Department or hospital admissions where possible. The roll-out includes:

- Locality Integrated Teams in Harrogate – to be known as Community Care Teams
- A Response and Overnight element of the New Care Model, covering the whole district
- Additional capacity in the GP Out of Hours Service
- 10 additional community beds (already live)
- Community Geriatrician capacity
- Social care assessors in each locality team
- Community Mental Health nurses available in each team
- Additional funding for social care support packages
- Pharmacists working in practices to support the release of GP time
- IT infrastructure: supporting teams to work together and roll-out of mobile working packages
- Support for the Harrogate and Ripon Centres for Voluntary Services
- Workforce and organisational development support

An extra-ordinary meeting of the HHTB was held on 11th August to spend time developing the model for health and care services across Harrogate District. The group expect the New Care

Model to be fully operational around the beginning of November. HHTB will be monitoring progress closely and developing the approach to sharing the risks and gains across the partnership.

The long term affordability of the New Care Model is predicated on assumed savings in acute activity and capacity modelling which pre-dated changes to the community services contract value. There are significant risks to achieving the scale of change at the pace required and these are being reviewed within the Trust risk management framework.

Future contracting models are under discussion including the potential for using an Alliance Contract. This will be explored in more detail at the next Board Strategy Day on 10 October.

Following discussion at the last meeting of HHTB when the future chairmanship of the group was discussed, I am pleased to confirm that I will pass on the chairmanship of the HHTB to an independent chair, Penny Jones, at the next meeting.

The Key Messages from July and August meetings are available in the Boardpad Reading Room. HHTB has a further meeting scheduled to take place on 22nd September.

4.3 West Yorkshire Association of Acute Trusts (WYAAT)

The key focus for WYAAT is the development of an STP which enables clinical and financial sustainability at a West Yorkshire level as detailed above. In parallel with and complementing STP planning, work exploring the potential for a West Yorkshire Dedicated Discharge Management Service has continued. Early scoping work supports the potential for WYAAT Trusts to form a West Yorkshire-wide dedicated discharge management company / enterprise which would work with corporate partners to ensure immediate discharge from hospital and resettlement of patients, once medically fit. A steering group has been established and will now start to develop a business case.

5.0 FINANCIAL POSITION

The reported position at the end of Month 5 (August) is that we are behind our operational plan by £781k, of which £117k was the variance for the month of August itself. Because of this adverse performance against plan, we have taken a prudent approach and not assumed any Sustainability and Transformation (S&T) funding for quarter 2 to date. This means that in addition to our operational variance we have not earned two months' worth of S&T funding which total £767k.

The pressures remain in relation to activity and income delivery and also expenditure on our wards. The Cost Improvement Programme (CIP) position is improving with 80% of schemes actioned and a risk adjusted total now at 95% of the required plan. In terms of actions, after a productive Senior Management Team (SMT) session at the end of August, recovery actions have been agreed in relation to both income and expenditure. These plans would sufficiently improve the run rate but the actions require delivery. Revised trajectories will be used to monitor performance from September.

Regarding delivery of the quarter 2 plan and therefore accessing the second tranche of S&T funding (a further £1.15m available), work is ongoing in terms of expediting VAT claims, undertaking stock checks, managing expenditure to commissioned contract funding, and undertaking a review of goods received and their value in the ledger. These will be actioned in September but we will require an improved operational run rate as well if we are to achieve our plan for quarter 2.

Further detail is contained within the report from the Finance Director.

6.0 SENIOR MANAGEMENT TEAM (SMT) MEETING

The SMT met on 24th August with a specific focus on financial performance and recovery.

Key issues discussed and for noting by the Board of Directors are as follows:

- The organisational imperative of achieving the agreed 2016/17 control total predicated on a targeted recovery plan, a full Cost Improvement Plan (CIP) programme and solid cost management and budgetary controls
- Drivers of overspend and adverse income variation were explored at directorate and service level
- Actions to address key drivers were agreed including more robust processes for employing additional unregistered staff; work on bed base requirements in the light of increased investment in community alternatives and review of the workforce establishments in the light of changing case mix
- All directorates are working up revised CIP plans to bring the risk adjusted plan up to target
- SMT noted the CCG's deteriorating financial position and the, as yet, unknown potential impact on HDFT activity
- SMT also asked for continued diligence in completing internal audit actions and signing these off.

In relation to the meeting held on September 21st, the key issues discussed and for noting by the Board of Directors are:

- Further discussion in relation to managing our ward establishments alongside our anticipated bed base for winter
- The need to justify any additional staffing costs if there is no increase in service provision or no quality issue to address – this being a key message from NHS Improvement
- Update in relation to the wheelchairs contract, the impact on service users, and concerns about the necessary risk assessment process being used to manage expenditure within commissioned funds
- Contingency plans regarding the incident at Leeds Teaching Hospital NHS Trust that has meant that pathology tests and results cannot be communicated in a timely manner from Leeds
- Updated corporate risks following corporate risk review (as per 7.2 below)
- The roll out of Schwarz rounds to provide support to staff
- The impact on the trust of being a part of the Accelerated Zone for Emergency Department performance, alongside other trusts in West Yorkshire

The Minutes from SMT meetings are available in the BoardPad Reading Room.

7.0 BOARD ASSURANCE AND CORPORATE RISK

The summary current position of the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) is presented below. There will be an opportunity to discuss both the BAF and CRR during the confidential session of the Board, due to the detail of their content. The full BAF is available for Board members in the BoardPad Reading Room.

7.1 Board Assurance Framework (BAF)

The BAF was reviewed by the Executive Directors during week commencing 8th August and 12th September. All BAF entries have action plans to address the gaps in controls and all action plans have progress scores of 1 or 2, providing assurance that actions to mitigate existing gaps in controls are being progressed. A review of key controls has been undertaken as a result of the completion of actions, and additional actions have been added to mitigate increased levels of risk, where appropriate.

Changes to the Board Assurance Framework since July

Risks removed

It is proposed that the Board of Directors agree to remove the following strategic risks due to the completion of associated actions and there being no further gaps in control:

- BAF# 6 – Understanding the market (risk that the Trust lacks market intelligence to make informed commercial decisions);
- BAF# 7 – Lack of robust approach to new business (risk that the Trust fails to undertake appropriate due diligence and agrees contracts which are loss-making);
- BAF# 8 – Visibility and reputation (risk that the Trust has low recognition outside the current and traditional markets or fails to maintain a reputation as a high-achieving Trust);
- BAF# 11 – Risk to current business (there is a risk that the Trust fails to properly manage current business and fails to defend a market challenge due to a lack of foresight).

New risks

The Board of Directors are asked to agree the inclusion of a new risk BAF# 16 to reflect the requirement to ensure a fit for purpose critical infrastructure. This entry is designed to better describe current risk and does not represent a previously unknown risk.

Amendments to current BAF entries

Despite the attainment of BAF# 8 target scores, it is acknowledged that visibility and reputation remained a significant risk to the Trust, and has now been reflected in BAF# 5. BAF# 5 (risk to sustainability of services if the Trust fails to retain core business due to re-tendering of services) has also been amended to incorporate Sustainability and Transformation Planning risk.

BAF# 10 has been re-worded for clarity to reflect the risk of breaching ‘the terms’ of the NHS Provider Licence.

Changes to residual risk scores

The residual risk score for BAF# 9 – risk of failure to deliver the Operational Plan – has increased from Amber 8 (consequence score of 4 X likelihood score of 2) to Red 12 (consequence score of 4 X likelihood score of 3), due to the lack of System Resilience (SRG) funding and associated risk to the achievement of Sustainability and Transformation funding.

Summary

Seven risks (BAF numbers 2, 6, 7, 8, 11, 12, and 13) are currently assessed as having achieved their target risk score. There are six strategic risks (BAF numbers 1, 4, 9, 12, 14 and 15) which are assessed at a risk score of ‘Red’ 12. No BAF entries have scores greater than 12. The strategic risks are as follows:

Ref	Description	Risk score	Progress score
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 2
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	Red 12 ↔	Unchanged at 1
BAF 5	Risk of maintaining service sustainability	Amber 8 ↔	Unchanged at 2
BAF 6	Risk of a lack of understanding of the market	Amber 8 ↔	Improved to 1
BAF 7	Risk of a lack of a robust approach to new business	Yellow 4 ↔	Improved to 1
BAF 8	Risk to visibility and negative impact on reputation	Amber 8 ↔	Reduced to 2

BAF 9	Risk of a failure to deliver the Operational Plan	Red 12 ↓	Unchanged at 2
BAF 10	Risk of breaching the terms of the Trust's Licence to operate	Amber 10 ↔	Unchanged at 2
BAF 11	Risk to current business	Yellow 4 ↔	Unchanged at 1
BAF 12	Risk of external funding constraints	Red 12 ↔	Reduced to 2
BAF 13	Risk of a reduced focus on quality	Yellow 4 ↔	Improved to 1
BAF 14	Risk of delivery of integrated models of care	Red 12 ↔	Unchanged at 2
BAF 15	Risk of misalignment of strategic plans	Red 12 ↔	Unchanged at 1
BAF 16	Risk that the Trust's critical infrastructure is not fit for purpose	Amber 8 new risk	Progress Score of 1

Key to progress score on actions:

1. Fully on plan across all actions
2. Actions defined – some progressing, where delays are occurring, interventions are being taken
3. Actions defined – work commenced
4. Actions defined – work not yet commenced/behind plan

7.2 Corporate Risk Register (CRR)

The CRR was reviewed at the monthly meetings of the Corporate Risk Review Group on 12th August and 9th September. The Corporate Risk Register contains eleven risks. Changes to the CRR since the July meeting of the Board of Directors are:

New Risks

CR13 - risk to response time and capacity of services provided in the community due to a reduction in the 2016/17 block contract value was escalated to the Corporate Risk Register with a score of 'Red' 12.

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, was escalated to the Corporate Risk Register with a score of 'Red' 12.

CR8 – risk of harm to ophthalmology patients as a result of being lost to follow up was escalated to the Corporate Risk Register with a score of 'Red' 12.

Changes to the Corporate Risk Register

The risk score for CR10 – risk to patient experience and performance due to limited availability of anaesthetists and therefore elective patients being cancelled – was reduced from 'Red' 12 to 'Amber' 9, due to no patient cancellations since the end of July and the successful recruitment of three locum consultant anaesthetists.

The risk scores for CR9 and CR11 remained the top scoring risks at Red 16:

- CR9: Risk to the sustainability of service delivery and acute rotas due to withdrawal of trainees in Medicine.
- CR11: Financial and Regulatory risk due to non-compliance with agency cap rules.

Risks CR9 and CR12 have reported actions behind plan with the progress score of 3.

Dr Ros Tolcher
Chief Executive
September 2016

Report to the Trust Board of Directors: 28 September 2016	Paper No: 6.1
Title	Harrogate and District Sustainability and Transformation Plan
Sponsoring Director	Dr Ros Tolcher, Chief Executive
Author(s)	Dr Ros Tolcher, Chief Executive
Report Purpose	To provide the Board of Directors with the Harrogate and District STP for information and comment
Key Issues for Board Focus:	
<p><u>Executive Summary</u> Organisations across the NHS and Local Government in West Yorkshire have been planning together to develop the five year West Yorkshire STP (WYSTP). The WYSTP is formed from local place-based plans and a set of 6 supporting West Yorkshire programmes: Bradford and Craven; Calderdale; Harrogate and Rural District; Kirklees; Leeds; and Wakefield.</p> <p>This report provides the Board of Directors with the supporting STP for Harrogate and District. The Board are asked to note:</p> <ul style="list-style-type: none"> • The requirement to submit a clear plan of how each STP footprint will work towards closing the three gaps across the health care system identified in the 5-year forward view by 21 October; • The need to reflect clear plans within individual CCG and provider Operational Plans over the next two years; • Note progress made to enhance governance and engagement to ensure collective decision making, work towards reducing the gaps, and managing associated risks to sustainability; • Note the significant risk to the Harrogate and District position as a result of new guidance for NHS planning; • Note the next steps to: submit a final draft WYSTP by 21 October; submit draft two-year operational plans for 2017/18 and 2018/19 by the end of November; and submit final operational plans with signed contracts by 23 December 2016. 	
Related Trust Objectives:	
To deliver high quality care	Yes – the report reflects a sustained organisational focus on providing high quality care in a collaborative way, in line with the 5-year forward view.
To work with partners to deliver integrated care	Yes – the report provides updates on the work of the HHTB and the development of the Harrogate and District STP through partnership working in Harrogate and West Yorkshire areas.
To ensure clinical and financial sustainability	Yes – the report provides an update on plans to provide sustainable delivery of care in the future.
Risk and Assurance	Strategic and operational risks are noted in section 6. 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 Implications	There are no legal/regulatory implications highlighted within the report.
Action Required by the Board of Directors	
The Board is requested to receive and note the content of the report.	

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Sustainability and Transformation Plan: Harrogate District (5.3) **Working Document v10**

Nominated Lead: Amanda Bloor, Chief Officer (amanda.bloor@nhs.net)

Organisations within the STP Footprint: NHS Harrogate and Rural District Clinical Commissioning Group, North Yorkshire County Council, Harrogate Borough Council, Harrogate and District NHS Foundation Trust, Tees , Esk and Wear Valleys Foundation Trust, Yorkshire Health Network.

Our collective leadership aim is to achieve the best possible outcomes for the population through delivery of the Five Year Forward View

We have guiding principles that shape everything we do as we build trust and delivery

- We will be **ambitious** for the populations we serve and the staff we employ
- The WYSTP belongs to **commissioners, providers, local government and NHS**
- We will **do the work once** – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict.
- We will undertake **shared analysis** of problems and issues as the basis of taking action
- We will apply **subsidiarity** principles in all that we do – with work taking place at the appropriate level and as near to local as possible

What does this mean for people using our services?

Priority areas:

- **Prevention at Scale**
- **Mental health**
- **Stroke**
- **Cancer**
- **Urgent and emergency care**
- **Specialised commissioning**
- **Primary and community services**
- **Acute reconfiguration**
- **Standardisation and reducing variation**



Creating healthy places and healthy communities ensuring that every place is child friendly and allows people to age well.



Preventing ill-health and looking after yourself you'll be given more support and information to **look after your own health and wellbeing to prevent ill-health** before it occurs. If you do need to access services, you'll be supported to get to the right service and professional to meet your needs.



Primary and community services you'll see **more services being delivered locally**, to support you at home **and in your community to manage your health and wellbeing**, whether your need is planned in advance or you require urgent support, for your physical or mental health or social needs.



Ensuring our hospital services are stable in the long-term - because more care will be delivered in communities and some specialist services are not delivering the best outcomes for people, **some of our hospital services (for physical and mental health) will need to look different and be delivered from different places** to make sure everyone gets the best care regardless of where they live.



Using technology to support populations and our staff we can use the technology we use in our everyday lives to help both people using services and the people caring for them to deliver **care as close to home as possible** and to make sure **you tell your story only once**

2. OUR CASE FOR CHANGE

2.1 Our Case for Change: A Picture of Our Place

Serving a population of approximately **157,200***

- Harrogate Borough Council
- Harrogate and District NHS Foundation Trust
- Harrogate and Rural District Clinical Commissioning Group
- Harrogate College
- North Yorkshire County Council
- North Yorkshire Police
- North Yorkshire Fire & Rescue Service
- Office of Police and Crime Commissioner North Yorkshire
- Department of Work and Pensions
- Tees, Esk and Wear Valleys NHS Foundation Trust
- Yorkshire Health Network
- Yorkshire Ambulance Service
- Yorkshire & Humber Academic Health Science Network
- 17 GP Practices
- 81 registered care homes (residential and nursing home).
- Extra Care Housing
- 2 Independent Sector Healthcare Providers (in-patient)
- Healthwatch North Yorkshire
- Harrogate & Ripon Centres for Voluntary Services
- Volunteer Centre
- Numerous community and voluntary organisations
- 250 Support Groups

*ONS mid-2014 population estimate (JSNA Refresh, 2016)



A total allocation of **£293m** across health and social care in 2016/17, rising to £323m by 2020/21.

2.2 Our Case for Change: Constitutional Targets and Outcomes

NHS Constitution Requirements			
Indicator	Period	Target	Performance
Ambulance waits: Red 1 & 2 responded to within 8 minutes (YAS)	April 2016	75%	Red 1: 69.1% Red 2: 74.2%
A&E (All): wait time within 4 hours (HDFT)	May 2016	95%	95.5%
18 weeks Referral to Treatment (HDFT)	May 2016	92%	96.2%
Diagnostic test Waiting Time: longer than 6 weeks (HDFT)	May 2016	<1%	0.1%
Cancer 1 st consultant appointment < 2 weeks (HDFT)	May 2016	93%	96.05%
Cancer: decision to treat < 31 days (HDFT)	May 2016	96%	96.97%
Cancer: treated within 62 days of urgent GP referral (HDFT)	May 2016	85%	93.10%

Population Health Characteristics	Period	England	HaRD CCG
Obesity: QOF prevalence (16+)	2014/15	9.0	7.5
% of physically inactive adults	2014	27.7	19.3
Est smoking prevalence (QOF)	2014/15	18.4	15.0
Smoking cessation support and treatment	2014/15	94.1	97.1
Alcohol-specific hospital admission	2014/15	374	323
Hypertension: QOF prevalence (all ages)	2014/15	13.8	14.8
Depression: QOF prevalence (18+)	2014/15	7.3	8.2
Learning disability: QOF prevalence	2014/15	0.4	0.6 (high)
Premature mortality from coronary heart disease	2014	40.0	23.6
Premature mortality from stroke	2014	13.5	15.7
Premature mortality from respiratory disease	2013	28.1	15.4

National Child Measurement Programme: Indicators	Period	England	NYCC
Reception: Prevalence of underweight	2014/15	0.96	0.52
Reception: Prevalence of healthy weight	2014/15	77.2	78.4
Reception: Prevalence of overweight (including obese)	2014/15	21.9	21.1
Reception: Prevalence of obesity	2014/15	9.1	8.1
Year 6: Prevalence of underweight	2014/15	1.42	1.04
Year 6: Prevalence of healthy weight	2014/15	65.3	68.9
Year 6: Prevalence of overweight (including obese)	2014/15	33.2	30.1
Year 6: Prevalence of obesity	2014/15	19.1	15.2



Antimicrobial Resistance	Period	England CCG Median	HaRD CCG
Reduction in the number of antibiotics prescribed in primary care	April 2016	1.094	0.915
Reduction in the proportion of broad spectrum antibiotics prescribed in primary care	April 2016	9.7	6

Using **existing engagement information** to inform all of our plans and priorities

National Surveys
Adult Inpatient Survey
Accident & Emergency Survey
Community Mental Health Survey
GP Patient Survey
Staff Survey

Friends and Family Test
10 million pieces of feedback nationally
In May 2016 patients recommended local services as follows:
Inpatient care – 97%
A&E – 95%
Primary care – 87%
Community care – 94%
Mental Health – 87%
Maternity – 96 to 100% (4 Questions)
Outpatients – 96%

Local Surveys
Gluten Free Prescribing Survey
Dementia Strategy Survey
Discover! Maternity engagement project
Engagement events and survey with people with autism and their families in North Yorkshire
Community Engagement
Patient Participation Groups

Local Strategy Development
Example: 2020 North Yorkshire Care and Support Where I Live Strategy. In 2014 we asked people what they thought of our plan.
“They said we should help people to live independently in their own homes.”
“They said we should make sure people could have good quality homecare.”
“They said we should provide more extra care housing.”
“We should help people with home adaptations to make it easier for them to live on their own.”
“We should make sure people could get good information and advice. We should help people to stay safe in their home. This could include giving them special equipment or provide Telecare.”

New Care Models “What Matters to Us”
“I have easy-to-understand information about care and support which is consistent, accurate, accessible and up to date, in order to prevent illness, remain as independent as possible and in times of need”
“I know who to contact to get things changed”
“I am in control of planning my care and support and respected as understanding my own health and conditions”
“I feel safe receiving preventative, long term condition management, crisis and end of life care closer to home”
“I am supported by a team of people who are confident, happy, coordinated, know what they are doing and trust each other so I don’t need to tell my story again and again”

2.4 The Case for Change

The Harrogate and District STP is a description of the local approach to the West Yorkshire STP priorities and the system response to the uniqueness of the population.

Health and Wellbeing:

- **We have an ageing population** – 10 years ahead of the national aging curve with 1 in 5 people aged over 65. This is set to increase to 1 in 3 over the next two decades.
- The **working age population** (15-64) is shrinking as a proportion of the overall local population – with more outward migration of working population than inward migration. This has implications for the health and social care workforce. Workplace health initiatives can help address the two biggest causes of sickness absence across the NHS – mental health and musculoskeletal problems.
- An increase in the number of people who have a **limiting long-term illness** and the number living with **dementia** by 2020.
- Life expectancy for both men and women is higher than the national average – but the life expectancy gap between the most affluent and most deprived is 8.38 years for males and 5.9 years for females.
- While the district is relatively affluent there are pockets of deprivation and rural isolation – with **children living in poverty and households in fuel poverty**.
- There were a total of 90 **excess winter deaths** reported in Harrogate in 2013-14. For every excess winter death it is estimated that there are an additional eight emergency admissions to hospitals.

Quality and Care:

- 1 in 5 acute admissions could be managed in less acute settings, 2 in 3 acute beds occupied by people whose needs could be met in a less acute environment.
- There is a fragile residential and nursing care market with issues of quality and affordability . There are a number of factors for this including workforce retention, providers leaving the market and the physical standards of buildings not meeting regulations.
- People's changing expectations about what they need, and how they want to live their lives.

Finance and Efficiency:

The health care system faces a **funding gap of £42.2m by the end of 2020/21 – based on 'do nothing'**.

The STP builds on existing priorities and plans to deliver the Harrogate Health Transformation Board vision. The locality is already developing a **New Care Model**, implementing Integrated Care Teams from four community based hubs which include GPs, community nursing, adult social care, occupational therapy, physiotherapy, mental health and the voluntary sector. Boundaries between primary, community, acute, mental health and social care will be removed and acute hospital beds will be used only when they are truly needed. The locality is also **one of eighteen transformation areas** nationally in 2016/17 focussing on technology, GP access, urgent and emergency care reform and mental health. The next phase in the transformation of out of hospital care is the transformation of current primary care to a sustainable model of primary care at scale, including extended access and links to out of hours and an urgent care facility.

3. OUR PRIORITIES

3. Our Priorities – Delivering the Triple Aims

1 Sustainability and Transformation Plan for West Yorkshire, made up of:

6 local plans:

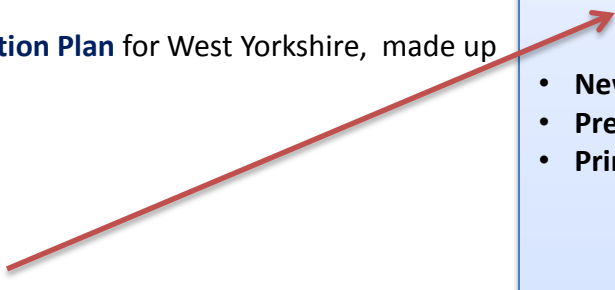
- Bradford and Craven
- Calderdale
- Harrogate and Rural District
- Kirklees
- Leeds
- Wakefield

West Yorkshire wide priority areas:

- Prevention at Scale
- Mental health
- Stroke
- Cancer
- Urgent and emergency care
- Specialised commissioning
- Primary and community services
- Acute reconfiguration
- Standardisation and reducing variation

West Yorkshire wide enabling workstreams:

- Workforce
- Digital
- Leadership and OD
- Communications and engagement
- Finance & Business intelligence
- Innovation and best practice
- Commissioning



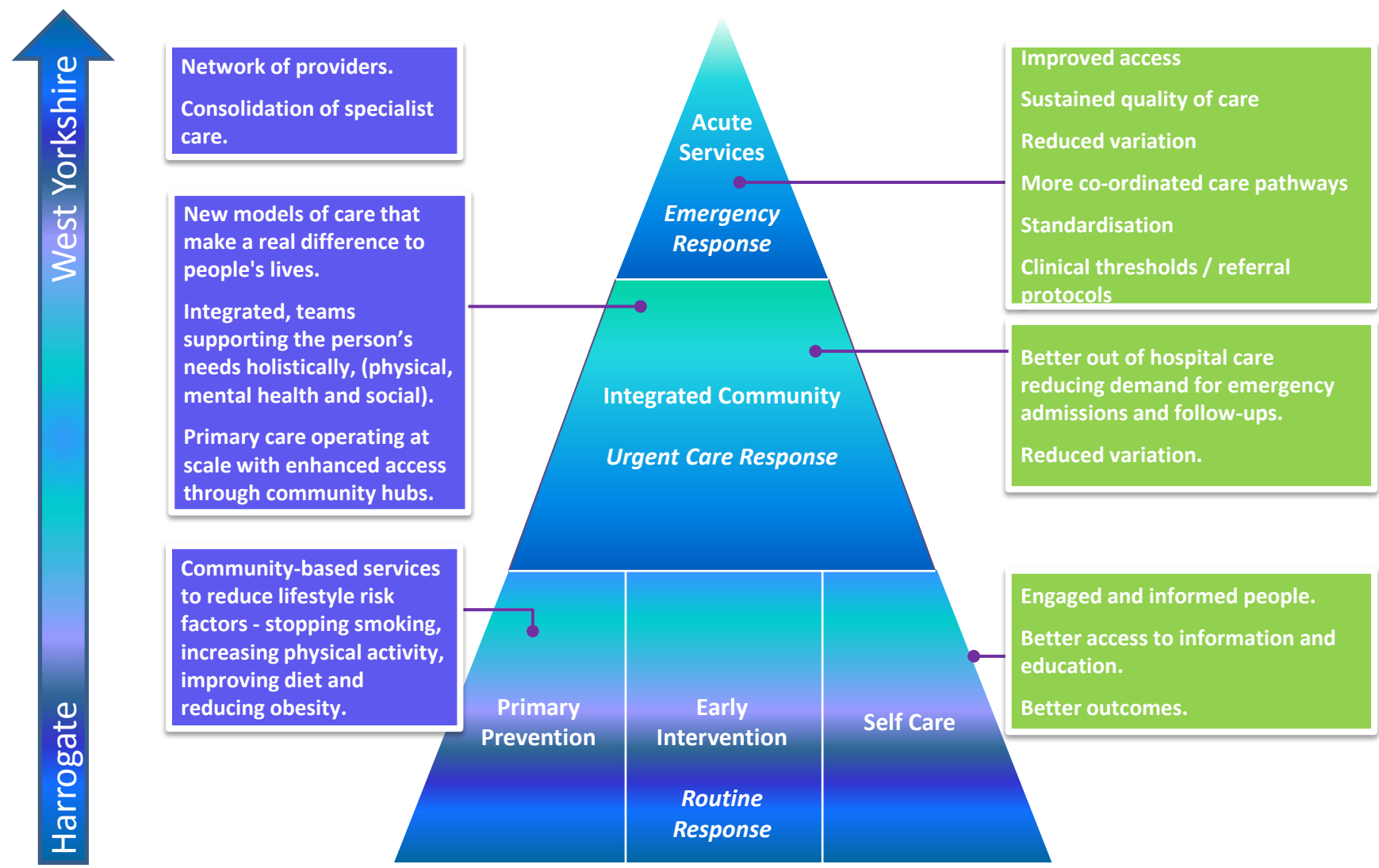
Our Harrogate and Rural District Priorities

- **New Care Model:** ‘What Matters to Us’
- **Prevention is Better Than Cure**
- **Primary Care Transformation**
 - 10 High Impact Actions to Release time to Care
 - Primary Care at Scale
 - Enhanced Access
- **RightCare:**
- **Mental Health**
 - Early Intervention Psychosis
 - Improving Access to Psychological Therapies
 - Local Transformation Plans for Children and Young People
 - Dementia
 - Building the Right Support
- **Cancer**
 - Prevention: Promoting lifestyle changes
 - Maximising screening uptake
 - Supporting early diagnosis of cancer
 - Living With and Beyond Cancer
- **Stroke**
 - Prevention: Promoting lifestyle changes
 - Hypertension
 - Atrial Fibrillation
 - Early Supported Discharge
- **Integrated Urgent Care**
- **Integrated Health and Social Care Commissioning and Service Delivery**
- **Finance and Efficiency**

Our Enablers

- Digital Transformation
- Workforce
- Estate and Assets

3 Our Priorities – Where will we be in five years time?



3.1 Our Priorities – New Care Model ‘What Matters to Us’

Our New Care Model will dissolve the boundaries between primary, community, acute, mental health and social care services locally. Existing clinical teams will come together and operate as a single team around the person (and their carers) whilst also embracing the benefits of both community and voluntary organisations to enhance local services.

We are transforming the experience of care, underpinned by:

- Integrated, expanded community-based teams capable of supporting the person’s needs holistically, including their physical, mental health and social needs. Our touchstones are person-centred and led care, care optimised through proactive management, and people supported to manage their conditions in the way that suits them and are enabled to self-care.
- More capacity and enhanced skills to respond rapidly when a person is very unwell and to support them at home whenever this is safe.
- Prevention and early intervention are embedded in our community in collaboration with an empowered and active voluntary sector.
- Development of a needs-based information portal to help people and professionals navigate and explore services, in particular those of the voluntary sector, to help maximise independence and self care.
- We are investing in IT to create a sustainable infrastructure that will enable integrated assessment and care planning and monitoring of costs and quality indicators across the entire health and social care system.

This will be achieved through case-finding and optimization of care at home and a rapid response service which will divert admissions and provide intensive support, including overnight care. We have also opened additional community beds to provide step-up intermediate care as an alternative to non-elective admissions.

Our immediate priorities include:

- **Community Geriatrician** appointed to provide high level clinical

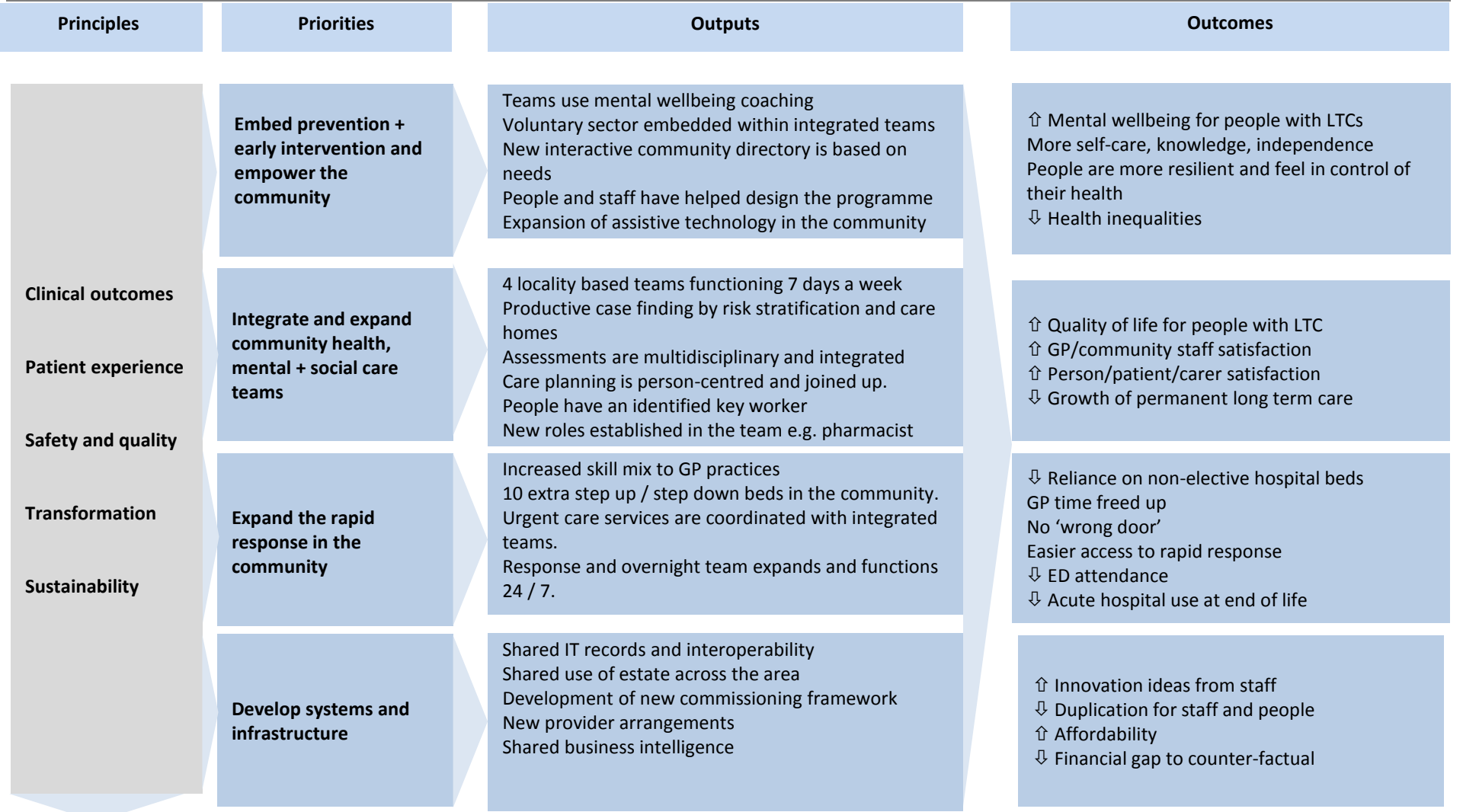
management and optimised care of frail older people.

- Establish **Local Integrated Teams** with mental health nurses and social care staff as well as District Nurses and the voluntary and community sector working together to address person needs in the community in collaboration with GPs .
- Package of **primary care** resources, including practice-based pharmacy support, developed to free up GP time to allow GPs to collaborate with Local Integrated Teams, Response and Overnight Service and community beds to keep their patients safe and well in the community.
- **Response and overnight team** expands and functions 24/7 across the district.
- Establishing and managing **community beds** that provide wrap around care and rehabilitation as an alternative to acute hospital based care .
- Implement the ‘**Calderdale Framework**’ process to support the identification of opportunities to reduce duplication and streamline services in our community health and care system
- Giving stability to the residential and nursing care market by agreeing fee structure up to 2020 and improving healthcare support to providers through primary care.
- Improved **end of life care** in the community recognising how improvements in end-of life care can have a high impact on patient experience as well as the experience of family members and carer - offering a gold standard of care for people with a serious illness who may be in their last year of life. We want to develop a single point of contact for help and advice that patients and their carers can access 24 / 7 – supporting people in their preferred place of care wherever possible.

We anticipate that the implementation of the new care model will reduce non-elective admissions by 16% by 2020/21 and A&E attendances by 11% by 2018/19.

3.1 Our Priorities New Care Model - What Matters to Us

Rationale: Care is not joined up; 1 in 5 acute admissions could be managed in less acute setting; 2 in 3 acute beds occupied by people whose needs could be met in a less acute environment; lack of capacity in community and primary care settings resulting in not enough 'time to care' ; avoidable admissions to long term social care; duplication between teams; gaps between services; lack of continuity of care; high demand for admission; uneven care home provision; system sustainability; people tell us they want to tell their story once and have a truly seamless services ; need for parity of esteem between mental health and rest



Enablers: Quality Transitional funding Co-production Technology Workforce System Leadership

3.2 Our Priorities – Prevention is Better Than Cure

The purpose of this work stream is to develop an integrated approach to prevention as part of the new model of care. Prevention, as a theme, flows through the whole model: we are interested in preventing inappropriate use of services, avoidable growth in demand and unnecessary dependence on services. Our new care model aims to deliver the right care in the right part of an integrated system, as close to home as possible, with admission to hospital only when it is really necessary. Our Local Integrated Teams are developing their approach to proactive case management to prevent avoidable escalation of people's long-term conditions and our Response and Overnight Service and community step-up beds will have a direct impact on preventing avoidable unplanned admissions.

This work stream, however, is concerned specifically with earlier interventions that support people and communities to stay healthy, well and independent, intervening before more intensive interventions from statutory health and care services are required. The intention is to reduce or delay this, and in some scenarios, prevent it altogether. The work stream will also develop the local approach to supporting people to become more active participants in keeping well and in managing their own health, particularly when they have long-term conditions.

Our approach is as follows:

- Mapping of existing commissioning activity across partners in relation to prevention services: identification of gaps, overlaps and duplication.
- Mapping of the total expenditure across the partners on prevention

activities, including grants.

- Review of the available evidence of the impact of existing schemes.
- Review of the available national evidence of approaches to prevention that have greatest impact on health and wellbeing.
- Development of a clear set of shared commissioning priorities.
- Joint commissioning of a suite of prevention schemes.
- Decommissioning of schemes that do not contribute to the shared priorities and which do not demonstrate a return on investment.
- Establish an approach to evaluation that is able to provide the partnership with performance information on outcomes, quality and value for money/return on investment.

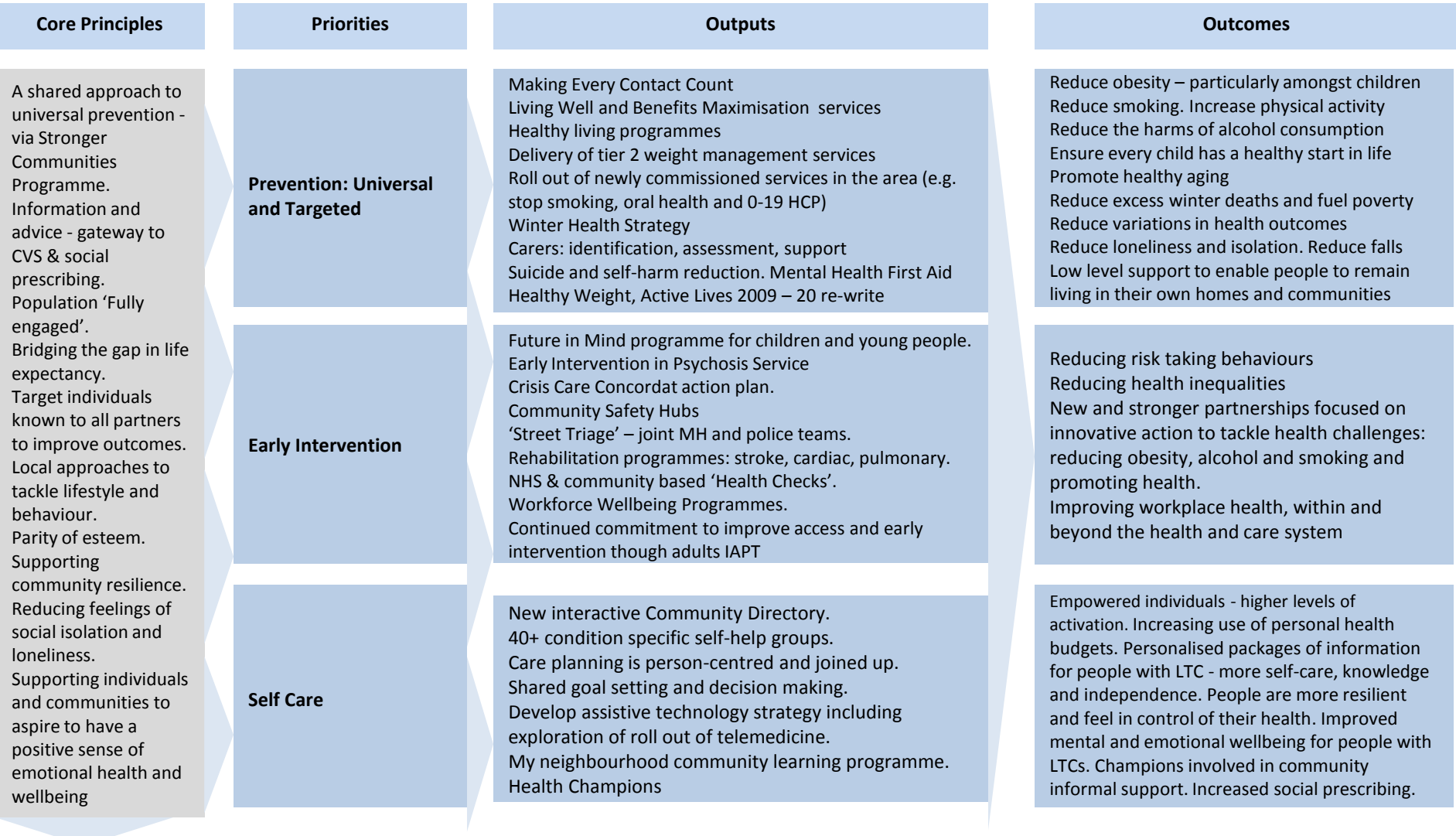
We recognise that the wider determinants of health, such as housing, access to activity and avoiding social isolation are key to the health and wellbeing of our local population. Our first priority is targeting falls: instead of taking a medical model approach to this, Harrogate Borough Council services including their Independent Living Service (sheltered housing support) and sport and leisure, as well as a wide range of voluntary and community sector organisations and therapy services, will be working together to develop a coordinated and proportionate response to falls as well as focusing on keeping people fit and mobile.

We are also linking voluntary and community services to our Locality Integrated Teams to support the development of priority areas such as:

- Frailty.
- Loneliness and social isolation.
- Supporting self-care and patient activation.

3.2 Our Priorities – Prevention is Better Than Cure

Rationale: : NHS, local government and the third sector have a role to play in building confident and connected communities, where everyone, but especially those at highest health risk, can tap into social support and social networks, have a voice in shaping services and are able to play an active part in community life. We want to use community-centred approaches as a tool to consider potential options for commissioning health improvement and preventive services



Enablers: System Leadership Engagement Technology Workforce Estate